Good

Cheshire and Wirral Partnership NHS Foundation Trust

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

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)
RXA19	Bowmere Hospital	Beech ward, Willow ward	CH2 1UL
RXA54	Clatterbridge Hospital	Brackendale ward, Brooklands ward	CH63 4JY
RXAAE	Jocelyn Solly (Millbrook)	Adelphi ward, Bollin ward	SK10 3JF

This report describes our judgement of the quality of care provided within this core service by Cheshire and Wirral Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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 Cheshire and Wirral Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cheshire and Wirral Partnership NHS Foundation Trust.

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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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.

Summary of findings

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Summary of findings

Overall summary

We rated acute wards for adults of working age and psychiatric intensive care units as good overall because:

- Patients had a comprehensive assessment which included their mental, physical and social needs, and any potential risks to themselves or others. Following the assessment, patients had a recovery focused care plan. Care plans were person centred and reflected the individual's needs. Patients had a risk assessment carried out, and the findings of this were included in their care plans. Patients had discharge plans and care programme approach meetings.
- Patients were generally positive about the service and care they received. Patients told us that overall staff were helpful and treated patients with respect. There was patient and carer information on all of the wards.
- There were adequate numbers of nursing and medical staff to provide care for patients. Staff had an induction when they were employed by the trust, and received appraisal, supervision and training. The occupational therapy service provided assessments and activities on the wards. The pharmacy team provided advice and support, and carried out medicines reconciliation when patients were admitted.
- Staff prescribed, stored, administered and disposed of medication safely. Staff were trained to respond to medical emergencies. Resuscitation and other medical equipment was available, and in working order.
- Staff were familiar with the trust's values, which centred on the "6 Cs". These were: care, compassion, commitment, competence, communication, and courage. Staff were mostly positive about their teams and managers. Data packs were produced for each ward that included key governance information about patients, staff, practice issues, and audits. This supported managers to monitor the performance of the service.
- Serious incidents were responded to, reported, investigated and followed up on. Lessons learned were shared amongst staff.
- Although there were potential ligature points in high risk areas of the wards, the trust had a plan of action for monitoring and taking action or mitigating against these risks.
- Following the June 2015 inspection we told the trust that it must take action to improve acute wards for adults of working age and psychiatric intensive care units. It had taken this action with regards to the governance arrangements for the oversight of the Mental Health Act, and the recording of rights of detained patients, promoting access to an independent mental health advocacy service, recording the use of seclusion, recording capacity and consent to treatment, and recording and managing risks.

However:

- The rating of the safe key question remains as requires improvement, and a requirement notice was issued with regards to breaches of the Department of Health's guidance on same sex accommodation. The trust had taken action to improve the provision of same-sex accommodation, but there were still repeated breaches.
- The trust had a nicotine management policy, and smoking was not allowed in the trust's services. There had been a number of incidents related to patients bringing lighters and tobacco on the wards.
- Although some staff used a psychological approach in their work with patients, there was limited access to psychology on the wards.

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:

- At our inspection in 2015 we found that the trust did not comply with Department of Health guidance on same-sex accommodation. At this inspection we found that although the trust had made improvements in the provision of same-sex accommodation, there were still repeated breaches.
- There had been a number of incidents related to patients bringing lighters and tobacco on the wards. The trust had a nicotine management policy, and did not allow smoking in any of its services.

However:

- Although there were potential ligature points in high risk areas of the wards, the trust had carried out suicide prevention environmental risk assessments. An action plan had been developed from these, with action taken to remove some risks, and raise staff awareness to mitigate others. There was a ligature remedial plan for 2015-2020. Ligature and other clinical environmental risks were routinely reviewed, and reported to a board level subcommittee.
- At our inspection in June 2015 we found that seclusion facilities, and the recording of seclusion episodes, did not always reflect the Mental Health Act Code of Practice. At this inspection we found that these concerns had been addressed. The seclusion facilities had been refurbished and complied with the guidelines in the Code of Practice. Seclusion records were completed correctly, and routinely audited.
- Staff were trained to respond to medical emergencies. Resuscitation and other medical equipment was available, and in working order.
- There were adequate numbers of nursing and medical staff to provide care for patients.
- Patients had a risk assessment carried out, and the findings of this were included in their care plans. The monitored the use of restraint and rapid tranquillisation.
- Medication was prescribed, stored, administered and disposed of safely.

Summary of findings

- Serious incidents were responded to, reported, investigated and followed up on. Lessons learned were shared amongst staff.

Are services effective?

Good

We rated effective as **good** because:

- Staff completed a comprehensive assessment which included the patient's mental, physical and social needs, and any potential risks to themselves or others. Following the assessment, staff created a recovery focused care plan, which they discussed with the patient and reviewed regularly. Staff used nationally recognised tools and rating scales to assess and monitor patients' needs and the outcome of their care.
- Staff had an induction when they were employed by the trust, and received appraisal, supervision and training.
- The occupational therapy service provided assessments and activities on the wards. The pharmacy team provided advice and support, and carried out medicines reconciliation when patients were admitted.
- The Mental Health Act was administered effectively. At our last inspection in June 2015 we found gaps in the recording of various aspects of the Act. At this inspection we found that the Mental Health Act records had been completed in accordance with the Code of Practice.
- There was limited use of the Deprivation of Liberty Safeguards. Staff understood the five statutory principles of the Mental Capacity Act, and patients had their capacity to consent recorded.

However:

- Although some staff used a psychological approach in their work with patients, there was limited access to psychology on the wards.

Are services caring?

Good

We rated caring as **good** because:

- Patients were generally positive about the service and care they received. Patients told us that overall staff were helpful and treated patients with respect.
- Care plans were person centred and reflected the individual's needs.

Summary of findings

- There were regular patient experience meetings on each of the wards, where patients could raise concerns or make suggestions.
- Each ward had information on display for patients and carers. This included information about the staff, ward routines, and how to get additional information and advice. There were information leaflets about a variety of topics, which included details of specific medicines, illnesses, and activities.
- The majority of respondents to the friends and family test had said they were likely to recommend the service to others.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Patients had discharge plans and care programme approach meetings. The crisis and home treatment teams visited the wards every day to discuss each patient's discharge plan.
- At the time of our inspection, there were no patients in out of area placements, and no patients recorded as a delayed discharge.
- The service had two psychiatric intensive care units. The psychiatric intensive care unit provided an in reach service to the acute wards, offering advice and reviewing patients who may need their units.
- The wards had access to lounges, activity rooms and outdoor space. On some wards, staff considered the outdoor space to be part of the ward. On others, they had to escort patients to a communal garden. There was a programme of activities.
- Patients were generally satisfied with the food. There was access to drinks and snacks at all times. Food was available for patients with specific dietary requirements.
- Patients with physical healthcare needs were catered for. For example, there were assisted bathrooms and specialist beds.
- Patients knew how to raise concerns. Complaints were managed by the Complaints and Incidents Team, who had close links with the Patient Advice and Liaison Service.

Are services well-led?

Good

We rated well-led as **good** because:

Summary of findings

- Staff were familiar with the trust's values, which centred on the "6 Cs". These were: care, compassion, commitment, competence, communication, and courage. Staff were mostly positive about their teams and managers.
- Ward managers had key performance indicators to achieve. They were supported to do this by the use of locality data packs produced for each ward that included key governance information about patients, staff, practice issues, and audits.
- An audit of key patient information was carried out every other month. Five records were selected from each ward, and a check was carried out to ensure each of the elements had been completed correctly, and to take action if there were gaps.
- The Mental Health Act was administered effectively. At our last inspection in June 2015 we found gaps in the recording of various aspects of the Act, and in the oversight of the administration of the Act. These had both been addressed. The governance arrangements for ensuring the Mental Health Act was administered and monitored effectively had improved.

Summary of findings

Information about the service

Cheshire and Wirral Partnership NHS Foundation Trust provides inpatient services for men and women aged 18 years and over with mental health conditions.

The trust has six acute inpatient wards and two psychiatric intensive care units over three hospital locations.

Clatterbridge Hospital Mental Health Unit (also known as Springview) is on the Clatterbridge Hospital site on the Wirral and has three wards:

- Brackendale ward – a 20 bed mixed-sex acute admission ward for adults and older adults with a functional mental illness
- Brooklands ward – a 10 bed mixed-sex psychiatric intensive care unit for adults
- Lakefield ward – a 20 bed mixed-sex acute admission ward for adults.

Bowmere Hospital on the Countess of Chester Hospital site on the outskirts of Chester has three wards:

- Beech ward – a 22 bed mixed-sex acute admission ward for working age adults
- Juniper ward – a 22 bed mixed-sex acute admission ward for working age adults
- Willow ward – a seven bed mixed-sex psychiatric intensive care unit for working age adults.

Jocelyn Solly (Millbrook) Unit on the Macclesfield General Hospital site has two wards:

- Adelphi ward – a 23 bed mixed-sex acute admission ward for adults and older adults with a functional mental illness
- Bollin ward – a 21 bed mixed-sex acute admission ward for working age adults.

Our inspection team

Our inspection team was led by:

Team Leader: Lindsay Neil, Inspection Manager, Care Quality Commission.

The team that inspected acute wards for adults of working age and psychiatric intensive care units comprised an inspection manager, three CQC inspectors and a nurse specialist advisor with a background in acute inpatient services.

Why we carried out this inspection

We undertook this unannounced focussed inspection to find out whether Cheshire and Wirral Partnership NHS Foundation Trust had made improvements to their acute wards for adults of working age and psychiatric intensive care units since our last comprehensive inspection of the trust on 22 June 2015.

When we last inspected the trust in June 2015, we rated acute wards for adults of working age and psychiatric intensive care units as requires improvement overall. We rated the core services as requires improvement for three domains: safe, caring, and well-led.

Following the June 2015 inspection we told the trust that it must take the following actions to improve stay/ rehabilitation mental health wards for working age adults:

- The trust must review ward composition and practices to ensure they comply with the Department of Health required guidance on same sex accommodation.
- The trust must ensure that standards of record keeping improve in the following areas:
  - The recording of rights to detained patients including refusals and attempts made and timely action where a patient does not understand their rights.

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- The recording that qualifying patients are informed of the independent mental health advocacy service.
- The recording of episodes of seclusion including the doctor attended seclusion and the cogent reasons if there is a delay in the doctor's attendance, the threshold for segregation and determining the regularity or reviews when segregation is used.
- The recording of consent and capacity to consent on administration of treatment for mental disorder and when other key decisions are made for patients where there may be doubts about their capacity.
- The recording of risks to ensure that risks are properly managed.

- The trust must improve its governance arrangements relating to the oversight of the Mental Health Act to address fully the identified issues.

We issued the trust with three requirement notices that affected acute wards for adults of working age and psychiatric intensive care units. These related to:

- Regulation 12: Safe care and treatment, person centred care
- Regulation 17: Good governance

How we carried out this inspection

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

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

This inspection was unannounced, which meant the service did not know that we would be visiting. Because the service was rated requires improvement in three of the five domains, we carried out a full comprehensive inspection of all five domains to fully understand whether the required improvements to the acute wards for adults of working age and psychiatric intensive care units had been made.

During the inspection visit, the inspection team:

- visited four of the six acute wards (Adelphi, Beech, Bollin and Brackendale wards), and both psychiatric intensive care units (Brooklands and Willow wards) across three hospital sites, and looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 18 patients
- spoke with the managers or acting managers for each of the wards we visited
- spoke with 36 other staff members including doctors, nurses and occupational therapists
- attended a multidisciplinary team meeting
- looked at 15 care records of patients
- carried out a specific check of the medication management on four wards
- looked at a range of policies, procedures and other documents relating to the running of the service, which included the six wards we visited and the two wards we did not visit.

What people who use the provider's services say

The patients we spoke with were mostly positive about the service and the care they received.

The patients we spoke with were mostly positive about staff, and found them helpful. Most patients felt involved in their treatment, and had received information about it.

They knew who to approach to ask about their care and treatment. Patients had a physical healthcare assessment on admission, and felt that their physical healthcare needs were addressed.

Most patients said they attended or knew there was an activity programme available. Some patients said they

Summary of findings

were bored, or were not interested in the activities that were available. Patients told us they knew how to make a complaint, or knew who they would speak to if they wanted to make a complaint.

There were regular patient experience or community meetings on the wards. The format varied, but patients used them to make suggestions and raise concerns about the ward.

From April to September 2016, 101 out of 124 people who completed the friends and family test said they were likely or extremely likely to recommend the service to others. 10 people said they were unlikely or extremely unlikely to recommend it.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that it implements the Department of Health's guidance on same sex accommodation.

Action the provider SHOULD take to improve

- The provider should review access to psychology in its inpatient services

Cheshire and Wirral Partnership NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Beech ward, Willow ward	Bowmere Hospital
Brackendale ward, Brooklands ward	Clatterbridge Hospital
Adelphi ward, Bollin ward	Jocelyn Solly (Millbrook)

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.

At the inspection in June 2015 we found gaps in the recording of information in relation to the Mental Health Act, but this had been addressed at this inspection. Mental Health Act documentation was completed correctly.

Patients had their rights read to them, and this was repeated weekly. Staff recorded whether the patient had understood their rights in the patient's care record.

Patients had their capacity to consent to treatment assessed. Consent to treatment was assessed, and the correct processes followed, including an assessment by a second opinion approved doctor when required.

The Mental Health Act administration office managed and monitored the implementation of the Mental Health Act, and provided advice and support for staff. Mental Health Act paperwork was received, reviewed and scrutinised.

Most staff had received training on the Mental Health Act.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards were not used regularly within the acute wards and psychiatric intensive care units. There had been no applications made within the last six months, but they had been used in the past.

Staff had received training on the Mental Capacity Act and the Deprivation of Liberty Safeguards. They were familiar with the five key principles when assessing capacity, and understood that capacity could fluctuate, and was decision specific.

Medical staff carried out assessments of each patient's capacity, and these were recorded in detail in patients' records.

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 environment

Each ward had a suicide prevention environmental assessment report, which was carried out in 2014. There was a ligature management plan for each ward, which identified action to be taken to remove or reduce the risks. This included physical controls including locking doors to high risk areas, and clinical controls including ongoing patient risk assessment and observation of patients, and proposed remedial works.

Each ward had a zoned risk map, with different shades of red (indicating high risk), yellow (medium risk), and green (low risk). For example, en suite bathrooms were dark red, bedrooms medium red, corridors yellow, and communal areas green. This provided staff with a visual reminder of higher risk areas on the ward.

The trust had a ligature remedial works programme for 2015 to 2020. It aimed to replace bedroom windows with an anti-ligature specification in 100% of high risk wards, 50% of medium risk wards, and 25% of low risk wards, with a minimum of four bedrooms per ward by 2020. The programme also included upgrading all communal bathroom and toilet facilities by the end of the 2016 to 2017 financial year. The windows were of a different design on each of the units, and could be locked to reduce the ligature risk. Staff considered whether a patient's bedroom window needed to be locked as part of their risk assessment.

Work had been implemented to reduce and manage risks, particularly the high risks. This included the use of mirrors to increase visibility in hard-to-see areas, and alarms sensitive to weight had been fitted to the tops of en suite bathroom doors. Bathroom facilities were undergoing refurbishment, and there was an ongoing plan to replace window fittings.

The environmental risk assessments and ligature management plan were reviewed by the trust's 'suicide prevention, clinical and environmental work stream' which met every two months and was chaired by the clinical services manager for low secure services. The group reported to the compliance, assurance and learning subcommittee, which was chaired by the trust's medical director.

We observed potential ligatures and ligature points in the patient phone rooms on some of the wards, which was not identified in the ligature risk assessments. This was raised with the trust and addressed during the inspection.

There had been a fire in one of the bathrooms the week before our inspection. The trust, in common with many trusts and other organisations, did not allow smoking in its services, which included its buildings and grounds. Staff told us that implementing the policy was problematic, and there had been a number of incidents of patients smoking and hiding lighters, or becoming verbally abusive. During our inspection, we smelt smoke on one of the wards. Staff included the risk of smoking or bringing in smoking materials as part of each patient's risk assessment. Patients had access to nicotine replacement therapy. Nursing staff were able to provide this to patients on each of the wards, and there was a process for storing and recording when this had been provided.

At the inspection in June 2015, we found that some of the wards did not comply with the Department of Health's guidance on same-sex accommodation. At this inspection we found that whilst improvements had been made this had still not been fully implemented.

All the wards had female lounges, and most had separate areas for male and female bedrooms. Staff were clear about same-sex guidance, and told us that if a female patient was in a bedroom in a male area (or vice versa) then this was a breach. This was recorded as an incident, and was reviewed by the clinical lead, managers and matron. The trust had provided privacy and dignity maps for staff, to reduce the flow of patients passing through gender specific areas. The trust had a local policy about the implementation of same-sex accommodation, which referred to the Department of Health guidance. For six months up to the end of September 2016 there were 78 reported instances of patients having a bedroom that was not in their designated gender area. These were mostly on the acute and psychiatric intensive care wards, but two incidents were on the young people's wards. The trust

Requires improvement

Are services safe?

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stated that 11 of the 78 instances were not a breach, and 67 of them were a "justified breach". The Department of Health guidance states that justified breaches are usually in emergency care, or in other specific circumstances, such as in younger people's services. It states that there is rarely a rationale for a justified breach in mental health and learning disability services. The trust policy did not clarify how its criteria for a justified breach met the Department of Health guidance.

Willow ward were in breach of the guidance at the time of our inspection, and this had been recorded as an incident. Willow ward had seven single rooms, and two communal bathrooms. One of the bathrooms was in the seclusion suite, so was not available to the other patients on the ward when the suite was in use. At the time of our inspection, the suite had been in use for several days, meaning that the two women on the ward had to walk past male bedrooms to get to the only available bathroom. This bathroom was used by both men and women. Staff told us that they managed this through high general levels of observation on the ward, and ensured that observation panels in the bedroom doors were always closed.

The bathroom in the female corridor on Bollin ward was temporarily out of use due to damage. This meant women were temporarily having to use the facilities in the male area. Staff told us they supervised patients when this happened.

At the inspection in June 2015 we found that the seclusion rooms on Adelphi and Bollin wards did not meet the standards set out in the Mental Health Act Code of Practice. At this inspection, we found that work had been carried out across the trust to refurbish the seclusion facilities. Adelphi ward no longer had a seclusion room. Seclusion facilities were now available on Bollin ward, Brooklands ward and Willow ward. The suites were fitted in accordance with the Mental Health Act Code of Practice. This included an adjoining toilet and shower room, and remotely adjustable light, heat and blinds. Patients in seclusion could see a clock and the date, and there was an intercom so they could speak with staff outside. Staff told us they had antiligature clothing and bedding for patients to use in the room.

Each ward had a resuscitation trolley. This included equipment and medication that may be required in the event of a medical emergency. An automatic external defibrillator, suction machine and oxygen were available. The equipment was regularly checked by staff, and time sensitive items were in date. Staff had access to ligature and wire cutters on all the wards. Staff were aware of the action to take in the event of a medical emergency.

Medical equipment was clean and maintained. For example, the electrocardiograph and suction machines had stickers that indicated when they had been serviced, and when a service was next due. They were stored appropriately, and had no visible signs of damage.

The wards were generally clean and well maintained. Cleaning schedules were completed, and showed that the wards were routinely cleaned. There was graffiti in the communal areas and a bathroom on Bollin ward. Staff told us that this had been a problem recently, and that estates were in the process of addressing it. The patient-led assessments of the care environment scores for cleanliness were 99% for Bowmere Hospital, 99% for Clatterbridge Hospital and 98% for the Millbrook Unit. The patient-led assessments of the care environment scores for condition, appearance and maintenance were 98% for Bowmere Hospital, 99% for Clatterbridge Hospital and 94% for the Millbrook Unit.

Infection control principles were applied on the wards. There were handwashing gels and handwashing sinks located around the ward. A patient who was barrier nursed because of an infection had a sign on their bedroom door, and there was personal protective equipment (such as gloves and aprons) available.

Infection control audits had been carried out using the Infection Prevention Society quality improvement tool. Where concerns were found these had been addressed. For example, in 2015 the infection control audit of Bollin ward scored 97%, but in 2016 had scored 94%. The audit found that there was a lot of damaged furniture, and a report with photographs was produced. Recommendations were made to replace the furniture with items that were more robust so that this was less likely to happen in the future. This had been implemented.

Patients' bedrooms were fitted with nurse call alarms. Staff carried emergency alarms, and responded quickly when they were activated. Staff on each ward were allocated to respond to the alarms on a shift-by-shift basis.

Safe staffing

The staffing establishments in whole time equivalents, for all staffing groups except administration staff, on the 30

Requires improvement

Are services safe?

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

September 2016 were: Adelphi ward 27.2, Beech ward 29.6, Bollin ward 31.8, Brackendale ward 28.3, Brooklands ward 31.2, Juniper ward 26, Lakefield ward 27.3 and Willow ward 24.9.

Staff told us that staffing levels had been reviewed to achieve the current levels. Standard staffing levels on each ward could be increased if necessary, and there was a process for managing this and recording the reason. Managers told us that leave and activities were rarely cancelled, and if they were this would be reported. Staff told us it was uncommon for leave and activities to be cancelled because there were not enough staff.

The wards had low numbers of vacancies. The overall vacancy rate for all staff, which included nurses, administrators and other professionals, was minus 6.7 whole time equivalents. This meant that the wards were effectively overstaffed in some roles although there were vacancies in others.

For the three months from July to September 2016, there had been nine registered nurse shifts and 62 care support worker shifts covered by bank staff across the eight wards. There had been one shift covered by agency staff. There had been eight registered nurse and 24 care support worker shifts that went unfilled.

The sickness rates for the year ending 30 September 2016 ranged from 4% to 8% across the eight wards, which was an average of 6%. The trust has an online system for recording staff attendance. This linked into the electronic staff record, and managers had access to a dashboard to see who was off sick and recorded absence monitoring information.

Staff turnover varied from 0% on four wards (Brackendale, Brooklands, Lakefield and Willow) to 2% (Beech ward) to 6% (Juniper Ward), to over 8% on Bollin and Adelphi wards. This was an average across all eight wards of just over 3%.

Up to the 30 September 2016, 85% of staff were up to date with their mandatory training. This ranged from 79% on Beech ward to 90% on Lakefield ward.

There was adequate medical cover. Each ward had a mix of consultant psychiatrists, due to the catchment area and age range of its patients. For example, Adelphi and Bollin ward shared two consultant psychiatrists who each worked with working age adults from different geographical areas. Adelphi ward also admitted patients aged over 65, so also had an older person's consultant psychiatrist. Junior doctors also worked on the wards under the supervision of the consultant psychiatrists. There was a rota for 24-hour on-call consultant and junior doctor cover.

Beech ward had an advanced nurse practitioner, who was one of seven across the trust.

The advanced nurse practitioner had a caseload of five patients, who could be informal or detained, and worked under the supervision of the consultant psychiatrist.

Assessing and managing risk to patients and staff

We reviewed 15 care records.

Patients had a detailed risk assessment carried out using a recognised tool called the clinical assessment of risk to self and others. This included historic and current risk, and factors that increased or protected against these risks. The staff we spoke with identified potential risks, and how they may be managed. Each ward had a patient status at a glance board, that contained key information about each patient. For example their Mental Health Act status, section 17 leave, when risk assessments were due, observation levels, and physical healthcare conditions. This enabled the staff team to quickly see what the key risk information was, and where there were any gaps. The board folded over so that patient information was not on display.

We saw no evidence that unjustified blanket restrictions were in use. Some items were not allowed on the wards, such as glass and lighters. Items such as mobile phones and chargers were individually risk assessed.

Staff had completed management of violence and aggression training, which for qualified nurses included rapid tranquilisation and immediate life support training. Staff told us that prone restraint was rarely used, but may be necessary to administer an injection however this would be for the least possible time. The trust categorised restraint from Level 1 (least restrictive, such as gentle holding) to level 4 (most restrictive, full restraint lying on the floor). In the six months to the end of September 2016, there had been 267 restraints. These ranged from 10 restraints on Brackendale ward to 68 restraints on Bollin ward. Forty-one of the 267 restraints involved prone restraint, where the person is face down. These ranged from one prone restraint on Lakefield ward to 11 prone restraints on both Beech and Bollin wards.

Requires improvement

Are services safe?

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

The trust had a project to reduce the use of physical restraint when responding to challenging behaviour. This showed a significant reduction in the use of prone restraint since April 2014, and detailed analysis of different aspects of restraint such as the types of holds used, and how long they were employed for. This information was presented at governance meetings to understand, learn from and reduce the use of restraint.

Staff spent time with patients following an incident or restraint to discuss what had happened.

In the six months to the end of September 2016 there had been 88 uses of seclusion, which involved patients from five wards. Most patients were from the wards with seclusion suites, but five episodes involved patients from two other wards.

At the inspection in June 2015 we found that the seclusion paperwork was not always fully completed in accordance with the Mental Health Act Code of Practice. At this inspection, staff had completed the sample of four sets of seclusion paperwork we reviewed correctly. They showed that staff had carried out the necessary checks. They had recorded the Information on the seclusion paperwork, and logged this on the electronic records system. During and at the end of each seclusion episode a manager reviewed the seclusion checklist to ensure that staff had completed all the necessary steps. This had been completed in the three seclusion records we reviewed. The inpatient safety metrics were a two-monthly peer review audit programme completed across all inpatient wards. The checklist showed that all the necessary checks had been completed in accordance with trust policy. This included nursing and medical reviews, the care bundle or monitoring forms for the use of seclusion, and the seclusion review chart.

The care records documented that seclusion was regularly reviewed, and attempts were made to move patients out of seclusion as soon as possible. When patients were transferred to seclusion the least restrictive options were discussed.

In the six months up to the end of September 2016, there had been two episodes of long-term segregation recorded.

Safeguarding concerns were included in the initial assessment of each patients. When concerns were identified, a safeguarding referral was made. There was a safeguarding flowchart and the contact details were on display in staff offices. Most safeguarding alerts were investigated by the trust's safeguarding department, but a small number were referred to the local authority in accordance with locally agreed policies. For the 12 months to the end of September 2016, there had been 334 referrals to the trust safeguarding team, and 11 of these had been sent to the local authority.

The trust had a clear policy on the use of enhanced observations. Patients were risk assessed on admission, and their initial level of observation determined. Observation levels were reviewed twice a day, and the patient's level of risk assessed and documented. At the time of our inspection, there was one patient on a one-to-one nursing observation on Beech ward, and one person on Willow ward. This did not include patients in seclusion who are observed by a member of staff at all times during the episode. Staff checked all patients on the ward at least once an hour. A member of staff was allocated to carry out the hourly and intermittent checks, and this was recorded on an observation form.

The trust had a policy on searching patients, which was based on individual risk assessments. Staff told us that patients had been hiding lighters and cigarettes, and this had led to an increase of patients smoking on the wards.

A pharmacy technician carried out medicines reconciliation when patients were admitted. They documented this in each patient's records. If the technician identified discrepancies, they sought advice from a qualified pharmacist.

Medication was provided by an external pharmacy who carried out checks of stock medication on the wards. The trust's pharmacy team carried out checks of individual patients' medication. The two teams were clear about their roles and responsibilities.

Medication was prescribed, stored, administered and disposed of safely. Controlled drugs were managed and stored safely and securely. Clinic room and medication fridge temperatures were monitored and within the correct range. The medication fridge on Beech ward was broken. Staff told us this had happened a couple of months ago, and had been reported. Staff were using the fridge on another ward to store medication that required refrigeration. Unwanted medication bins were used for the disposal of no longer required medication, and denaturing kits were used for the disposal of controlled drugs.

Requires improvement

Are services safe?

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

There was an emergency/out of hours medication cabinet on each site. All qualified nursing staff had access to this, and it stored non-stock items that may be required urgently such as antibiotics. Staff had a secure log-in to the cupboard, which opened the electronic lock only for the drawer of the medication they required. The cabinet automatically notified the external pharmacy that the item had been taken, so that it could be replenished. The temperature of the cabinet on Millbrook Unit was consistently above 25 degrees. The trust confirmed that this had been identified as a concern, and was within its tolerance range. They stated that if the temperature rose above 30 degrees, then the pharmacy staff would follow their standard operating procedures to ensure appropriate action was taken.

In the six months up to the end of September 2016, there had been 124 uses of rapid tranquillisation. This varied from five instances on Adelphi ward to 23 instances on Lakefield ward. The trust policy followed the National Institute for Health and Care Excellence (NICE) guidance Violence and aggression: short-term management in mental health, health and community settings; NG10 (2015) for managing aggression, and prescribing and administering medication for rapid tranquillisation. Staff described to us the correct monitoring that should take place after a patient had received rapid tranquillisation. Medical staff carried out an audit of rapid tranquillisation, following the Royal College of Psychiatrists' Prescribing Observatory for Mental Health guidelines. The audit started on the 5 September 2016, and information gathering was due to finish on the 25 November 2016.

Track record on safety

From 1 September 2015 to 30 Sep 2016 there had been 10 serious incidents requiring investigation. One of these was an unexpected death, and the remaining nine incidents were graded as severe. They occurred across five different wards, and were in six different categories so there were no identified themes or patterns.

Each serious incident was investigated and where actions had been identified they had been implemented. Five of the investigations were ongoing, and of the five that were completed three had action plans that were still ongoing.

The week before our inspection, there were two fires on Bollin ward. The incidents were safely managed, and appropriate actions had been taken by the trust. The trust was carrying out an investigation in conjunction with the police and fire service. Immediate actions had been taken to reduce the risks. Staff and patients had separate debriefing sessions, and these were documented on the incident management system.

Reporting incidents and learning from when things go wrong

All incidents were reported through the trust's electronic reporting system. Incidents involving patients were also recorded in the patient's record with the incident number so that it could be cross referenced. The staff we spoke with knew how to report incidents. Incidents were reported by staff, then reviewed by the ward manager and matron locally. The incidents were reviewed and monitored through the trust's governance systems. The ward manager signed off any incidents and captured any lessons learned.

Discussion of incidents and sharing of learning took place through the weekly managers' meeting, and in the shared learning bulletin that was emailed to all staff.

Staff told us they had been supported following serious incidents, which included through debriefs and supervision. Patients were also supported following incidents, and records showed examples of where incidents had been discussed with patients.

Following the death of a patient, the investigation identified a potential risk on the ward that had not been included in the ligature and environmental risk assessments. This risk was reviewed, and action was taken to manage and remove this risk. Unexpected deaths were reviewed by the trust's central suicide prevention group.

The trust shared information about incidents that occurred in other parts of the trust. For example, there had been a problem with an oxygen cylinder, and information about how to avoid this had been circulated to all areas of the trust that used oxygen.

Publically funded organisations have a statutory duty to inform people and apologise when mistakes have been made; this is called the duty of candour. The trust's shared learning bulletin, which was emailed to all staff, focused on the duty of candour in May 2016. The staff we spoke with did not all know what the duty of candour was. However, they all told us that if they made a mistake they would apologise to the patient and tell them what had happened. We saw an example where a patient had complained about

Requires improvement

Are services safe?

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

an incident. The staff involved had written to the patient and apologised. They had explained why the incident had happened, how it might be done differently in the future, and the learning they had taken from it.

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

We looked at 15 care records.

Patients were assessed on admission, and this included their mental and physical health, and social needs. A detailed risk assessment was carried out using a recognised tool called the clinical assessment of risk to self and others. Patient records had risks and allergies highlighted in red on the 'front page' of their electronic record.

Patients had an up to date care plan that was person centred and recovery focused. They were mostly written in plain English, and as if they were being written to the patient. Patients had had their capacity assessed, and had their treatment discussed with them. Patients had been given or offered a copy of their care plan. Daily records were made of the patient's progress against their care plans.

Patients had their physical health assessed. They had a physical examination on admission, which included baseline recording of observations such as blood pressure, pulse and weight. Where necessary these were repeated during the patient's stay in hospital. Risk tools for physical healthcare were used. This included falls assessments, the Waterlow scale (which is used to assess and monitor skin integrity) and nutritional assessments. Clients were referred to dietitians and physiotherapists when necessary.

Patients' records were primarily stored in an electronic records system. This was accessible to staff in other parts of the trust, such as the community mental health teams and home treatment teams. Paper records were made when this was more effective or necessary. For example, Mental Health Act paperwork was stored separately, and there were individual paper files for section 17 leave forms and seclusion records.

Best practice in treatment and care

High-dose antipsychotic therapy monitoring forms were completed for patients on high doses or above British National Formulary recommendations of antipsychotics. This included a reminder to check for cumulative doses of multiple antipsychotics, or where the same medication was given both orally and by injection. The form included a rationale for the use of the medication, baseline observations, and ongoing monitoring.

Staff used recognised rating scales to monitor outcomes for patients. A Health of the Nation Outcomes Scale was completed for each patient. The Liverpool University Neuroleptic Side Effect Rating Scale was used to monitor patients' side effects from antipsychotic medication. The Model of Human Occupation Screening Tool was used by occupational therapists to gain an understanding of a patients occupational functioning. Other tools were used when required and included the Waterlow scale to assess skin integrity, and the Montreal Cognitive Assessment to detect cognitive impairment.

Staff used the Lester tool to assess and monitor cardiometabolic risk. This was because certain medications can increase this risk, as can smoking and being overweight. Cardiometabolic risk may also impact on the effect of some medication.

All patients had a physical examination and their physical healthcare monitored. Where patients had physical healthcare needs these were monitored, care planned and addressed. We saw examples of some patients with complex and serious physical conditions, but a mental health ward was deemed the most appropriate place to provide care for them. The staff had received additional training to give them the knowledge and skills to care for this patient.

Most patients on the acute wards and the psychiatric intensive care units did not have access to a psychologist. Patients who were engaged with the dialectic behavioural therapy programme before admission, could continue this during their inpatient treatment. Patients could be referred to a psychologist in the community, for after they were discharged. Some staff followed a psychological approach with patients. For example, the occupational therapy team used a psycho-social framework. Some nursing staff, which included nurse consultants and advanced nurse practitioners, had had specialised training and provided psychologically based interventions such as cognitive behaviour therapy and anxiety management therapy.

Skilled staff to deliver care

Staff had a corporate and local induction. The local induction included a checklist with information that staff should know before commencing working on the ward, such as a tour of the ward, review of documentation, key policies, management of violence and aggression, and specific information about the ward they are working on.

Are services effective?

Good

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Staff received supervision, but the frequency varied. The recording of supervision varied between wards. The staff we spoke with told us they received supervision, and found this helpful. The sample of staff records we looked at showed that the number of supervision sessions recorded over the last six months ranged from none to six. The records showed that staff had had at least three supervision sessions over the last six months.

Up to 30 September 2016 there were 259 staff across the eight wards, of these 172 staff had had an appraisal in the last 12 months, and 9 staff had been employed within the last 12 months so did not yet require an annual appraisal. This meant that 69% of eligible staff had had an annual appraisal. The trust had introduced a new appraisal system. Staff told us that the trust was in the process of implementing the new appraisal system, which was due to be fully implemented by January 2017. This started with the band 7 staff, such as ward managers, and was rolled out through the rest of the staff. This impacted on the number of staff who had a completed appraisal.

Staff told us that they were able to access additional training if required. For example, ward managers and band six staff had access to management and leadership training. Other staff had had training in particular skills such as phlebotomy.

Occupational therapists and technical assistants worked on all the wards, and coordinated activities five days a week. One of the wards was temporarily offering an assessment only service because of staff sickness. A pilot project had been carried out to provide a seven day a week service. This had been successful and recruitment was underway to the additional post. Art therapists provided one or two sessions a week to each of the wards.

Pharmacists and pharmacy technicians visited the wards regularly. The pharmacists attended multidisciplinary team meetings, and the pharmacy technicians carried out medication reconciliation when patients were admitted. There was no psychology service on the wards. Patients could be referred to the community mental health team psychology service when inpatients, but this could only be accessed after discharge.

Multi-disciplinary and inter-agency team work

Each consultant psychiatrist led a multidisciplinary team meeting each week. These were typically attended by the consultant psychiatrist, nurses, occupational therapist, pharmacist, staff from the crisis and home treatment team, and staff from the community mental health team. The meetings were recorded in the electronic record system.

There were nursing handovers between shifts, which went through key elements of each patient's care. The electronic patient records were accessible to staff across the trust. This meant that staff from the community and crisis and home treatment teams could find out about the care and treatment of patients on the ward, and vice versa.

The wards had effective working relationships with the crisis and home treatment teams, who visited the wards each day and discussed each of the patients.

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

On 30 September 2016, 77% of staff on the acute wards and psychiatric intensive care units were up to date with training on the Mental Health Act.

At the inspection in June 2015, we found gaps in the recording of information in relation to the Mental Health Act. At this inspection, we found that this had improved. All staff were aware of the gaps from the last inspection. An audit tool had been created to capture the actions that should be completed.

Mental Health Act documentation was completed correctly. We found an error on one of the sample of Mental Health Act documents we looked at. This was discussed with the provider who resolved the issue.

Patients had their rights under the Mental Health Act explained to them, and this was repeated at least once a week. Staff documented if a patient appeared to have understood their rights or not. Patients were offered and had access to independent Mental Health Act advocates.

Patients had their capacity to consent to treatment assessed. This was generally well documented. Consent to treatment forms, commonly referred to as T2s and T3s, were completed and attached to the medication charts. Second opinion approved doctors assessed the prescribed medication as required under the Mental Health Act. Each ward had a patient status at a glance board that contained key information about each patient. This included information about each patient's Mental Health Act status,

Are services effective?

Good

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when their rights needed to be re-read, and when their T2 or T3 was due to be reviewed. One of the trust's "Share Learning" bulletins from August 2016 focused on T2 and T3 forms and consent to treatment.

There was a section 17 folder in each office, which contained each patient's current section 17 leave form. The folder was used when patients signed in and out of the ward to use their leave.

There was a process for receiving, reviewing and scrutinising Mental Health Act paperwork. All section papers were electronically scanned from the wards to the Mental Health Act administration team, who arranged for the forms to be medically scrutinised. The Mental Health Act administration team managed the administration of the Mental Health Act, and provided advice and support for staff.

We reviewed the records of a patient who was subject to a community treatment order, and had been returned to hospital. The consultant psychiatrist had written to the patient and explained why this had happened.

Good practice in applying the Mental Capacity Act

Up to the 30 September 2016, 82% of staff on the acute wards and psychiatric intensive care units were up to date with training on the Mental Capacity Act.

The staff we spoke had an understanding of the Mental Capacity Act and the five statutory principles, and that capacity fluctuated and was decision specific. The trust issued cards as a quick reference to the five principles.

There were no Deprivation of Liberty Safeguards in place at the time of our inspection, and no applications had been made within the last six months. The trust had systems for recording and monitoring the use of Deprivation of Liberty Safeguards. Staff described examples of when they had made applications in the past, and the difference between urgent and standard applications. For example, when a Deprivation of Liberty Safeguards application had been made for a future placement, or for treatment for a physical healthcare condition.

Medical staff carried out assessments of each patient's capacity, and these were recorded in detail in patients' records.

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

We spoke with 18 patients.

Patients were generally positive about the service and the care they received. They told us that they felt safe on the wards, particularly when they got used to being there. Some patients had a key to their room and/or to lockable storage but others did not, depending on the ward they were on. Patients told us the wards were usually clean.

The patients we spoke with were mostly positive about staff, and found them respectful, polite and helpful. Most patients felt involved in their treatment, and had received information about it. They knew who to approach to ask about their care and treatment. Patients saw their consultant each week, but only about half knew who their named nurse was. Patients had a physical healthcare assessment on admission, and felt that their physical healthcare needs were addressed.

The patients we spoke with were mostly positive about the food. We saw from the minutes of patients' meetings that there had been problems with the food in some of the units, but these had been addressed. Most patients said they attended or knew there was an activity programme available. Some patients said they were bored, or were not interested in the activities that were available. Patients told us they would speak to staff or the ward manager if they wanted to make a complaint.

The interactions we observed between staff and patients were mostly positive. Staff spoke about patients in a respectful and person centred manner.

The patient-led assessments of the care environment scores for privacy, dignity and wellbeing were 95% for Bowmere Hospital, 97% for Clatterbridge Hospital and 85% for the Millbrook Unit.

The involvement of people in the care that they receive

On admission, patients were shown around the ward. There were leaflets available that showed information about the ward, such as meal and visiting times. There were noticeboards that displayed the names, role, and photographs of staff. There was a range of information leaflets on all the wards. This included information about medication, activities, and general ward information.

Care plans were person centred, and reflected the individual's needs. Care plans were not written from the patient's perspective, but as if writing to the person. For example "… you have been admitted to hospital because…" This made the plan of care and the reason for it very clear. Patients' records showed that patients had been asked who they wanted their information shared with. There was a carers' board on each of the wards, with information and advice for family and friends. Care records showed that where appropriate families were involved in their relative's care.

The friends and family test is a national initiative that asks if you would recommend the service to others. The uptake of the friends and family test was variable, and in many months there were no responses at all from individual wards. From April to September 2016 there had been 124 respondents to the friends and family test from the acute wards and psychiatric intensive care units. These were mostly positive. One hundred and one people said they were likely or extremely likely to recommend the service to others, whilst 10 people said they were unlikely or extremely unlikely to recommend it.

Information about the performance of the ward was on display, and included standard monitoring information that was captured every two months. This included information about falls assessments and nutrition assessments, medication monitoring and the quality of care plans.

Each ward had a patients' meeting. The agenda and frequency varied, but they took place either daily or weekly and were documented. Patients were able to give feedback and raise any complaints or maintenance issues. For example, about the food, or if items were broken. These were addressed by staff, and fed back at subsequent meetings.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Bed occupancy for acute and psychiatric intensive care units overall was 96% over the three months to 30 September 2016. This ranged from 93% on Bollin ward to 100% on both Brackendale and Juniper wards.

Discharge plans were discussed in multidisciplinary team meetings, and documented in the care records. The crisis and home treatment team visited the wards every day to discuss each patient's discharge plan, and whether they were suitable for home treatment. Information provided by the trust stated that there had been no delayed discharges in the three months to the end of September 2016. The trust had no out of area placements for patients who required an acute or psychiatric intensive care bed. The trust had a process for reviewing and returning patients if they were admitted to a hospital outside the trust.

There were two psychiatric intensive care units in the trust: Brooklands ward had 10 beds in Wirral, and Willow ward had seven beds in West Cheshire. Both wards were mixed sex. Patients would preferably go to the ward nearest where they lived, but they could be admitted to either ward depending on bed availability.

The psychiatric intensive care unit provided an in reach service to the acute wards. Staff visited the acute wards based in the same hospital, and rang the wards at the Millbrook unit. Their role was to discuss any potential referrals to the psychiatric intensive care unit, and to offer advice on how to manage any aggressive or challenging behaviour. Staff told us that it was a straightforward process to refer patients to the psychiatric intensive care units, but the availability of beds varied. Staff at the Millbrook Unit told us that as they did not have a psychiatric intensive care unit onsite, patients were transferred using secure transport.

Adelphi and Brackendale wards admitted patients over 18 with no upper age limit. The other acute wards admitted patients up to the age of 65. Concerns had been raised at the previous inspection that patients with dementia were being cared for on the acute wards, which was creating difficulties. Ward managers told us that it was possible that some patients may have the early signs of cognitive impairment. However, if the prevailing symptoms were of a functional mental illness, then they would be treated for this on an acute ward. This was supported by the sample of records we reviewed of patients with potential cognitive impairment. The records showed that consideration had been made to the suitability of the placement dependent on their presenting symptoms.

The facilities promote recovery, comfort, dignity and confidentiality

The wards had a range of rooms and equipment that facilitated patient care. Each ward had day rooms, with separate female and quiet rooms. There were activity rooms where crafts could be carried out, and some wards had access to gym equipment and the internet. There were laundry facilities on all the wards.

Adelphi ward and Bollin ward had three double rooms. In one of these rooms there was no divider to give the occupants privacy, though there were fittings for a curtain and rail. This was reported to the manager, and the trust informed us the following day that the rail and curtain had been fitted. Each of the wards had inbuilt blinds in the windows of bedroom doors. These could be operated by staff with a key from the outside, but could not be adjusted by the patient from the inside. The blinds were not always closed on all the wards.

Patients had a key to their rooms and secure storage on some of the wards, but not on others. For example, patients on Adelphi and Bollin wards did not have keys to their rooms. However, patients on Beech and Willow wards had electronic fobs, which unlocked their bedroom doors.

Pre-prepared meals were delivered to the wards for re-heating in a dedicated food trolley. There was a three week rolling menu, and patients chose what they wanted from the menu each day. Food was served by housekeeping staff.

The kitchens were locked, but clients could access water and drinks at any time in the dining rooms. Patients could request snacks from staff. On Willow ward, patients could request drinks whenever they wished, but they were made by staff in the main kitchen.

The occupational therapists ran the activity programmes on each of the wards, often supported by a technical assistant. The activities were provided from Monday to Friday. The range of activities varied across the ward, but included relaxation, cooking, healthy lifestyles and art and craft groups. Bollin ward had reduced activities because of

Are services responsive to people's needs?

Good

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

temporary staff shortages. However, the ward had successfully piloted a seven-day activity programme, and was in the process of recruiting to the additional posts to implement this permanently.

The location of the wards determined if patients had access to outdoor space. Wards on the ground floor had direct access to a garden. Beech and Bollin wards were on the first floor, so patients who were on enhanced levels of observation were escorted to the communal gardens if they wanted to go outside.

There were private phone rooms on each of the wards. Most patients had their own mobile phone. Patients were risk assessed as to whether they were safe to have their own phone and charger on the ward.

Meeting the needs of all people who use the service

The wards had an assisted bathroom. Specialist beds were provided when necessary. For example airflow mattresses for patients at risk of pressure sores.

A variety of information leaflets were available in English on the wards. On the back of the English leaflet, there was information in several different languages advised people to contact the communications team if they wanted the leaflet in another language, in audio, braille or large print. Easy read medication leaflets were available through the trust's intranet. Patients had access to face-to-face and telephone interpreting services.

Staff could order meals and food for people with special dietary needs. This included people with health conditions such as diabetes, vegetarians, or patient who required halal or kosher food.

There were multifaith rooms on all sites, and spiritual leaders were accessible.

Listening to and learning from concerns and complaints

Patients we spoke with told us they either knew how to make a complaint, or knew who to speak with if they wanted to make a complaint. There was information on display about how to make a complaint, and this was also on the trust's website. Information leaflets were on the wards titled "tell us what YOU think about CWP" to encourage patients to give feedback about the service.

Staff knew how to manage complaints. They told us they would try to resolve the problem locally. If this was not possible, or if a patient wanted to make a formal complaint, they would send this to the trust's Complaints and Incidents Team. The Complaints and Incidents Team led investigations into complaints, and had close links with the Patient Advice and Liaison Service.

Are services well-led?

Good

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

The trust's values centred around the "6 Cs". These were: care, compassion, commitment, competence, communication, and courage. Information was on display about the trust's 6 Cs. The staff we spoke with were familiar with the 6 Cs. The 6 Cs were embedded into the trust's new appraisal system. Mangers told us they were discussed in supervision, so were incorporated into practice.

Staff knew who the senior managers were within their service, which included the matron and clinical service manager. The matrons visited the wards most days, and they were visible and supportive.

Good governance

The trust collated information about its staff and services, and used this for monitoring and improvement.

Each ward had an allocated resource manager with responsibility for dealing with the business side of the ward, such as finances and recruitment. They worked with the ward manager, and had a monthly meeting with staff from the central human resources and finance departments. Ward managers met as a group with the associate director of nursing and therapies for mental health. Managers told us that they had completed a safer staffing exercise and this had successfully increased the staffing levels on the unit.

Ward managers had key performance indicators to achieve. These included targets for patients' 72-hour assessments, completion of Health of the Nation Outcomes Scales, and supervision, appraisal and training.

A locality data pack was produced for each ward. It included key governance information about patients, staff, practice issues, and audits. For each area there was comparative information, such as the number of restraints per month, with a basic summary or narrative within each section. The information was clearly presented, and provided a quick and accessible means of monitoring different pieces of information.

Information about each ward was reported to the relevant clinical commissioning group. As the wards covered different geographical areas, information could be sent to up to five different clinical commissioning groups. There were no specific targets or performance indicators for acute wards or psychiatric intensive care units. The information reported included bed occupancy, the number of new episodes of treatment and discharges.

Ward managers could submit items to the trust's risk register. They were aware of the key risks that were relevant to their services, such as potential ligature points.

Leadership, morale and staff engagement

Staff were positive about their teams and managers. They felt able to raise concerns. Staff told us that morale was generally good at Clatterbridge Hospital and Bowmere Hospital. However, a consultation was planned about the potential closure of the Millbrook Unit, which had caused uncertainty about the future.

Commitment to quality improvement and innovation

The inpatient safety metrics were a bimonthly peer review audit programme completed across all inpatient wards. These picked out five patients' records each month and checked whether key elements had been completed correctly. This included falls assessments, medication reviews, the Mental Health Act, safeguarding, management of violence and aggression, and the quality of inpatient care plans and discharge planning. The most recent safety metrics was completed in July 2016. The target for completion was 100%. Where this was not reached, an action plan was implemented with a date for completion.

The wards were not accredited through the Royal College of Psychiatrists accreditation for inpatients mental health services initiative.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The trust did not always comply with the Department of Health guidance on same sex accommodation.