

Good



North West Boroughs Healthcare 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)
RTV2M	Atherleigh Park	Westleigh unit Sovereign unit	WN7 1YN

This report describes our judgement of the quality of care provided within this core service by North West Boroughs Healthcare NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Summary of findings

Where applicable, we have reported on each core service provided by North West Boroughs Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of North West Boroughs Healthcare 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



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

Following the inspection in July 2015, we rated the core service as good for the key questions of effective, caring, responsive and well-led. We did not inspect these key questions during the most recent inspection in July 2017 and we have not changed these ratings.

Following the inspection in July 2016, we rated safe as good. As a result of this most recent inspection, we have revised this rating to requires improvement. This was because:

- There was no current written guidance for staff to follow when patients went missing, as required by the Mental Health Act Code of Practice.
- Following incidents of patients going absent without leave, records did not always indicate that staff took timely and clear action to ensure patients safely returned to the ward
- Psychiatrists were not always clearly recording section 17 leave decisions, did not always provide clear conditions of leave and did not clearly record a proper risk management rationale for continuing patients' leave following recent incidents of patients going absent without leave.

- Patients on Westleigh unit did not routinely receive a copy of any section 17 leave authorisations to enable them to fully understand their leave and any conditions.
- Following completion of a risk assessment for each patient, staff did not always complete a robust risk management plan and instead the risk management plans usually consisted of a simple chronology of events and incidents.
- The trust had not completed a recent audit of section 17 leave and therefore had not fully considered and addressed the wider shortfalls.

However:

- There had been recent reduction in the numbers of patients going absent without leave directly from the ward as there had been several changes to the ward environment to try and reduce these incidents.
- Staff discussed measures to reduce patients going absent without leave directly at team meetings and there had been changes to staff practice.
- Patients were given a wristband on admission which allowed them to unlock and access their bedrooms or other patient accessible rooms.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- There was no current written guidance on missing patients, as required by the Mental Health Act Code of Practice. This meant that staff did not have definitive guidance on what to do when a patient went missing and in what circumstances to call the police.
- Following incidents of patients going absent without leave, records did not always indicate that staff took timely and clear action to ensure patients safely returned to the ward.
- Psychiatrists were not always clearly recording section 17 leave decisions and did not always provide clear conditions of leave.
- Psychiatrists did not clearly record a proper risk management rationale for continuing to patient's leave especially following recent incidents of patients going absent without leave.
- Patients on Westleigh unit did not routinely receive a copy of any section 17 leave authorisations as required by the Mental Health Act Code of Practice.
- Following completion of a risk assessment for each patient, staff did not always complete a robust risk management plan and instead the risk management plan consisted of a simple chronology of events and incidents.
- The trust had not carried out a clinical audit of section 17 leave or absence without leave incidents. The trust had therefore not fully considered and addressed the wider shortfalls such as failing to meet the Code of Practice requirements and addressing fully the increase in patients failing to return from agreed leave

However:

- The environmental shortfalls had been identified and addressed by the trust with trust board oversight and there had been several changes to the ward environment to try and reduce the incidents. This included improving the robustness of the exit doors, changes to the door release system and curved mirrors at height.
- There had been an actual reduction in the patients going absent without leave directly from the ward.
- Staff discussed measures to reduce patients going absent without leave directly from the ward regularly at team meetings and there had been changes to staff practice to reduce incidents. For example, staff being stationed at the serving hatch in the dining room.

Requires improvement



Summary of findings

- Patients were given a wristband on admission which allowed them to unlock and access their bedrooms or other patient accessible rooms.

Summary of findings

Information about the service

North West Boroughs Healthcare NHS Foundation Trust had ten acute wards for people of working age across five hospital locations for adults who required hospital admission due to their mental health needs. The wards provided assessment, treatment and care for adults who had functional mental health problems (such as depression, schizophrenia or bipolar disorder).

On this inspection our focus was on the services provided at one location, Atherleigh Park. Atherleigh Park was a newly registered location in March 2017 with acute wards and the psychiatric intensive care services transferring from Leigh infirmary.

The wards at Atherleigh Park were:

- Westleigh unit - a ward for female patients with 20 beds.

- Sovereign unit - a ward for male patients with 20 beds.
- Priestner's unit - a ward for both men and women at providing psychiatric intensive care and had eight beds.

We conducted a comprehensive inspection of the trust's acute wards for adults of working age and psychiatric intensive care units under the Health and Social Care Act in July 2015. We issued one requirement notice against regulation 12 for acute wards. This was for safe care and treatment due to ligature risks and the seclusion room environments on the wards.

We returned in July 2016 and found that the trust had improved in these areas.

We have not inspected the Atherleigh Park location before.

Our inspection team

The team was comprised of two CQC inspectors and a MHA reviewer.

Why we carried out this inspection

We undertook this focused, unannounced inspection to North West Borough Healthcare NHS Foundation Trust to follow up on information we had received from the police about an increase in incidents of patients going absent without leave.

When we last inspected the trust in July 2016, we rated wards for acute wards for adults of working age and psychiatric intensive care units as good overall and for all key questions.

How we carried out this inspection

We undertook this focused, unannounced inspection to follow up on information we had received about incidents at Atherleigh Park involving patients going absent without authorised leave.

Before the inspection visit, we reviewed information we held about the service including statutory notifications sent by the trust. A notification is information about important events, which the trust is required to send to us

via a national database. We asked other organisations to share what they knew. We carried out an unannounced inspection on 7 July 2017 to acute wards for adults of working age at Atherleigh Park.

During this inspection:

- We visited two adult acute wards at Atherleigh Park.
- We looked at the quality of the ward environments.
- We spoke with the managers for each of the wards, two service managers and a consultant psychiatrist.

Summary of findings

- We looked at six care records of current or recent patients who had gone absent without leave.
- We looked at incident information and data for the two acute wards we visited and Priestner's unit.
- We looked at leave authorisations relating to 17 current patients who had authorised leave.
- We spoke with a representative of the local police force.
- We looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke to two detained patients in private and other patients informally whilst doing a tour of the ward. The other patients either did not wish to speak with us or were too mentally unwell to have the capacity to make a decision whether or not to speak with us.

The patients we spoke to in private told us they felt safe in their rooms and liked the environment but did not feel safe in the rest of the environment. One patient we spoke

to informally felt that they had not received information about their rights as a detained patient, including their right to tribunals. We passed these concerns on to the ward manager.

Patients we spoke to did not raise issues about incidents of absent without leave which was the focus of this inspection.

Good practice

- Patients were given a wristband on admission which allowed them to unlock and access their bedrooms or other patient accessible rooms. The wristbands were individually programmed and room access could be changed depending on patients' risks

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that there is written guidance on missing patients, as required by the Mental Health Act Code of Practice.
- The trust must ensure that, following an incidents of absence without leave, staff take timely and clear action and always record efforts to ensure the patient is safely returned to the ward in line with the trust's written guidance and as required by the Mental Health Act Code of Practice.
- The trust must ensure there are improvements in recording section 17 leave decisions including conditions of leave especially following incidents of absence without leave with a proper risk management rationale for leave authorisation decisions

- The trust must ensure that patients on Westleigh unit routinely receive a copy of any section 17 leave authorisations as required by the Mental Health Act Code of Practice.
- The trust must ensure that it improves its systems to fully identify and address shortfalls in the records and practices relating to section 17 leave and absence without leave.

Action the provider **SHOULD** take to improve

- The provider should continue to ensure that staff complete a risk management plan for each patient following a risk assessment (rather than a simple chronology of events).

North West Boroughs Healthcare 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
Westleigh Unit Sovereign Unit	Atherleigh Park

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. On this inspection, we looked at the arrangement for section 17 of the Mental Health Act which were the arrangements for patients receiving leave from the hospital and section 18 of the Mental Health Act which relates to the return and readmission of patients who go absent without leave. We found:

- There was no current written guidance on missing patients, as required by the Mental Health Act Code of Practice. This meant that staff did not have definitive guidance on what to do when a patient went missing and in what circumstances to call the police.

- Following incidents of patients going absent without leave, records did not always indicate that staff took timely and clear action to ensure patients safely returned to the ward.
- Psychiatrists were not always clearly recording section 17 leave decisions and did not always provide clear conditions of leave or record a proper risk management rationale for continuing to patient's leave following recent incidents of patients going absent without leave.
- Patients on Westleigh unit did not routinely receive a copy of any section 17 leave authorisations as required by the Mental Health Act Code of Practice.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not look at the Mental Capacity Act on this inspection. This was because our inspection, focused on whether safe care and treatment was being delivered.

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

Atherleigh Park was a new location registered in March 2017. All the mental health wards previously located at Leigh Infirmary had relocated to Atherleigh Park. The ward environments were much improved when compared to the previous wards at Leigh Infirmary. This was because the wards at Atherleigh Park all had individual bedrooms, with ensuite shower and toilet facilities rather than mostly dormitory style wards. On each ward, there was a lounge and dining room, a seclusion suite, a de-escalation room, a clinic and treatment room and a range of other communal spaces including an activities room and relaxation room, as well as two enclosed courtyards on each ward. The wards were clean and designed to a modern specification.

The police raised concerns that since moving to Atherleigh Park, the incidents of patients going absent without leave had increased. The police stated that they had several meetings with the managers at Atherleigh Park to establish how the hospital could be encouraged to improve systems of working that would reduce the numbers of patients absconding from the wards or going absent without leave. We therefore requested data from the trust about the absconsions. The data supplied by the trust confirmed there had been an increase in absconsions by adult patients directly from the wards at Atherleigh Park compared to the equivalent wards at Leigh Infirmary.

On the inspection, we looked at the ward environments to understand why there had been a recent increase in the number of patients who were reported as going absent without leave directly from the ward. We looked at what measures had been introduced within the ward environment to prevent such occurrences in the future.

The existing environment was designed to prevent absconsions with locked doors, a manned locked reception area to each ward, enclosed courtyards (with specialised drainage and fixed planters and furniture to prevent patients leaving the courtyard) and closed circuit television in public corridor areas to monitor patients accessing and exiting the ward.

From the information we received, we saw that most of the absconsions directly from the wards were patients pushing through one set of doors to then hit the automatic release button in the locked reception area of the ward. There had also been an absconson through the dining room hatch on Westleigh unit and through a window in a patient bedroom on Sovereign unit.

There had been improved security changes to the door mechanisms across all the wards. In addition to staff having a wristband which opened internal doors, the internal doors on the wards into the locked reception had a fire door release nearby. These release mechanisms had been changed to requiring a key. The front entrance of the wards at the locked reception maintained a fire door release button. This was maintained so visitors in reception could leave the area in the event of a fire without staff intervention. The trust provided ongoing assurances to us that overall fire safety had not been compromised by these changes to the fire safety arrangements.

The units also had introduced a procedure whereby staff could lock the front doors to Atherleigh Park locked automatically if a patient absconded from the ward to prevent them from leaving the building. This was controllable from each ward.

One patient on Sovereign unit went absent without leave through the patient bedroom window. The windows in patient bedrooms had a modern slide mechanism with a mesh design to provide fresh air. Often this design was used in secure care to prevent absconsions and was increasingly used in acute settings too. The patient was able to override and release the central locking mechanism unit at the window and escape from the ward. Since this incident, staff were carrying out window locking checks and the wards had a special suction device to ensure the windows were properly locked without resorting to unlocking and relocking the windows.

One patient on Westleigh unit went absent without leave from the serving hatch into the dining area and then through the reception. Following these incidents, the hatch was locked unless in use and when it was unlocked, a member of staff was deployed close to the hatch to prevent absconsions.

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We saw there had been changes to staff practice and improved relational security arrangements to reduce absences directly from the ward. This included staff checking through the door window of the ward and utilising the new curved mirrors which had been placed at height so staff could check if any patients were near to the exit to the ward before entering. There was also signage by the exit to remind staff to check through the window. Staff were also utilising a second entrance to the ward which avoided areas patients could access unsupervised.

These environmental and procedural changes and actions had led to an actual, recent reduction in the patients going absent without leave directly from the wards at Atherleigh Park. This meant that staff had taken sufficient action to try and reduce the incidents of patients absconding directly from the ward.

Patients had access to their bedrooms at all times. Patients were given a wristband on admission which allowed them to unlock and access their bedrooms or other patient accessible rooms. The wristbands were individually programmed and room access could be changed depending on patients' risks. Any changes to access were discussed with patients before implementation.

Assessing and managing risk to patients and staff

As this was a focused inspection, we only looked at how staff were assessing and managing risks to patients and the wider public when detained patients were given leave and if they went absent without leave. There had been several instances of patients going absent without leave since the wards opened at Atherleigh Park. One detained patient had gone absent without leave the day before our inspection and was still absent throughout our time on the ward but was later returned safely.

As patients were detained under the Mental Health Act for their own health or safety or for the protection of others, it was important that when patients went missing from the ward or went absent without leave, staff took timely action to return the patient to the ward safely (including requesting police assistance, where necessary). We asked staff at Atherleigh Park what guidance they followed when detained patients went missing but they were not aware of current trust wide guidance and there was no policy on the trust intranet where policies were usually kept. Managers at Atherleigh Park told us that there had been a trust policy but this had been withdrawn in approximately April 2016 as it was out of date. The trust had a draft 'absence without

leave procedure' but this had not been ratified and required additional processes and protocols to be reviewed and developed locally with each police force areas the trust worked within.

There was therefore no current, operational, written guidance on missing patients, as required by the Mental Health Act Code of Practice. This meant that staff did not have definitive guidance on what they should do when a detained patient or vulnerable informal patient went missing to enable them to manage the risks to the patient and the public and in what circumstances to call the police. The trust did not have this guidance available to staff; senior managers were not able to provide cogent reasons for departing from the Mental Health Act Code of Practice in this case.

There was a system in place to record section 17 leave. Each ward had a responsible clinician attached to the ward full time. Daily ward rounds occurred which meant that section 17 leave decisions could be reviewed regularly for any given patient.

On Sovereign ward, section 17 leave records showed that when patients were given leave that it was properly authorised, had clear parameters for leave in terms of time and area and clear and detailed conditions placed on the leave by the responsible clinician. On Westleigh ward the recording of conditions of leave was minimal and did not clearly direct patients of what was expected of them whilst on leave. For example, one patient continued to use alcohol and illicit substances and their leave form did not provide a condition to state that they should refrain from illicit drug use and overconsumption of alcohol during their leave period.

We saw one example on Westleigh ward, where the responsible clinician had initially authorised three hours leave. This had been increased verbally to five hours but this was not recorded on either the local section 17 leave form or as a clinical record. The patient failed to return after five hours and then the staff reported the patient as a missing person. We spoke with the responsible clinician who accepted the shortfall in recording the revised section 17 leave authorisation in this case. We also heard that whilst the daily multidisciplinary meetings were minuted, decisions regarding changes to patient care such as changes to leave were not always copied into the patient electronic clinical record and relevant documentation amended to reflect the changes such as the locally devised

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section 17 leave form. Following our inspection, the trust accepted that the patient electronic clinical record and relevant documentation also needed to be updated to reflect the decisions made. Psychiatrists were therefore not always clearly recording section 17 leave decisions and did not always provide clear conditions of leave.

The Mental Health Act Code of Practice required that patients should be given copies of their section 17 leave authorisation forms. This helped to ensure that patients were fully informed of their leave, any conditions placed on their leave and the time they should return to the ward to support adherence to the section 17 leave given. None of the current section 17 leave forms on Westleigh ward showed that the patients or their carers had been offered a copy of their leave form. Staff confirmed that patients on Westleigh unit did not routinely receive a copy of any section 17 leave authorisations. On Westleigh unit, the Mental Health Act Code of Practice requirement was therefore not met without proper reasons. However, on Sovereign unit, nine out of ten current section 17 leave forms we looked at showed that the patients received a copy.

We saw that on Westleigh unit, staff recorded the time patients went on leave, their expected time of return and their actual return time. The current section 17 leave form was also attached to the record. There were some gaps in the record especially of the recording of the actual return time. On Sovereign ward, staff recorded this information on a white board.

We saw that on Westleigh unit, staff took a description of the clothes patients were wearing immediately before they went on leave. This helped staff to give the police a description to help return the patient. On Sovereign unit, staff did not routinely record details of the clothes patients wore. Neither ward routinely took a photograph of patients to give the police to assist their search. This was despite the fact that the Mental Health Act Code of Practice recommends patients' descriptions and photographs were taken.

Following incidents of patients going absent without leave, records did not always indicate that staff took timely and clear action to ensure patients safely returned to the ward. This was because records showed that on occasions there was a slight delay in phoning police and/or informing the nearest relative or that the time key people were informed was not fully recorded. This was often because daily clinical

records were often written retrospectively at the end of shift rather than after key events or incidents. We therefore found it difficult to assess whether there was a delay in staff acting or whether it because of the time elapsed when staff recorded the action they had taken.

In some cases, whilst it was clear that staff made some initial efforts to return the patient to the ward by searching the grounds, informing relatives and the care coordinator, if patients were still missing after a prolonged period; from the records viewed, staff relied on only contacting the police to enquire of their efforts to return the patient to the ward.

The records did not always indicate whether the patient's nearest relative was informed when the patient went absent without leave. In one case, one patient had a detailed care plan which stated if they went absent without leave, their mother and sister should be called. These directions were not followed following one incident of the patient going absent without leave, as the patient's mother was not called or informed. In another case, a patient's mother was called initially when the patient went absent without leave, but when the patient returned early in the morning, staff did not inform the mother of their loved one's safe return without proper reason. Consequently the patient's mother complained the next day that they were not informed. This meant that staff were not always informing, or keeping, nearest relatives informed when patients went absent without leave.

We saw that patients who went absent without leave had their leave reinstated very quickly without any clinical decision or risk assessment that the continuation of leave was appropriate and without any debriefing of the patient to enquire about the incident from the patient's perspective. We saw two cases where the care plan indicated that leave should be suspended for 48 hours after any episode of patients going absent without leave including failing to return from section 17 leave. In each case, following the patients failing to return within the specified time, their leave was only suspended for a few hours and then reinstated without any clinical review, risk assessment review or record of the rationale for continuing leave. In one case, the patient had leave reinstated, failed again to return and self harmed through superficial

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lacerations to their leg. Psychiatrists did not clearly record a proper risk management rationale for continuing patient's leave following recent incidents of patients going absent without leave.

Following completion of a risk assessment for each patient, staff did not always complete a risk management plan and instead the risk management plan was a simple chronology of events and incidents. For example, many records identified past risk incidents of patients going absent without leave without detailing how current and future risks would be managed. We did see one patient who had an extensive risk management plan regarding their frequent absent without leave incidents formulated into her care plan. Patients' risk assessments were therefore lacking in detail and did not guide staff on how to reduce the risks of patients going absent without leave.

The trust accepted that the current format of their risk documentation did not support staff to formulate risk events into a risk management plan. The trust told us that risk documentation was being reviewed at trust level and the draft version was more individualised and user friendly. The proposed changes would enable staff and patients the opportunity to collaboratively formulate risk factors and develop strength based risk management plans.

Staff were not fully protecting patients and there was the potential for serious incidents to occur because the trust were failing to ensure that staff were fully meeting their responsibilities around the management of section 17 leave and absence without leave incidents for detained patients.

Track record on safety

We requested data from the trust about the absconsions. The data supplied by the trust confirmed there had been an increase in absconsions by adult patients directly from the wards at Atherleigh Park compared to the equivalent wards at Leigh Infirmary. There were:

- Twelve absconsions from Westleigh unit in the period 7 March 2017 to 1 July 2017 (averaging 1.7 absconsions a month); whereas there had been two absconsions from Cavendish ward from 1 July 2016 to 7 March 2017 (averaging 0.2 absconsions a month);

- Five absconsions from Sovereign unit in the period 7 March 2017 to 1 July 2017(averaging 1.2 absconsions a month); whereas there had been seven absconsions from Lakeside ward from 1 July 2016 to 7 March 2017(averaging 0.9 absconsions a month);
- Four absconsions from Priestner's unit in the period 7 March 2017 to 1 July 2017(averaging 1 absconsion a month); whereas there had been no absconsions from the PICU ward from 1 July 2016 to 7 March 2017

Since June 2017 and as a result of environmental improvements to the wards, there had been a reduction in the patients going absent without leave directly from the ward.

We looked at the incidents of patients going absent without leave because they failed to return within the time specified on their authorised section 17 leave from the wards at Atherleigh Park compared to incidents on the equivalent wards when they were bases at Leigh Infirmary. We saw:

- There had been five incidents of patients failing to return from leave from Westleigh unit from 7 March 2017 to 1 July 2017; whereas there had been 16 such incidents from ward between 1 April 2016 and 7 March 2017.
- There had been four incidents of patients failing to return from leave from Sovereign unit from 7 March 2017 to 1 July 2017; whereas there had been seven such incidents from this ward between 1 April 2016 and 7 March 2017.
- There had been no incidents of patients failing to return from leave from Priestner's unit from 1 April 2016 to 1 July 2017.

There had not been any recent serious incidents to patients whilst patients went absent without leave from Atherleigh Park. We identified one patient had taken a non-life threatening overdose and one patient had self harmed with superficial lacerations to their leg; both whilst absent without leave. We saw staff had suffered minor injuries trying to prevent patients going absent without leave.

Reporting incidents and learning from when things go wrong

We saw that absence without leave episodes were recorded as incident notifications. A notification is information about important events, which the trust is required to send to us via a national database. We sampled

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the incident records data on absence without leave incidents on the national database for the trust. This sample what we saw in patient records on the inspection and the incidents reported by the trust in the national database correlated. This meant that we were assured that staff were reporting absence without leave incidents correctly.

The increase in absence without leave episodes directly from the wards following the move to Atherleigh Park had been recognised through incident monitoring and reported to the trust board. The trust board had asked for ongoing assurances. The director of operations and integration visited Atherleigh Park in May 2017 to review the physical environment and put in place immediate corrective measures. This included improvements in the environment, procedural changes and training to prevent further occurrences. Since June 2017 and as a result of these improvements, there had been a reduction in the patients going absent without leave directly from the ward.

Staff discussed measures to reduce patients going absent without leave directly from the ward regularly at team meetings and there had been changes to staff practice to reduce incidents. For example, staff being stationed at the serving hatch in the dining room.

We asked the trust for details of recent audits they had they carried out relating to section 17 leave, absence without leave incidents and patients failing to return from section 17 leave covering services at Wigan and Leigh since April 2016 and associated action plans. The trust told us that an audit had taken place but it was still in draft form.

This meant that whilst the environmental issues had been identified and addressed absence without leave from the

wards, the trust had not fully considered and addressed the wider issues such as failing to meet the Code of Practice requirements and addressing fully the increase in patients failing to return from agreed leave.

The trust had taken action following the incident where a staff member let the patient off psychiatric intensive care unit ward without challenge. The trust carried out a 72 hour safety check investigation which identified actions to be taken in relation to training, supervision and recommended full disciplinary investigation to take place. The disciplinary investigation was ongoing.

Following the inspection the trust told us that they had taken action to address the shortfalls we found on the inspection and ensure lessons were fully learnt from the recent incidents. This included action to ensure that:

- All section 17 leave plans were updated to incorporate the purpose of leave, parameters, risk assessment and crisis plan.
- Leave plans were to be shared with, agreed and signed by the patient, where possible.
- If 'absence without leave' risks were identified, the risk would be highlighted in the individual patient's care plan together with detailed actions to be taken if the patient goes absent without leave.
- Prior to patients going on leave, staff would carry out a mental state examination and risk assessment and record this assessment.
- Any decision made at the daily clinical meeting would be copied into the patient electronic clinical record and other relevant documentation.
- Senior leadership team had completed an analysis of absconsions and absent without leave incidents.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Care and treatment was not provided in a safe way for service users.

Staff were not doing all that was reasonably practicable to mitigate risks to the health and safety of service users when patients went on leave and following incidents of service users going absent without leave. This was because:

- Responsible clinicians were not always clearly recording section 17 leave decisions and did not always provide clear conditions of leave.
- Responsible clinicians did not clearly record a proper risk management rationale for continuing to patients' leave especially following recent incidents of patients going absent without leave.
- Patients on Westleigh unit did not routinely receive a copy of any section 17 leave authorisations as required by the Mental Health Act Code of Practice.

This was a breach of regulation 12 (1) (2) (a) and (b).

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems and processes were not effective. The systems and processes were not established to guide staff regarding following incidents of service users going absent without leave and mitigate the risks.

There was no current written guidance on missing patients, as required by the Mental Health Act Code of Practice.

The trust had not completed a recent audit of section 17 leave or absence without leave episodes. The trust's

This section is primarily information for the provider

Requirement notices

systems had not identified and addressed that section 17 leave authorisation decisions were not always fully recorded with clear conditions. The trust's systems were not effective as they had not fully considered and addressed the wider issues found on the inspection such as failing to meet the Code of Practice requirements and addressing fully the increase in patients failing to return from agreed leave.

There was not an accurate record which was maintained. Following incidents of patients going absent without leave, records did not always indicate that staff took timely and clear action to ensure patients who were absent were safely returned to the ward.

This was a breach of regulation 17 (1) (2) (b) and (c).