Independent Health provider well-led assessment

Priory Group

Date of inspection: 1 September to 24 September 2022

Our findings

Overall summary

Inspected but not rated

This report describes our judgement of the quality of care given by this registered provider of health and social care. It is based on a combination of what we found when we carried out a reactive provider well-led assessment, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations. The assessment focused on how well-led the organisation is, looking at leadership and management, governance, quality assurance and continuous improvement, to ensure the delivery of safe, high quality services.

We have not rated this provider as part of this assessment as this is not part of the current methodology for independent health care providers.

We found that whilst there were areas for improvement, Priory was mostly aware of them and was already introducing changes.

We found a number of areas where significantly more work was needed:

- At the time of the inspection staff turnover across the organisation was extremely high at 40%. In some services this was having an impact on the quality and safety of care delivered. Priory was very aware of this challenge and correctly identified this as a high risk for the organisation and they had reinstated their workforce committee. They had made changes such as improving the pay of their healthcare assistants, support workers, nurses and psychologists. They were appointing a director for talent acquisition but there was not a clear approach for ensuring that they fully understood the reasons for the turnover and were systematically making improvements.

- Co-production at a provider level with people who use services and their carers needed more development and focus. We saw service user involvement and feedback taking place at most individual services. At an organisational level Priory undertook surveys to get feedback from people who use their services. However, a co-production approach was not embedded across the organisation. For example, people who use services were not routinely involved in staff recruitment, staff training, organisational delivery of quality assurance, quality improvement and research. The employment of peer support workers and people with lived experience was not widely implemented.

- The arrangements for staff to speak up was not working as it should be. This meant there was a risk of the senior leadership team not knowing about things that got in the way of staff doing a good job and delivering high quality care. The current freedom to speak up

guardian had other significant responsibilities, meaning this function did not have the focus it required. The number of contacts by staff across the organisation with the speak up guardian was low. Priory had not explored different models for how the speak up arrangements could be delivered effectively across its services.

We found a number of areas where there had been considerable progress but there was more to do:

- Priory recognised that a continuous quality improvement approach had not been the focus whilst the integration with MEDIAN took place and the new governance structures were established and introduced. There was an understanding of the benefits this could bring to the organisation. A quality improvement approach was better established within the adult care division, and further work was now needed to introduce this in a more systemic way to the healthcare division. Priory was working with a quality improvement academy to promote this development.

- Priory recognised that further work was needed to ensure that they created a diverse and inclusive environment for their staff and people who use their services. Priory was reviewing its equality and diversity strategy and had sought external expert advice on areas for improvement. They recognised that the quality of the data they collected to understand the experiences of employees from black and minority ethnic backgrounds needed to be improved. Priory also acknowledged that there were eight staff networks that needed to be strengthened. Further work was needed to promote equality and inclusion amongst patients and the experience of specific patient groups was not routinely explored.

- The well led review took place at a time of significant digital investment and transformation within the organisation with an initial focus of introducing electronic records for people using adult care services. It was recognised that this program which would take at least a couple of years to deliver would dramatically improve the availability of live data across the organisation. The inspection found that Priory had access to a lot of data which was used to inform the governance processes. Some of this would benefit from better presentation so it would be possible to see trends over time. Some data was presented without analysis and when the information raised concerns there was not always a summary of how these were being addressed.

- Staff we spoke with recognised that morale in the senior leadership team was high, but this was variable across different sites. Priory had introduced staff engagement leads and sites were offered specific support around morale. Learning was taking place at locations where morale was high, in order to share any good practice. Priory had a vision, strategy, values and behaviours but recognised that the vision and strategy would take time to embed within an organisation of their size.

- Allied health professionals were not clearly represented on the operational leadership team. This meant they may not be able to influence strategic decisions. However, those professionals did have access to clinical training and supervision. Medical and nursing had leadership arrangements in place throughout the organisation.

- Work had started on several enabling strategies to deliver the organisational strategy. The completion of this work with the appropriate level of engagement was needed to ensure the effective implementation of the strategy. Outcome measures were also in development to allow progress to be monitored.

- Priory knew that they could make improvements to their risk register. The risks were not described as clearly as they could have been and the mitigations and controls were often very general in nature. As such it was difficult to see how the top corporate risks were getting managed to a reasonable level. Work was also needed to ensure that risks from sites were appropriately escalated.

- The recording of safeguarding incidents needed to be improved. There was a risk that safeguarding incidents might not be correctly escalated and feed into decisions about which services needed enhanced support. Work was ongoing to ensure all information relating to safeguarding was recorded appropriately on the incident reporting system. At the time of the well-led assessment, staff used both the incident reporting system and a separate safeguarding log to record information. This had been identified by the head of safeguarding as an area of focus.

- The Mental Health Units (Use of Force) Act 2018 was commenced on 31st March 2022. Priory had developed a policy outlining how the provider would comply with the Act and allocated a responsible person for the Act. However, there were some omissions in the policy which needed to be addressed.

- The recording system in place to ensure the executive team had the necessary fit and proper person checks in place was not as effective as it should be. These checks provide assurance that people were suitable and fit to undertake the responsibilities of their role. Paperwork we reviewed for three operational board members did not contain all the relevant documents required.

We found a number of areas where the provider was performing well:

- Priory had developed a governance structure to create clear lines of accountability and reporting within two divisions. Some senior roles spanned both divisions, so that learning and good practice could be identified and shared across them. Staff understood the governance processes and recognised the value of more joined up working between the healthcare and adult social care divisions. There were examples of adult social care services developing to support the discharge of patients from hospital.

- A number of the senior leadership team had worked in the organisation or legacy providers for several years. This provided good continuity in terms of the knowledge of divisions and services. Senior leaders told us they worked well together and had quickly established a positive culture. We did observe positive professional relationships.

- A lot of the staff we spoke with during the well-led assessment said they were very proud to work for the organisation. They spoke positively about the chief executive and the changes they had implemented already. They also said the integration with MEDIAN had had a positive impact on the provider as a whole and MEDIAN supported several important initiatives. For example, becoming a more data driven organisation supported by well-functioning information technology systems.

- Priory had recognised the benefit of non-executive directors and had recruited two who joined the organisation in June 2022. We saw this was driving a culture of constructive, professional challenge and discussion. Feedback from non-executive directors had already been used to implement changes.

- Learning and development was promoted across the organisation. There was a learning and development lead who had responsibility for maintaining high quality essential training

and development of learning to support staff working in pathways to have the necessary skills and knowledge.

- The organisation used internal conferences and awards ceremonies to recognise the hard work of their staff and share good practice. Staff we spoke with told us about the benefits of these types of events. Priory had put on a Priory Awards Ceremony in September 2022 and given awards to several of their services and individual staff members. For example, for 'acting with integrity', 'being supportive', 'newcomer of the year', 'site of the year' and many more. There were photographs and videos made of the event so it could be shared with those who were unable to attend.

- Priory used several methods to identify for themselves, areas or services that needed additional input and support to improve quality of care. This included an internal compliance team, an annual review cycle and partnership working with external organisation that provided specific services, such a medicines audit. In March 2022, a patient safety team came into effect, led by an associate director of patient safety and experience. A patient safety lead had been established at each site.

- The provider had effective systems in place to monitor the use of medicines and medicine optimisation across the organisation.

- Priory was working effectively in partnership with external stakeholders. They were an active partner in 22 provider collaboratives. They met regularly with commissioners to develop an understanding of the challenges within the systems and services needed to meet the needs of the population at a local level.

- There was oversight of the operation of the Mental Health Act 1983, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The provider had regional MHA administrator leads and a specialist MHA legal advisor.

- Priory had participated in a number of research projects over the last 2 years and following the integration with MEDIAN, a 3-year research plan has been created by the executive medical director.

Background to Priory Group

Priory was founded in 1980 with the purchase of a hospital site. Over the next decade, Priory acquired more hospitals and diversified its services. In 2015, Priory acquired Life Works, an addiction and mental health hospital and Progress Care. In February 2016, Priory became part of Acadia Healthcare, a worldwide provider of behavioural care. In November 2016, Priory merged with Partnerships in Care, which was owned by Acadia and resulted in 66 sites and 1,890 beds joining Priory. In January 2021, Priory was acquired by Waterland Private Equity. Waterland had existing companies, including MEDIAN, which is Germany's largest provider of rehabilitation, neurology and orthopaedic treatments. In July 2021, Waterland unified Priory and MEDIAN operations.

Priory comprises of a healthcare and adult care division. Priory employs 14,800 staff in England and supports approximately 35,000 service users every year.

Priory has services in Wales, Scotland and Northern Ireland, but we are not carrying out an assessment of these services as they are regulated by other national bodies.

At the time of the inspection, Priory was registered to provide care at 63 hospital locations and 208 adult social care locations. The hospital locations provide a range of mental health services for

adults and children, including psychiatric intensive care, high dependency care, acute mental health wards, brain injury services, eating disorder services, rehabilitation and recovery services and secure services. The adult social care locations include specialist residential services, supported living services and older people's care services.

Specialist residential services provide residential and supported living services for people over 18 with a learning disability, autism, brain injury, Prader-Willi Syndrome, behaviours that challenge or a mental health condition. Supported living services help people live independently in their local community.

Older People's care services include services for residential care, care homes with or without nursing and personal care, dementia care, respite care, day care, end of life care and mental health care.

A breakdown of the adult social care sites that were registered with the Care Quality Commission (CQC) were as follows:

- Acquired brain injury services
- Autism services
- Learning disability services
- Mental health services
- Older people services
- Prader-Willi Syndrome services
- Supported living services
- Five dormant sites

A breakdown of Healthcare sites that were registered were as follows:

- Mental health hospitals. Including those for the treatment of depression, anxiety, stress, obsessive compulsive disorder, post traumatic stress disorder, eating disorders, secure services, rehabilitation and recovery, brain injury and young people's services.
- Hospitals providing addiction treatment programmes
- Wellbeing centres
- Four dormant sites

At the time of our inspection, the overall breakdown of Care Quality Commission ratings of Priory locations was as follows.

In adult care:

7 outstanding (3%)

169 Good (81%)

28 requires improvement (13%)

1 inadequate (less than 1%)

3 (1%) that were not currently rated

In hospitals:

4 outstanding (6%)

42 good (67%)

12 requires improvement (19%)

4 inadequate (6%)

1 not rated (2%)

Analysis of the ‘must do’ actions in the inspection reports for all inspections between June 2018 and May 2022 for all Priory locations found that the regulations with the most frequent breaches were as follows (from 20 adult social care locations and 34 hospital locations):

- 37 breaches of Regulation 12: Safe care and treatment
- 10 breaches of Regulation 9: Person Centred Care
- 8 breaches of Regulation 13: Safeguarding service users from abuse and improper treatment
- 6 breaches of Regulation 10: Dignity and Respect

Analysis of issues identified in 21 Mental Health Act monitoring reports that took place between August 2021 and July 2022 in Priory hospital locations registered to provide assessment or medical treatment for people detained under the Mental Health Act 1983, showed the following:

- 26 individual issues with Section 132 rights for patients
- 21 individual issues with Section 17 leave paperwork

Our inspection Team

The team included a head of hospital inspection for mental health, a head of hospital inspection for adult social care, one inspection manager, two inspectors with a specialist portfolio of independent health providers, two inspectors from the adult social care directorate, a Mental Health Act reviewer, a pharmacy inspector, an analyst team leader, and a senior analyst. The team was advised by three executive reviewers who are senior leaders in their own organisations. The executive reviewers came from the NHS and independent health sector. Their roles within their organisations were as chair, chief executive officer and governance lead.

How we carried out the inspection

We carried out the following activities as part of this well-led assessment:

- A Care Quality Commission led survey of Priory staff completed by 1,352 people (15% of Priory staff)
- A survey of Care Quality Commission inspectors with a Priory service on their portfolio
- A request for information used by Priory as part of their day to day operations
- An observation of a corporate clinical governance meeting
- An observation of an operational board meeting
- Focus groups with Priory staff attended by 100 people
- Interviews with 21 leaders within Priory
- An interview with a senior leader from MEDIAN Group

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

Why we carried out this inspection

We conducted a well-led assessment of Priory as part of our risk-led schedule of independent health provider well-led assessments. Priory was selected due to its inherent risk of caring for a range of vulnerable people with complex care needs.

Areas for improvement

Action the provider MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the provider MUST take to improve:

- The provider must work systematically to understand the reasons for high staff turnover and make changes which lead to a significant reduction to ensure services have enough permanent staff with the appropriate skills and experience to deliver consistently high quality care and treatment. (Regulation 18: Staffing)

- The provider must ensure that a culture where staff are encouraged and supported to speak up is continuously promoted and that the systems and processes are in place to support staff to do this. This would enable the provider to receive and act on feedback from staff to continually evaluate and improve the services. (Regulation 17: Good governance)

- The provider must continue to strengthen its coproduction with people who use services and their families/carers. This will ensure that care and treatment is designed to meet the preferences of the service users and meets their needs. (Regulation 9: Person-centred care)

Action the provider SHOULD take to improve:

- The provider should continue to develop its enabling strategies with an appropriate level of engagement. The associated outcome measures should also be in place so progress can be monitored. The provider should continue to use and embed the strategy so that it is clearly understood and used by staff.

- The provider should continue to improve its oversight of diversity, equality and inclusion both within its staff group and service-user population and use this information to make tangible changes to how equality and inclusion are understood and promoted as part of the culture of the organisation.

- The provider should continue to develop and embed its quality improvement approach and ensure this is widely embedded with the associated cultural shift with a specific focus on the healthcare division.

- The provider should continue its digital transformation with the aim of having live data to monitor the quality of the sites and the outcomes for service users. The provider should also continue to improve how data is presented and analysed to support current governance processes.

- The provider should continue to identify sites with lower staff morale and take steps to improve the culture of the team.

- The provider should take the steps to ensure allied health professionals including social workers are appropriately represented by the senior leadership so they can have input into strategic decision making.

- The provider should continue the work to ensure safeguarding incidents are appropriately feeding into the data for governance processes to ensure they correctly help inform the sites where more support is needed.

- The provider should update and strengthen its overall approach to the management of corporate risk so as to ensure the top risks are clearly identified, monitored, controlled and mitigated.

- The provider should continue to promote learning from incidents across services, with the focus on informing front line staff and reducing the same types of incidents being repeated.

- The provider should review its policy for the Mental Health Units (Use of Force) Act 2018 to ensure it has been developed appropriately and includes all the necessary guidance.

- The provider should continue its work to support staff and service users to engage in research projects and have an ongoing program of research projects across the organisation.

- The provider should ensure the recording system for paperwork showing the executive team have the necessary fit and proper person checks in place is effective.

Is this organisation well-led?

Inspected but not rated

We did not rate the provider at this inspection.

Vision and Strategy

- Priory had a vision which was to become the leading European provider of high-quality mental health and medical rehabilitative services.

- At the time of the well-led assessment, Priory had developed a new high-level strategy that was yet to be fully embedded. The organisation was planning to formally launch the strategy in early 2023. The strategy document stated the organisational purpose of supporting people to 'Live your life'. The strategy had five key values which were 'people first; supportive; integrity; positive; excellence'. The strategy reflected the wider challenges for providers operating in the current health and social care landscape. At the time of the inspection more work was needed to bring the strategy to life across the organisation as the people who were interviewed or joined focus groups did not refer to the strategy.

- Priory was developing the enabling strategies needed to operationalise the organisational strategy and measure its progress. The strategy document listed seven strategic goals for the organisation for 2022 to 2025 which were developed when Priory joined MEDIAN. There was a commitment to developing outcome measures and ensuring these were regularly reviewed but these were not yet in place. Priory recognised the need to ensure that the development of the enabling strategies was done in partnership with people who use services, families, staff and other stakeholders. Priory intended for the strategic goals to be embedded within their governance arrangements but at the time of the inspection the papers presented at the governance meetings did not demonstrate clear alignment to the strategic goals.

- Priory was also working strategically to improve its clinical care and treatment within the healthcare division. The focus of this work was to develop updated operating frameworks with clear outcome measures for patients accessing specific care pathways. This work linked to current evidence based best practice. The use of data feeding into dashboards identified areas for development. At the time of the inspection the care pathways with outcome measures had been developed for the acute, forensic and eating disorder services and were in development for psychiatric intensive care, rehabilitation services and CAMHS.

- Priory recognised that there were strategic benefits to the healthcare and adult social care services working more closely together. For example, they recognised that they could support the pathways for patients discharged from hospital to move into social care with opportunities for more independent living. Some services including some individual bespoke placements had already been developed in partnership with external stakeholders such as provider collaboratives.

- There was a nursing strategy in place that was due for review in 2022 and needed updating to reflect the current nursing structures, staff in senior positions and the refreshed recruitment and retention approach.

- Priory worked collaboratively with external stakeholders. Priory was an active partner in 22 provider collaboratives. There were formal agreements in place with commissioners and regular meetings to build a shared understanding of the challenges within the systems and services needed to meet the needs of the population in different areas. Priory has adapted well to the introduction of integrated care boards and rolled training out to their staff to update them on changes. In response to the introduction of integrated care boards, Priory created an organisational wide system to manage information about referrals and patients within their care. Staff we spoke with said since Priory had merged with MEDIAN, there was more autonomy at site level around decisions, including in relation to the appropriateness of referrals, and this had a positive impact on quality of care and experience of the patients already being cared for at a site.

Leadership

- The Priory UK operational leadership team had several members who were recently appointed, but the inspection found they had the necessary range of skills and experience and were working effectively together. The chief executive and other operational leaders had come into post from 2021. Following the integration of MEDIAN and Priory operations in July 2021 the Priory UK operational leadership team had been reconfigured. Some roles had been changed with a revised portfolio. Most members of the operational leadership team had worked for the provider in different roles and so had knowledge of the organisation and services provided.

- Individual members of the Priory UK operational leadership team were able to describe their areas of responsibility. They all had significant areas of work they were responsible for delivering. There was a recognition that further work was needed to ensure clarity of roles and avoid unnecessary duplication. For example, some of the work on patient safety led by one associate director had significant overlap with the work led by the director of risk management who had oversight of incidents and the themes coming from these. The provider was aware of this and the need to keep the structure and portfolios responsibilities under review.

- The Priory UK chief executive had worked in Priory for 10 years and was appointed to this role in November 2021. They had a professional nursing background and had held the roles of director of quality in Priory Healthcare, Priory Group director of performance and regulation and chief operating officer for Priory adult care, prior to their appointment as chief executive. The chief executive was well known across the organisation and staff we spoke with described them as being very accessible.

- The MEDIAN chief executive, chief finance officer and chief operating officer were actively involved in the leadership of the Priory UK operational leadership team. Some leaders in the UK team reported directly to them. This included the UK director of finance, director of IT, director of estates and facilities, marketing director, general counsel and company secretary (including legal services and risk management) and director of strategy. At the time of the inspection the Priory UK chief executive had 11 direct line management reports. This included the managing directors in the healthcare and adult care division. The provider had recognised and considered the potential impact of having this many reports on the capacity of the chief executive to focus on the strategic development of the organisation.

However, MEDIANs approach was based on a flat management structure with strong connections to services. The Priory UK chief executive was supporting the healthcare and adult care managing directors to be more autonomous facilitated by improved data from services linked to digital transformation to provide up to date information on service delivery.

- The senior leaders we spoke with were proud to work at Priory. They reported that the chief executives appointment had been positive. They felt well supported by MEDIAN and the Priory UK operational leadership team.

- The lead nurse within the organisation held the role of chief quality officer. This role had evolved over the last 12 months to include the quality lead role which spanned both the healthcare and adult care division. The chief quality officer had worked within the organisation for a number of years and started this role in June 2022. The chief quality officer was the nursing professional lead and the lead for allied health professionals. They were the executive lead for safeguarding and infection prevention and control. They line managed the head of safeguarding and a lead for infection prevention and control.

- The nurse leadership had been strengthened across the organisation. The chief quality officer had established regional quality leads and teams within the healthcare and adult care divisions who led on embedding quality and patient safety work throughout the organisation. Other new roles had developed offering opportunities for nurses to develop their career. This included roles in operational management, learning and development including supporting the development of the nurse apprenticeship programmes. At the time of the well-led assessment, the provider was supporting 175 nurse apprentices and 20 nursing staff to access advanced nurse practitioner programmes.

- Within the organisation there were lead therapy roles, who had responsibility for professional leadership and development. Staff told us that the development of these roles was an area of focus at the time of the well-led assessment, as it was recognised that the representation of allied health professionals including social workers was not yet sufficient on the Priory UK leadership team.

- Priory had two non-executive directors that had joined the organisation in June 2022. The role of a non-executive director is to be an independent advisor, help a company achieve its goals and gather assurance on the quality of services through expert, independent challenge. The non-executive directors had careers as senior leaders, one within the NHS in England and one within audit and governance in several health, social care, housing and private sector organisations. The non-executive directors attended the healthcare and adult care operating boards and the quality assurance committee. We saw that their presence in these meetings brought constructive challenge and discussion, where other attendees did not. We noted that where they had previously raised areas for consideration and development, the organisation had responded positively and proactively. There was more work to do to develop the collective culture of constructive challenge within senior meetings.

- Priory had two divisions. These were healthcare and adult care. Each of the divisions had a senior leadership team and site leadership teams. Staff we spoke with at a senior and site level were aware of the recent changes to governance structures and spoke confidently about how they supported this work. The regional leads across healthcare and adult care

were observed throughout the well-led assessment to have a good understanding of their roles and were able to describe how they were identifying and addressing challenges and working to provide a high standard of care. Several staff mentioned how proud they were to work for Priory.

- Members of the board and operational leadership team carried out regular visits to sites. These were part of a scheduled plan or organised in response to a particular risk or positive work at a site. We heard how issues were fed back following the visits.

- Priory offered staff a range of development opportunities across all staffing levels and many of the senior leaders we spoke with had progressed within the organisation. The leadership opportunities included formal training and support to access university courses. Priory offered nurse training places to unqualified healthcare workers and supported clinical and non-clinical staff to access undergraduate and master's degree education. Priory held preceptorship academy training for newly qualified nurses to support their development. There were apprenticeships available for occupational therapists. The organisation had also supported a previous service user who wanted to work within the organisation and had recognised their professional development at a recent Priory awards event. Priory supported informal leadership and career development opportunities by allowing staff to move to new roles within the organisation to support their personal and professional development.

- The recording system in place to ensure the executive team had the necessary fit and proper person checks was not as effective as it should be. Paperwork we reviewed during the inspection for three operational board members did not contain all the relevant checks and documents required. However, evidence of these checks was supplied by the provider soon after the inspection. Two of the three records we looked at showed the staff member had a standard criminal record check in place, rather than an enhanced check, which appeared inconsistent with the provider policy. We queried this with the provider who confirmed that in their view, standard checks only were required for the two individuals, but in the interests of consistency, enhanced checks would be carried out. The fit and proper persons policy was refreshed in August 2022 and due for review in 2025. These checks provide assurance that people were suitable and fit to undertake the responsibilities their role.

- Priory recognised the need to have more formal succession planning in place. The company secretary had work planned with the non-executive directors to develop the measure of board effectiveness, with formal succession planning included in this remit.

Culture

- The Priory operational leadership team were working to improve the culture across the organisation. Priory's new vision and strategy were not yet fully embedded within the organisational culture and we did not hear staff talking about them during the interviews and focus groups. The morale and culture amongst the senior leaders were positive. They recognised that across the organisation, there were services where staff morale was low and they were working to provide additional support. Notable responses that Priory staff gave to the survey conducted by CQC as part of the well-led assessment included 65% (873 of 1352) saying they were proud to work for the organisation (15% saying they were

not proud and 20% saying they were neither), 61% (825 of 1352) saying they recommended this as a place to work (19% did not and 20% saying neither agree or disagree) and 76% (1158 of 1352) saying the organisation acts fairly towards staff regardless of protected characteristics (5% disagreed and 9% neither agreed or disagreed). Where morale was known to be high at sites, senior staff gathered information to share learning to enhance this at other sites.

- Staff we spoke with who held senior roles at site level said there had been a positive change in culture in the last two years and since the new chief executive had been in place. They described a change to a collegiate way of working from a previous command and control approach. They commented that leaders knew staff across the sites by name and had an open and transparent approach to their work.

- The executive and operational leadership teams used several methods to communicate with staff across the organisation. This included sharing information on the staff intranet, a good practice and innovation bulletin sent out each month and a weekly phone call where information was cascaded verbally across the organisation. This was particularly important for those members of staff who did not need an email address to do their job. The chief executive posted a weekly blog on the staff intranet. There were also regional staff 'your say' forums with representatives in individual services.

- In the healthcare division, during the Covid 19 pandemic, a weekly meeting with hospital directors was introduced to enhance the contact and support they had with senior staff during a challenging time. These had remained in place to allow a space for directors from different sites to meet regularly to access peer support and share learning and good practice.

- Staff we spoke with said the organisational wide conferences available to staff at different levels were positive and provided opportunities for strategic and operational developments to be discussed in an open forum.

- The provider did not use the annual staff survey as effectively as possible to understand its staff and respond to their needs. In the last Priory staff survey in 2021 there were limited questions about specific cultural issues such as bullying or issues relating to equality, diversity and inclusion. This meant the board relied on staff speaking up about this in other ways and did not have an organisational picture of these issues year on year. In the CQC survey of Priory staff, 15% (209 of 1352) said they had experienced bullying, harassment or abuse at work from a colleague in the last 12 months. Eleven per cent of people (151 of 1352) said in their CQC survey replies, that if they had experienced bullying, harassment or abuse from a colleague, they did not report this. The Priory staff survey did not ask about this in detail, meaning the organisation missed an opportunity to learn more about these cultural issues to help them address these concerns. Priory produced an action plan in response to their staff survey results, but this was not very robust. For example, the 2021 survey showed that 7% (431 of 6169) of staff said they did not have access to the training they needed to do their job well. This was not directly addressed in the survey action plan.

- The provider had not taken the opportunity to sufficiently understand the high levels of turnover within the organisation and why staff were leaving. This limited the effectiveness

and responsiveness of their retention plan. There was limited information on how often exit interviews were being carried out, who was conducting them and how the information was collated to inform the board of staff experience and reasons for leaving.

- There was scope to further strengthen the culture of speaking up at Priory. Most staff who responded to the CQC staff survey reported a culture of being encouraged to speak up and report incidents and concerns. Eighty-six per cent (1163 of 1352) of staff agreed that the organisation encouraged staff to report all concerns (6% did not and 8% neither agreed or disagreed). However, the CQC survey sent to Priory staff highlighted that 21% (134) of the 649 staff who responded to the question said they would not feel comfortable or safe to report a concern without fear of what would happen as a result. Further written feedback from some of these staff said that they felt unable to speak up due to favouritism, cliques or known friend and family connections between colleagues. Staff were able to speak with their managers, use a whistleblowing line or inbox or contact the chief executive directly if they wanted to raise a concern. We reviewed the Priory whistleblowing data from January to July 2022 and found the areas raised reflected those shared with the CQC from staff and patients through the 'share your experience' function. As part of this inspection we analysed the themes from 194 'give feedback on care' submissions from the past 12 months, 78 were from staff. The concerns from staff were mainly about staffing issues and staff not feeling valued.

- Priory recognised that the speak up guardian role was not yet adequately developed across the organisation. The current speak up guardian undertook this role on top of an already very demanding job and did not have the necessary capacity. The provider had not explored the different ways in which this role could be delivered to identify the one which would work best for the organisation. This meant there was a risk that staff may not feel safe or empowered to escalate concerns and the organisation will not be able to learn from this and make improvements.

- Work to address risks of closed cultures at specific sites was ongoing. The provider had completed a closed cultural audit tool based on the Care Quality Commission's closed culture guidance at all its sites and had plans to build on this tool to develop it further.

- Oversight of whether the organisation's responsibility under the Duty of Candour was being effectively carried out needed to be strengthened. Duty of candour is a professional responsibility to be honest with patients when things go wrong, and there are required steps to take to ensure this happens. Compliance with this responsibility was not reported at the meeting minutes we saw during the well-led assessment.

- Priory had established ways in which to promote equality and inclusion for its staff and recognised there was more work to do in this area. In May 2022, the diversity and inclusion committee chair and director of communications and engagement set up a group to assess and understand the next phase of work to build on the diversity and inclusion strategy introduced in 2019. At the time of the well-led assessment, the group were considering the recommendations given to them from an independent party they had employed to assist them. Since 2019, Priory had developed eight active staff networks. These were a Black and minority ethnic (BME) staff network, an LGBTQ+ network, a women's network, men's network, parent's network, neurodiversity network, disability and difference network and a menopause network. Some networks had been established recently and been put together by staff who approached leaders with their idea. Staff we spoke with who were involved in

the networks said since the new chief executive had come into place, there had been a re-focus on equality and diversity as a priority. There was a dedicated email address for staff to use if they had information to share or questions to ask about diversity and inclusion. The equality, diversity and inclusion team had a calendar which outlined important dates. Information about upcoming events was sent out in staff reminders.

- In August 2022 the LGBT+ network lead organised for any Priory staff and patients who wanted to, to attend Chester Pride. Staff members and service users from different sites and areas travelled to the event to take part in the parade.

- There was scope for employee voice, especially from staff networks, to be more visible across the organisation. Information and feedback from staff networks was not routinely examined at board level meetings. Priory had not explored any cultural issues around people feeling able to join networks without worry of judgement from their colleagues or localised barriers to attending meetings. For example, having a manager support someone taking time to attend. Further work was needed to ensure diversity and inclusion was embedded consistently at different sites and in different geographies. There were no specific policies for promoting equality and inclusion amongst patients and the experience of specific patient groups was not routinely explored, for example, LGBT+ patients.

- The provider recognised the importance of staff wellbeing and was developing a wellbeing strategy. A range of wellbeing initiatives were available to staff. This included organisational wide initiatives as well as local site level initiatives. For example, wellbeing days, team quizzes and group walks. Priory used a colleague assistance provider and staff could access online resources and weekly online webinars that could be watched anytime. Information about this was shared at regular information cascades. The organisation was open to supporting staff in important initiatives. We saw an example where the organisation had matched the funds raised by staff to go towards a humanitarian crisis.

- Several people also spoke about the positive impact of the Priory awards ceremony, where staff were recognised for their contribution and hard work.

- Priory had a head of learning and development and a learning and development programme available to staff. Essential training and career development pathways were considered for staff groups. There was a clear list of mandatory training which was available using online and in-person courses. Training compliance rates were presented in governance meetings at the regional and divisional level. We saw that where compliance rates were below the required level, the data was checked and actions assigned at a senior level to achieve them. Where staff wished to access specific training outside of mandatory training, this was managed at site and service line level. Doctors across the organisation had an academy where they could request specific areas of learning.

Governance

- A clear framework set out the structure of service, division and senior staff meetings. Priory reviewed its governance structure in 2021 after the integration of Priory and MEDIAN operations. The new structure included operating boards for each division, one for healthcare and one for adult care. These were underpinned by regional and site level meetings, designed to ensure accountability. The revised governance arrangements had

streamlined several meetings. Alongside the operating boards was a Priory wide quality assurance committee. These fed into the Priory UK Board. Staff at all levels we spoke with understood the governance arrangements, their roles and responsibilities and what to escalate to a more senior person.

- The governance structure was designed to allow the Priory UK Board to have more strategic discussions whilst maintaining an overview of the key risks and developments. Detailed operational oversight sat with the chief executive and the managing directors in the two divisions. The operating board, quality assurance and UK board meetings were held monthly and fed into one another. Committees for specific subject areas had been established and fed into the board or the quality assurance committee. For example, the workforce committee, the suicide and self-harm committee and the safeguarding committee. The governance committees were still relatively new and needed be kept under review. Ongoing monitoring was required to ensure that the right people attended the different committees, that unnecessary overlaps were avoided and that the appropriate level of challenge was available particularly at the quality assurance committee.

- The governance processes were pulling together a range of data into a performance framework and enabling services where there were problems to be identified and for support to be put into place. For example, this considered changes in the leadership team at the service and whistle-blowing concerns. The operational information team were collecting feedback from staff about what other pieces of information would be useful to include in the framework. There was a recognition of the need to be mindful of potential closed cultures. Where needed services were offered enhanced support. Senior leaders and site staff, where possible, worked together to put an action plan in place with measurable outcomes and clear responsibility. Support would be provided by quality improvement leads and other staff within the regional and divisional structures. This would involve them either being on site or maintaining regular contact. We saw that site action plans were detailed, included appropriate actions to address a concern and it was clear who was responsible for the action and the progress against it. Where a site was deemed not able to deliver a safe service, Priory had taken the decision to close the service, on a temporary or permanent basis. For example, being unable to recruit permanent staff to the required posts.

- Some small improvements could be made board and committee papers to make them easier to access. Papers for meetings did not include information about who was the author, which executive was the lead for the area and how it linked to the strategic priorities. Not all documents had a contents page with page numbers for different papers, which did not make it easy to find information quickly. However, the agenda for operations boards and committee meetings made it clear whether the information included in the papers was for noting, for review, for discussion or for approval.

- Priory recognised that there was a need to improve access to timely data, showing trends over time with an appropriate level of analysis. For example, staff recruitment and retention were the greatest risk for the provider and data was presented to the Priory UK board for the last year but without any commentary on the key issues and how they were being addressed. Similarly, themes from whistle-blowing were presented without showing trends or how issues were being addressed. At the time of the well-led assessment a data strategy had been submitted to the board for review and sign off. This sought to formalise and

record the work being done around data use and quality assurance within the organisation, as well as align processes across the healthcare and adult care division. Feedback from staff was that MEDIAN were a data driven organisation and supported Priory initiatives in this area.

- Priory had recently re-launched a set of annual clinical and non-clinical audits and had a schedule covering 2022 and 2023 across both divisions. Examples included a safeguarding audit, ligature audit, observation audit, restrictive practice audit, infection control. Standardised tools had been developed and were issued centrally, so that all sites completed the audits within the same month. The results would be analysed and reported to the divisional clinical governance committee. Action plans for each site were developed depending on the outcome of the audits. We saw the results of these audits were presented at the quality assurance committee and outlined learning and recommendations. The information in the committee papers did not include who was responsible for ensuring these would be completed and whether the action plan would be brought back for review in future meetings.

- Senior leaders had carried out thematic reviews based on key risks identified from the data. These have included choking, falls, medicines errors, absconsion and restraint reduction. For the review into choking, all reported incidents were reviewed from a set period of time to establish how it was managed in the moment, whether there were appropriate referrals, what and if lessons were learned and how this information fed into the overall strategy. As a result of the review, the incident reporting system was updated to include a category for choking, as this was not in place before. This allowed data on choking incidents to be more visible and accessible quickly.

- Priory had introduced the roles of staff engagement leads that worked across regions and sites. They were able to spend time on sites to establish what was needed to improve staff experience and quality of patient care.

- An internal quality and compliance team visited sites to assess and report on quality of care being delivered at the site. The team identified areas for improvement and sites developed action plans to address any areas and encourage service improvement.

- Appropriate governance arrangements were in place in relation to the Mental Health Act (MHA) administration and compliance. The provider had regional MHA administrator leads and a specialist MHA legal advisor. The staff we met with had considerable expertise and experience in this area. The regional MHA administrator leads had an established system for support and communication for all MHA administrators across the organisation and said they could get legal advice swiftly when needed. All Priory staff were able to contact a MHA administrator using a central email, as well as face to face contact on sites. Where they had identified areas of development, the regional leads had plans in place to address this. For example, to formalise the process for information sharing for all MHA administrators in the organisation. The provider had supported adaptions to the electronic patient record system to include a tab for actions required under the MHA. This was to ensure staff read patients detained under the MHA their rights within 24 hours of admission, recorded their action and regularly reviewed patients' rights with them.

- MHA administrators used an electronic dashboard to collate all information needed to oversee compliance with the MHA. For example, the dates of review for each patient. This was also available to relevant clinical staff and was backed up by paper records in case of an electronic record outage. The provider completed an annual MHA audit to review compliance with MHA requirements. In addition, MHA administrators completed monthly site audits on MHA paperwork. For example, section 17 and section 132 audits. The provider had supported staff to access university degree training to enhance their knowledge. For example, one member of staff had completed MHA laws and practice degree.

- In services where patients are detained under the Mental Health Act, the Care Quality Commission conducts regular Mental Health Act review visits to ensure compliance against the Code of Practice (2015). There had been 21 Mental Health Act monitoring visits that took place between August 2021 and July 2022. Within these reports, 266 individual issues were raised. The most common issues were no evidence of Section 132 rights being read (a persons legal rights whilst detailed), quality and staffing levels. of the ward environment, staffing and patient involvement in care planning. We saw that outcomes and feedback from these Mental Health Act review visit reports were presented in board papers and compliance with the MHA was a point on the healthcare divisional risk register.

- The Mental Health Units (Use of Force) Act 2018 was commenced on 31st March 2022. Statutory guidance sets out the requirements for providers to comply with the Act. Priory had allocated a responsible person for the Act, in line with guidance, and had developed a policy outlining how the provider would comply with the Act. Staff were provided externally accredited training that was compliant with the Restraint Reduction Network Standards. Priory monitored training compliance rates by site. Compliance rates we saw during the well-led assessment showed there were 16 healthcare sites where compliance was below 80%. The provider told us staffing rotas were designed to ensure there were enough trained staff on shift each shift. It was not clear whether patients or consultation with local communities or Healthwatch had taken place in the development of this policy, as suggested in the statutory guidance. Also, although the policy outlined requirements to include details about relevant patient characteristics where use of force had taken place (and defined use of force), it did not specify how different use of force techniques would be used for different patient groups.

- There were 30 positive behavioural support practitioners in place that supported 90 adult care sites. These practitioners were also responsible for analysing incidents to assess whether any non-approved interventions were involved.

- The provider understood and met relevant legal requirements, including Care Quality Commission registration requirements, safety and public health related obligations and the submission of notifications and other required information. Improvements were needed in timely and consistent reporting to the national mental health services data set which supported benchmarking against other providers and improve accuracy of reporting. We recognised that as a large, national, organisation providing varying numbers of NHS beds in different services, this presented a challenge. Priory had identified good practice from areas that were doing this well and shared this across the organisation. For example, asking managers to ensure staff responsible for submitting the data had protected time to do so.

- Priory had a complaint policy which clearly outlined the process and timelines for staff to follow in acknowledging and responding to complaints. Data on meeting these deadlines was monitored at site level and available in committee and board papers. Senior leaders used the content, number and type of complaint received across services as one of the indicators of quality of care. The CQC survey for Priory staff found that 83% (1,122 of 1,352) of Priory staff agreed that the organisation encouraged service users to provide feedback about services and suggestion for improvements. This was 80% (1077 of 1352) when asked about encouraging feedback from carers and service users' families. During the well-led assessment we reviewed four complaints and saw letters were detailed, compassionate and apologetic. They stated clearly whether a complaint was upheld and outlined what further action the patient could take or that the provider would take to address the concern. There was limited information available to the board to provide assurance that lessons learned from each complaint had been embedded.

Management of risk, issues and performance

- Priory was operating risk registers at site, divisional and corporate level. They recognised there was work to be done to update how they present risk as part of their governance processes. This was to ensure that risks and mitigations are clearly recorded and progress with addressing the risk is monitored over time.

- There were some areas of risk that had not been pulled through from a site or divisional level or were not made clear enough when they did appear. For example, although the divisional risk registers identified challenges in recruitment and retention of staff and outlined mitigating actions, the specific impacts of this on quality of care was not reflected. We saw that some healthcare sites had identified the risk of inconsistent care associated with a high use of agency staff on their risk registers, but this had not been pulled through to the divisional risk register. There are CQC inspection reports from the 12 months before the well-led assessment which highlighted the impact of staffing issues on quality of care. In the adult care division, the divisional risk register had not included information about potential risks associated with introducing electronic records at its pilot sites until two months after the pilot started.

- Priory had identified areas of learning for staff around risk management and delivered bespoke training and tools. For example, in August 2022 the director of risk management held three webinars for staff across healthcare about managing risk and implementing effective governance. They also developed a garden risk assessment tool which was shared and used by neighbouring NHS trusts.

- The most significant risk for Priory at the time of this inspection was staff recruitment and retention. Staff turnover was around 40% increasing from 30% in 2021. The provider was monitoring this and recognised this as their greatest risk. A workforce committee had been re-established. The recently recruited chief people officer was developing the people strategy to focus on staff and the strategic goal of being an employer of choice. There were several specific actions in place, for example they had employed a director of talent acquisition who would be starting soon after the well-led assessment and were recruiting nurses internationally as well as locally.

- There were systems in place to support the identification, reporting and management of safeguarding, to keep people safe from harm. Using the data available to them, the head of safeguarding had identified areas that needed strengthening and had delivered or planned several pieces of work. For example, they had developed training based on the results of the safeguarding audit. The head of safeguarding had identified a risk in how safeguarding information was recorded at site level and had plans in place to address this. Staff maintained safeguarding logs outside of the incident reporting system, and the lead was planning a scoping exercise to ensure staff were including all the necessary information in the incident report on the official system, as well as in the logs. If not, there was a risk that vital information was not being shared above site level. There were plans in place to start delivering training sessions for staff where they could discuss real time events in order to diversify their knowledge base and add a different approach to the mandatory training received. At the time of well-led assessment, this proposal was to be reviewed at the quality assurance committee for sign off.

- The head of safeguarding worked across both the healthcare and adult care division and reported to the chief quality officer. There were regional safeguarding leads that reported to the head of safeguarding. The regional safeguarding leads were responsible for looking at all safeguarding notifications to identify themes and ensure appropriate actions were being carried out. The head of safeguarding looked at all safeguarding incidents that were graded above 3. Staff we spoke with were able to clearly explain the responsibility of staff at each level. Staff at site level were responsible for making referrals to and liaising with the local authority. Each site had a safeguarding lead who provided a report on recent safeguarding that was reviewed at the monthly site governance meeting. Safeguarding adult training rates for permanent staff was 91.3% in healthcare and 94.6% in adult care. When including bank staff, the rates were 88.9% in healthcare and 93.6% in adult care.

- Staff we spoke with gave examples of learning identified from reviewing safeguarding information and described how actions were put in place to share learning amongst the team. Staff we spoke with described different levels of relationship established with the local authority. This was an area of development for the provider, who needed to embed the work they were doing across sites to learn what has gone well to establish strong working relationships and replicated this in other areas. Legal colleagues were preparing some guidance to help staff with this, but it was not yet available.

- Priory had an electronic system for staff to report incidents. The Care Quality Commission survey for Priory staff found that 92% (1249 of 1352) felt that the provider encouraged them to report errors, near misses or incidents. 5% neither agreed or disagreed and 3% disagreed.

- The governance review in 2021 had reviewed how lessons were learned across the organisation and the chief quality officer was implementing a number of improvements which were still in progress. This was also one of the priorities from the staff survey action plan from 2021. Governance processes were in place to enable details and learning from incidents to be escalated. Action points from the staff survey from 2021 included a relaunch of staff reflective sessions and ensuring lessons learned were discussed at staff meetings and supervision. There was still room for improvement in how information was presented at board level to give attendees assurance that the lessons learned had been sufficiently identified and that they were successfully embedded. For example, in adult care, a change in how confidential paperwork was disposed of was needed at a small number of sites. The

sites were asked to make this change, but there was limited follow up and information presented to the board to evidence whether this change had successfully taken place.

- There were effective systems in place to alert all senior staff of serious untoward incidents in a timely way. The associate director of patient safety and experience discussed all serious untoward incidents on a weekly basis and learning from these incidents was in information cascades and safety alerts. Associate directors of quality in the adult care division had carried out several thematic reviews based on themes from serious incidents. The outcomes from these reviews had been shared at board level as well as with staff at sites.

- Information relating to whistleblowing was discussed at governance meetings at different levels of the organisation. Details about themes were included in the sub-regional governance meetings. We saw that in operating board papers, the numbers of whistle blowing contacts for the month was summarised and the main themes identified. There was no detail about actions taken in relation to quality of care provided. We saw that for April to June 2022, themes were around culture and care. Whistle blowing contacts were investigated at site level and actions were developed to address areas of improvement.

- Data on mandatory training compliance was routinely collected and presented in meeting papers. In 2022, on the advice of its non-executive directors, Priory had increased its target compliance rate from 85% to 90% for all areas in both divisions. We saw that this was not being achieved in some areas. In healthcare, in September 2022, for permanent staff, six of the ten training modules had compliance rates between 86.2% and 89.8%. The remaining four were above 90%. When taking into account bank staff, rates were slightly lower, with nine training courses having compliance rates between 83.2% and 88.9%. The lowest compliance was in basic life support with defibrillator, including chocking, at 83.2%. Emergency first aid at work compliance was 90%. In adult care, eight of ten training modules had compliance rates of over 90% for both bank and permanent staff. Emergency first aid compliance was 81.7% for permanent staff and 79.1% when including bank staff. People handling was 79.1% for permanent staff and 75.9% when including bank staff. The provider had outlined plans to address the areas of low compliance.

- Priory had a team of internal health and safety advisors who carried out inspections of sites and made recommendations where needed. The results of these inspections were reviewed monthly at the quality assurance committee.

- In March 2022, a patient safety team came into effect, led by an associate director of patient safety and experience. A patient safety lead had been established at each site. This was open to all site staff to apply for. At the time of the well-led assessment, the group were developing a patient safety strategy. The strategy aimed to establish a stronger system for learning and good practice to enhance patient safety and experience. The patient safety leads were building on methods used to gather patient feedback to widen this from surveys to more regular face to face forums at site. Each site had a standard operating procedure outlining how they would function in their particular service. These would be attended by an expert by experience and staff to look at data relating to patient safety and experience.

- The provider had a process for reviewing deaths. A mortality review group met quarterly and was chaired by the director of risk management and attended by other senior clinicians

within the organisation. The group reviewed all deaths within the provider to establish lessons that could be learned and shared these lessons using the information cascade systems. Information from coroners about prevention of future deaths was disseminated by the director of risk management.

- The provider had effective systems in place to monitor the use of medicines across healthcare and adult care services. An external pharmacy carried out weekly audits and reports at each site. These were monitored by the medical director and where necessary, sites had actions plans in place to address issues and themes identified through audits. There were protocols in place for escalating concerns to the board. A drug and therapeutics committee examined themes and trends. They worked closely with external pharmacists to monitor use of medication. There were audits in place to provide organisational oversight of medicines optimisation. For example, the provider used regular medicine walk round audits to monitoring the use of covert medicines, controlled drugs and pain relief. The provider carried out periodic audits of use of high dose antipsychotic medicines and audited the monitoring of physical health after the use of rapid tranquilisation. The provider benchmarked themselves against other similar providers with regards to the use of medicines. They participated in the national project for stopping over medication of people with a learning disability, autism, or both (STOMP). The medical director entered data on medicine error rates to a national benchmarking data set.

- We saw examples where the provider made changes to the environment to improve patient safety. For example, there was a rolling programme of reducing ligature risks across mental health wards with a budget of £1.25 million. Two services, Kneesworth House and Stockton Hall had completed a full refurbishment. Following a serious incident Priory had carried out work to increase the height of the garden fences for the acute wards and psychiatric intensive care units.

- At the time of the review Priory UK had net liabilities of £184m associated with previous acquisitions. There was an annual turnover of £721m. MEDIAN had a strong commitment to invest in Priory UK, with a particular investment in digital transformation. The most significant financial challenge for Priory was its expenditure on agency staffing – although it used preferred agency suppliers. It was working to make savings through a procurement review which was saving £8.9m and through the standardisation of staffing models across the hospitals. Each of the sites had a financial business partner who supported them with budget management.

Information Management

- Priory had a clear plan in place for introducing new information technology (IT) to enhance the quality of care provided and allow data to be extracted to monitor quality and safety. Priory were introducing electronic patient record systems across the adult care division. Staff we spoke with noted that this was driven by the chief executive and supported by MEDIAN and was having a positive impact on staff experience and quality of care they could provide. For example, staff in adult care were using dictate technology for notes which was giving them more time to spend with residents. Staff also recognised it allowed for much easier auditing and quality assurance of care records.

- Priory had successfully rolled out several digital initiatives in the 12 months before the well-led assessment. For example, in the healthcare division, the incident reporting system had been linked to the electronic records system, which meant clinicians did not have to input information twice, and freed up clinicians' time away from a computer. Priory were part way through improving internet connectivity at several of their sites.

- At the time of the well-led assessment, clinical dashboards were being rolled out across each service line in healthcare. There were plans to roll these out in adult care at a later date. The clinical dashboard included information relating to the individual patient pathway within their specific service line and whether staff were carrying out their responsibilities in a timely way. For example, whether patients had the necessary care plans and risk assessments in place and whether these were reviewed as necessary. Only appropriate clinicians would have access to this dashboard. This had been rolled out in a small number of pilot service lines.

- Information governance and data protection systems were in place. The Caldicot Guardian was a senior member of staff and held responsibility for protecting the confidentiality of people's health and care information. They met quarterly with colleagues from IT security and data protection to discuss any incidents involving data protection, current processes in place and any changes needed. There had been no externally notifiable information governance breaches within the last 12 months. All staff received training around information governance as part of their mandatory training. Training compliance rates were above the target of 90% for permanent and bank staff in adult care but were 83.2% for permanent and bank staff in healthcare.

Engagement

- More dedicated resource was needed to develop and embed co-production throughout all levels of the organisation. The patient engagement lead also held other roles, meaning they did not have the capacity to focus on this at the level required for this size of organisation. At a site level there were examples of co-production. For example, patients attended the clinical governance meetings. When a location was being refurbished, patients had an input into design and changes and were able to give feedback once works had been completed. However, there were only limited examples of co-production across the organisation. For example, the operational information team had involved patients in devising the questions for the patient satisfaction survey. There was scope to ensure patients were routinely involved in staff recruitment and training; were active participants in the quality assurance processes including the internal quality and compliance team; were active participants in quality improvement projects; and that peer support workers were widely employed.

- Priory routinely collected feedback from patients about their experience in the service, both whilst they were there and soon after discharge. Feedback was collated and presented at regional clinical governance meetings. It was not clear from paperwork what work took place to address the areas of concerns raised. For example, in one survey, only 50% of patients in a healthcare setting said they felt safe on the ward.

- Work to engage carers took place across a number of sites but was not consistently promoted across the organisation.

- The provider had a website that gave information about what service it provided, who the senior staff were and news and updates about the organisation as a whole. It also had a section for helpful information for people seeking support. It was undertaking an independent audit of the website in line with national guidance to ensure it was accessible for people with all types, degrees and combinations of disability. There was guidance about changing settings to make it easier to navigate and read and links to additional resources. There was an email for people to request information in an easy read format and report any accessibility issues. Information about how to make a complaint was not as clear as it could have been.

Learning, continuous improvement and innovation

- Priory recognised that it was at the start of embedding the new strategy and that quality improvement work across both divisions would become more of a focus once they had established the operational platform. The adult care division had more experience in quality improvement work than the healthcare division at the time of the well-led assessment. The healthcare division had signed up with an organisation who would be supporting them with their quality improvement approach.

- Priory had several services who were active participants in the Royal College of Psychiatrists quality networks and accreditation schemes. This helped to promote high levels of care and provided access to a network which shared good practice. Two clinicians were appointed in voluntary roles within the Royal College of Psychiatrists.

- Senior staff supported the continuous learning of others within the organisation. For example, the medical director had supported speciality doctors from across the organisation to form a committee, where they previously had not had a formal, collective voice. Through this committee, they were able to arrange and access electrocardiogram (ECG) training. This is a simple test that be used to check a heat's rhythm and electric activity and an important part of physical healthcare for some patients taking medicines for their mental health condition.

- Priory was working on a collaborative project with IMPACT, a secure provider collaborative. This involved a 10-year plan with patients coming from medium secure with learning disabilities or autism with an aim to having them reintegrated into the community within 12 months.

- The provider had participated in 25 research projects between 2020 and 2022. These included research into staff experience and motivation, specific mental health conditions, specific medicines, evaluations of programmes delivered in services and several other areas. The executive medical director made an application for a 2023 research fund and was developing a 3 year Priory research strategy. The focus of this would be on encouraging network clinical projects with guidance from committee and divisional projects using outcomes data.