Requires improvement

Cheshire and Wirral Partnership NHS Foundation Trust

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

Quality Report

Trust Headquarters
Redesmere
Countess of Chester Health Park
Liverpool Road
Cheshire
CH2 1BQ
Tel:01244 650300
Website:www.cwp.nhs.uk

Date of inspection visit: 23-25 June 2015
Date of publication: 03/12/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXA54	Clatterbridge Hospital	Brackendale ward Brooklands ward Lakefield ward	CH63 4JY
RXA19	Bowmere Hospital	Willow ward Juniper ward Beech ward	CH2 1UL
RXAAEJ	Jocelyn Solly (Millbrook)	Adelphi ward Bollin ward	SK10 3JF

Summary of findings

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.

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We gave an overall rating for acute wards for working age adults and the psychiatric intensive care unit (PICU) as requires improvement because:

- Brackendale and Beech wards did not comply with the Department of Health required guidance on same sex accommodation.
- Acute wards were mixed gender. Not all bedrooms were en-suite and on some wards, female patients had to pass a male area to access toilet and bathroom facilities.
- Not all wards had designated female-only lounges.
- There were not clear lines of sight within the corridors housing patients of different genders.
- We observed a male and female patient going into a bedroom area, unobserved by staff.

Some of the seclusion records either did not record the time the doctor was informed and attended or did not explain the reasons why the doctor was delayed. This meant it was not always clear that the safeguards for seclusion or segregation were being met. Some of the restraint records did not record the time patients were restrained in the prone position.

Some patients' risk assessments were lacking in detail and some identified a list of past risk incidents without detailing how current risks would be managed.

There was variable adherence to the MHA Code of Practice particularly around significant delays in recording of rights, capacity to consent for treatment for mental disorder and seclusion recording.

The trust's governance arrangements relating to the oversight of the Mental Health Act was not effective. Our MHA reviewers had raised many of these concerns on previous MHA monitoring visits, but issues continued to be found.

Patients on Beech ward were not receiving regular input from the responsible clinician (RC), with some patients not seeing their RC for weeks.

However:

There were plans to improve the seclusion environment at the Jocelyn Solly (Millbrook) Unit as the current rooms used for seclusion did not meet the enhanced standards prescribed by the new Mental Health Act Code of Practice. There were significant efforts to reduce and review all episodes of prone restraint through various trust initiatives. Staff knew about potential risks to patients' health and safety, and how to respond to and manage these. There were clear systems in place for reporting safeguarding concerns and staff understood what they had to do.

Services were evidence-based and focused on the needs of patients. However, there was a lack of psychology input on the wards. Staffing levels were generally safe.

The trust provided a caring service for patients across the acute wards and the PICU. We saw examples of staff treating patients with kindness, dignity and compassion. The feedback received from patients was generally positive about their experiences of the care and treatment provided by the staff on the acute wards and the PICU.

Wards employed peer support workers so patients were supported by a staff team that included suitable people who had direct experience of mental illness. Ward managers were supported in the day-to-day management by a resource manager who managed the non-clinical aspects of running the ward. This enabled ward managers to focus on ensuring the wards provided good quality clinical care.

Patients were able to access beds in their local acute psychiatric service within reasonable timescales. Whilst there was some pressure on beds, this did not significantly affect patient care.

Patients told us they knew how to make a complaint should they need to.

The wards and PICU were committed to provide high-quality care and continuous improvement in line with the trust's stated values and strategy. Staff reported they felt well supported by their managers.

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:

- Wards did not comply with the Department of Health required guidance on same sex accommodation.
- Acute wards were mixed gender. Although wards had separate corridors for men and women, these were not always adhered to.
- Some bedrooms were not en suite and, on some wards, women could access bathroom and toilet facilities only by passing through the male corridors.
- Not all wards had designated female-only lounges.
- There were not clear lines of sight within the corridors housing patients of different genders.
- We observed a male and female patient going into a bedroom area unobserved by staff. Staff were attending a handover meeting so there was limited staff available for observations.
- Some of the seclusion records either did not record the time the doctor was informed and attended or did not explain the reasons why the doctor was delayed. This meant it was not always clear that the safeguards for seclusion or segregation were being met.
- Some of the restraint records did not record the time staff restrained patients in the prone position. The prone position was where patients were restrained on the floor face downwards.
- Risk assessments were in place to assess and manage risks to individuals. However, some risk assessments were lacking in detail and some identified a list of past risk incidents without detailing how current risks would be managed.
- The implementation of the no smoking policy within the trust was causing difficulties for patients and staff. The policy appeared to go beyond the legal powers available to the hospital for example patients were searched for tobacco, cigarettes and lighters; these items were confiscated and not returned until patients were discharged even if they went on overnight leave.

However:

Summary of findings

- There were plans to improve the seclusion environment at the Jocelyn Solly (Millbrook) Unit, as the current rooms used for seclusion did not meet the enhanced standards prescribed by the new Mental Health Act Code of Practice.
- There were significant efforts to reduce and review all episodes of prone restraint through various trust initiatives. New checks provided assurance to managers that prone restraint was only used when required.
- Staff knew about potential risks to patients' health and safety, and how to respond to and manage these.
- The acute wards were clean. Staffing levels were generally safe.
- There were clear systems in place for reporting safeguarding concerns and staff understood what they had to do.
- Incidents were reported and investigated.
- Lessons were learnt and shared to prevent incidents happening again.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- There was variable adherence to the MHA Code of Practice particularly around significant delays in recording of rights, capacity to consent for treatment for mental disorder and seclusion recording. Our MHA reviewers had raised many of these concerns on previous MHA monitoring visits, but we continued to find issues.
- Staff had not properly recorded consent and capacity to consent when key decisions were made for patients.
- Patients on Beech ward were not receiving regular input from the responsible clinician (RC), with some patients not seeing their RC for weeks.
- There was a lack of psychological therapy interventions on the wards.

However:

- Services were providing care and treatment which were underpinned by current guidance and focused on the needs of patients.
- The trust completed audits and had implemented changes to improve the effectiveness and outcomes of care and treatment.

Are services caring?

Good

We rated caring as good because:

- We saw examples of staff treating patients with kindness, dignity and compassion.

Summary of findings

- The feedback received from patients was generally positive about their experiences of the care and treatment provided by the staff on the acute wards and the PICU.
- Staff were knowledgeable about patients' needs and showed commitment to provide patient led care.
- Patients had access to advocacy when they were in-patients, including specialist advocacy for patients detained under the Mental Health Act.
- Patients told us they were involved in their care.
- Wards employed peer support workers so patients were supported by a staff team that included suitable people who had direct experience of mental illness.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Patients were able to access beds in their local acute psychiatric service within reasonable timescales. Whilst there were some pressures on beds this did not adversely affect patient care.
- Restrictions were usually kept to a minimum. Patients' individualised needs were met.
- The trust provided interpretation services to ensure that where there was a barrier for patients to communicate effectively, these were overcome using different approaches.
- The acute wards had multi-faith rooms to enable patients with religious beliefs to practice their faith.
- Patients felt they would know how to make a complaint.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- We continued to find and report on concerns relating to the adherence to the Mental Health Act and MHA Code of Practice (CoP). We have raised similar concerns in MHA monitoring visits. Despite the trust telling us they were addressing the issues we raised, we found continued concerns and similar problems persisting relating to the adherence to the MHA CoP on this inspection.
- Managers were not always being vigilant to ensure that Department of Health required guidance on same sex accommodation was being followed.

However:

- Staff were aware of their roles and responsibilities and staff had knowledge of the trust's values and objectives.

Summary of findings

- The wards were well led with effective management of the service through a commitment to provide high quality care and continuous improvement in line with the trust's stated values and strategy.
- Staff reported that they felt well supported by their managers and morale was good within the ward staff.
- There was a commitment to improvement.

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 acute wards provide care and treatment for older people with a functional mental illness, such as anxiety, depression or schizophrenia.

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

Clatterbridge Hospital psychiatric services (also known as Springview) on the Clatterbridge Hospital site on the Wirral 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 PICU 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:

- Willow ward – a seven bed mixed-sex PICU for adults
- Juniper ward – a 20 bed mixed-sex acute admission ward for adults and older adults with a functional mental illness
- Beech ward – a 22 bed mixed-sex acute admission ward for 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 23 bed mixed-sex acute admission ward for adults.

Each location provides inpatient mental health services for patients who were admitted informally and patients compulsorily detained under the Mental Health Act (MHA).

We have inspected the acute and PICU services provided at both Bowmere Hospital and Clatterbridge Hospital Psychiatric Services twice since registration.

- At the last inspection of Bowmere Hospital in August 2014, we found that the trust had taken action to improve the quality of the records.
- At the last inspection of Clatterbridge Hospital Psychiatric Services in July 2014, we found that the trust had taken action to improve identified patient nutritional issues and the quality of the records.

We have not inspected the services at Jocelyn Solly (Millbrook) before.

Therefore, at the time of this inspection, all locations of the trust were compliant with the regulations.

We have also carried out regular MHA monitoring visits to the acute wards and PICUs at Cheshire and Wirral Partnership NHS Foundation Trust within the last 18 months. Where we found issues relating to the MHA on these monitoring visits, the trust has provided an action statement telling us how they would improve adherence to the MHA and the MHA Code of Practice.

Our inspection team

Our inspection team was led by:

- Chair: Bruce Calderwood, Director Mental Health at Department of Health (retired)
- Head of Inspection: Nicholas Smith, Head of Inspection – Hospitals Directorate (Mental Health), Care Quality Commission
- Team Leaders: Sharon Marston, Inspection Manager (Mental Health), Care Quality Commission and Simon Regan, Inspection Manager (Acute and Community Health), Care Quality Commission

The team that inspected the acute wards and psychiatric intensive care units included a Care Quality Commission

Summary of findings

inspection manager, a Mental Health Act reviewer and a pharmacist inspector. We also had a variety of specialist advisors on the inspection team, including a consultant psychiatrist, two senior nurses, a social worker, a student nurse and an expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We arranged focus groups prior to the inspection, facilitated by a local mental health charity (Making Space) to reach out to patient groups. We also arranged focus groups prior to the inspection to meet with different staff groups and detained patients on the in-patient wards.

We carried out announced visits to the service on 23, 24 and 25 June 2015.

During the inspection visit, the inspection team:

- visited the acute wards and psychiatric intensive care unit (PICU) at three hospital locations
- looked at the quality of the ward environments
- spoke with 30 patients on the wards who shared their views and experiences of the services
- reviewed 24 comment cards left by patients and carers that specifically related to the mental health acute and PICU wards at the trust
- observed how patients were being cared for
- spoke with one carer
- spoke with the ward managers and resource managers for each of the wards
- spoke with 54 other staff members, including consultant psychiatrists, junior doctors, nurses, occupational therapists, housekeepers, student nurses, clinical support workers and a peer support worker
- spoke with managers, including a locality service director, clinical service managers and a modern matron
- spoke with representatives of two local independent mental health advocacy (IMHA) organisations that provided IMHA services
- looked at the treatment records of 38 patients
- carried out a specific check of the medication management on all the wards
- attended and observed two multi-disciplinary meetings, a care programme approach meeting and a business meeting
- looked at a range of policies, procedures and other documents relating to the running of the service including clinical and management records.

Summary of findings

What people who use the provider's services say

We spoke with 30 patients on the acute wards and PICUs who shared their views and experiences of the services we visited.

- Most patients were complimentary about the care they received from the staff on the acute wards.
- Patients told us that staff treated them with dignity, respect and compassion.
- They felt involved in the decisions about their care and treatment.
- Detained patients were generally aware of their rights whilst being on a section of the Mental Health Act.
- Two patients on Brooklands ward felt that they were subject to restraint that was excessive for the behaviour they were presenting and restraint was not carried out according to approved techniques
- Patients were very complimentary about the activities available during the week run by occupational therapists attached to the wards.

As part of the inspection, we left comment card boxes at various locations for people to tell us their experiences of the trust. We received 24 comment cards that specifically related to the mental health acute and PICU wards at the trust:

- Overall the comments were largely positive with people commenting that they were cared for well and the wards were kept clean.
- We received ten comments about Juniper ward, which included six positive comments, two negative comments and two neutral comments.
- We received six comments about Lakefield ward, which included four positive comments and two negative comments.
- We received four comments each about Brackendale and Beech wards; which contained all positive comments.
- There were no particular themes from the small number of negative comments we received.

We received many more completed comment cards (124 comment cards) but they did not indicate which service or ward they related to. It was therefore not fully clear which comments related to the acute wards or psychiatric intensive care units. Of these comment cards, 87% contained positive comments (108 comment cards) with 16 having negative comments.

Good practice

- Wards employed peer support workers so patients were supported by a staff team that included people who had direct experience of mental illness.
- Ward managers were supported in the day-to-day management of the ward by a resource manager who managed the non-clinical aspects of running the ward. This enabled ward managers to focus on ensuring the wards provided good quality clinical care.

Areas for improvement

Action the provider MUST take to improve

- The trust must review ward composition and practices to ensure they comply with the Department of Health required guidance on same sex accommodation. We found ward female patients having to walk through corridor areas occupied by male patients in order to access toilets and bathrooms; some wards did not have fully designated female lounge areas and we observed a male and female patient entering a bedroom without staff observing.

Summary of findings

- 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.

- 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.

Action the provider SHOULD take to improve

- The trust should continue to address the relatively high use of prone restraint episodes. In particular, the trust should ensure that recording is improved to ensure the time spent in prone restraint is properly recorded.
- The trust should ensure that patients on Beech ward have improved contact with the responsible clinician to review their detention, consider their care and treatment and ensure that patients are seen prior to decisions such as leave.
- The trust should review the practical implementation of the no smoking policy within the trust which was causing difficulties for patients and staff. In particular, it should consider whether the current policy and practice appeared to go beyond the legal powers available to the hospital. For example the searching of patients for tobacco, cigarettes and lighters and these being confiscated and not returned until patients were discharged even if they went on overnight leave.
- The trust should assure themselves that the systems for notifying us of a Deprivation of Liberty Safeguard (DoLS) application are robust to ensure that we are routinely informed of all DoLS applications once an outcome is known.

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
Brackendale ward Brooklands ward Lakefield ward	**Clatterbridge Hospital**
Willow ward Juniper ward Beech ward	Bowmere Hospital
Adelphi ward Bollin ward	**Jocelyn Solly (Millbrook)**

Mental Health Act responsibilities

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

We reviewed care and treatment of patients detained under the Mental Health Act. We found the service did not always adhere to the Mental Health Act Code of Practice (CoP).

We found there were systems in place to support the operation of the Mental Health Act. However, staff were not completing the appropriate records to evidence adherence to the Mental Health Act. These included:

- A lack of proper recording relating to consent and capacity to consent to treatment for decisions around treatment for mental disorder given to detained patients. For example on Beech ward there was no proper capacity assessments on first administration of treatment on six patient files.
- A small number of patients received treatment without the proper authorisation of medication for mental disorder for detained patients. On Brooklands ward, medicine prescribed for mental disorder was not included on one patient's legal certificate (T2). This was drawn to the prescriber's attention during our visit. One patient on Brooklands ward had his community treatment otder revoked and the legal certification for consent for treatment for mental disorder on a T2 form was not completed until eight days after the revocation without explanation. On Willow ward one patient was receiving a combination of anti-psychotic medication above British National Formulary (BNF) limits when the legal certificate stated they should be given within BNF limits.
- Incorrect information about patient's legal status recorded in care notes for example referring to the patient being informal when the patient was detained. On Beech ward, a number of patients were described as detained in care records when they were now informal; for example, on the standard front sheet detailing patient's details or within current care plans.
- Records showed that some patients had been not told about their rights under the Mental Health Act in a timely manner. This could have impacted on their understanding of and ability to exercise their rights, for example, how to appeal against their detention. One patient on a section 2 was not given their rights until six days after their section begun; another patient was not given their rights until nine days after his admission with the rationale given that he was in seclusion. On other records we saw that patients were not offered their rights until two or three days into the admission.
- Where patients did not understand rights, patients were not being revisited on regular occasions to support them to understand their rights. For example we saw on some files that patients who did not understand were given their rights only once per week as a matter of routine. On Adelphi ward, one patient on a section 2 was recorded as being first given her rights after three days. The patient did not understand their rights and it was noted that these would be provided again 11 days after the original section commenced with no explanation why these were not going to be repeated more regularly.
- Adherence to the CoP when patients were recalled on a community treatment order (CTO). For example, one patient who had been recalled to hospital from a community treatment order and their CTO revoked did not have any evidence that they were given their rights when the CTO was revoked. On Beech ward, a patient subject to a CTO was made informal because the legal paperwork revoking the CTO was not completed correctly.
- Some records showed that there had been no appropriate consideration whether specific patients would benefit from the services of an independent mental health advocate (IMHA) to support them to understand their rights. On Adelphi ward, one patient was recorded as lacking capacity on 8 June 2015. There were no entries or consideration of whether the patient would benefit from an IMHA. We saw an example of continued repeating rights for one patient where it was unlikely that the patient would understand their rights in the near future. On this patient's file there was no appropriate consideration of the patient's best interests to assist the patient to exercise their rights and involve independent mental health advocacy services. The IMHA at Bowmere Hospital confirmed that they did not receive referrals for patients who were deemed to lack capacity to understand their rights as detained patients.
- The recording of episodes of seclusion did not always record the time the doctor attended seclusion and the cogent reasons if there was a delay in attendance.
- The limited use of section 17 leave on Brackendale Ward, with only two out of 12 current detained patients having section 17 leave. It was difficult to see if this was clinically appropriate as section 17 leave was not recorded or discussed within many of the review meetings. On Beech ward, section 17 leave was authorised by the responsible clinician without them seeing the patient.

We have found many of these issues before when we carried out MHA monitoring visits and despite promised improvements the same issues kept reoccurring.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Decisions were made which may have warranted a formal capacity assessment but none was recorded as taking place. For example, one patient was admitted informally to one of the wards and was reported as being confused; another patient was on the psychiatric intensive care unit (PICU) as an informal patient and recorded as consenting. However, there were no associated capacity assessments to check that these patients could consent to the informal admission and PICU care respectively. We saw generic consent statements on some files where it was unclear which decision was being referred to and with no corresponding capacity assessment. Nursing staff told us that they lacked confidence in assessing capacity where necessary and would often defer any such decisions to the doctors and the training did not support them in building confidence as it was e-learning.

We saw that one patient on Willow ward had an advance statement. Although this had been followed largely, staff had not informed or involved the patient's advocate at the earliest stage as stated in the advance statement.

There was a discrepancy between the number of Deprivation of Liberty (DoLS) applications made and those that the trust had notified us about, as they are required to do. This discrepancy may be because the trust tell us when the outcome of the DoLS application was known. The trust should ensure that the systems for notifying us of DoLS applications are robust so that we are routinely informed of all applications once an outcome is known.

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

Summary of findings

Our findings

Safe and clean environment

Wards across the trust provided care and treatment for both men and women patients on the same ward. Although staff attempted to separate the genders into different corridors, this was not always possible. Wards did not always comply with the Department of Health gender separation requirements.

Toilet and bathing facilities were grouped to achieve as much gender separation as possible. However, this was not always possible and we found men and women patients cared for on corridors designated for the other gender. On Adelphi and Bollin wards, bedrooms were not en suite. Women patients had to pass a male area to access toilet and bathroom facilities and vice versa. On Adelphi ward, one male patient was placed in the female corridor and had to pass other female bedrooms to access the male bathroom. Not all bedroom doors were shut for privacy.

At Clatterbridge Hospital Psychiatric Services, all patient bedrooms were single occupancy and had an en suite shower and toilet. Staff told us that they had male and female corridors. However, we saw that on these wards this policy were not consistently maintained, and men and women's rooms were allocated throughout the wards. Staff told us that they considered patient mix and risks when allocating bedrooms. However, within the 10 care plans reviewed across Bollin, Adelphi and Beech ward the care plans did not always indicate that the risks associated with the mixed gender environment or with the patient's placement within the ward had been properly considered. On Lakefield Ward, male and female patients had been allocated separate bedrooms facing each other off an alcove at the end of the ward corridor. This area was not properly visible from the nursing station and main ward area, nor was it covered by curved mirrors to aid the line of sight and promote gender safety.

On Bollin ward, we observed a male and female patient going into a bedroom area together. Most staff were involved in a handover at the time, so this incident went unobserved by staff. We reported this incident to the ward manager to consider the impact of reduced staffing levels on the ward and how future risks can be minimised.

On some of the wards we visited there was no fully designated day lounge for use by women only. For example, Brackendale ward had a female-only lounge, but this was being used as a mixed therapy room on the day of our visit. Beech, Juniper and Willow had a female only lounge. On Lakefield ward, there was a quiet lounge but this was not designated as a female lounge. Adelphi and Bollin wards both had two lounge areas available but these rooms were not designated properly as female-only.

Every effort was made to ensure the availability of staff who were the same sex as the people they cared for.

There were a number of blind spots on the wards. Whilst there were curved mirrors within the corridor areas at Clatterbridge Hospital psychiatric services and Bowmere Hospital, not all areas were covered. This meant that patient safety could not be ensured within a mixed gender environment. For example, Brackendale ward had at least four blind spots along bedroom corridors with both male and female patients. On Beech ward, due to the configuration of the bedrooms, there were blind spots outside almost every bedroom.

The wards were clean and many had been newly decorated. During our visit, the housekeeping team were busy doing cleaning tasks. Patients and staff commented favourably on the cleanliness of the wards and the dedication of the housekeeping staff.

The trust had made attempts across the three locations to address the risks from ligature points, to reduce the risks of patients self-harming. For example, anti-ligature taps had been fitted in bathrooms and, on some wards, the disabled handrails used in the toilet were also ligature proofed. Alarms had been fitted over the doors in bedroom areas across the wards, which helped prevent people from using these as ligatures. Ligature points had been mitigated on the environmental ligature risk assessment, which included photos so people were clear about the risks of the environment.

Requires improvement

Are services safe?

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

Staff controlled access and exit from the wards. Exit from the PICU was through an air lock door, which helped to ensure patients were kept safe. The PICU wards had access to outside space, which had the appropriate level of fencing. There had been a low number of incidents of patients going absent without leave directly from the ward areas. Very few patients had gone absence without leave whilst on agreed escorted or unescorted leave.

We viewed the seclusion areas within the PICUs in Brooklands and Willow wards, which each consisted of a locked seclusion room and a separate toilet area. There was a clock outside of the seclusion room so patients that were secluded could remain oriented to time. There were means of controlling the lights and integrated blinds or coverings on the window so the light levels could be adjusted. The heating was controlled from a panel outside each seclusion room. The viewing panel in the seclusion room door permitted observations. The taps in the sink of the seclusion suite were anti-ligature. Strong seclusion-type mattresses, which afforded comfort especially during longer periods of seclusion, were used in each seclusion room.

As there was no PICU at Jocelyn Solly (Millbrook), staff managed patients presenting with disturbed behaviour until a PICU bed could be found elsewhere in the trust. Though seclusion was used on Adelphi and Bollin wards, the environments used were not recognised as seclusion rooms within the trust's seclusion and segregation policy (dated 18 June 2015). The environments used for seclusion rooms on Adelphi and Bollin ward also did not meet the enhanced environmental standards as prescribed in the revised MHA Code of Practice. There were no toilet or bathroom facilities nearby, except within the general area of the ward. The environments of the rooms (such as heating, ventilation and lighting) could not be externally controlled. There was a blind spot in the seclusion room on Bollin ward. There were well-developed plans to provide new seclusion facilities on Bollin ward. Despite this, seclusion was used on Adelphi ward 17 times and on Bollin ward 14 times in the period 1 October to 31 March 2015.

The clinic rooms were clean and tidy. Ward treatment rooms and refrigerators were properly monitored by ward and pharmacy staff to ensure that medicines were stored at the correct temperature and were safe to use. However, the fridge on Willow ward was not working; the ward staff were utilising the fridge on a neighbouring ward until the newly ordered fridge was delivered. The clinic room, which housed this fridge, had no windows and the air conditioning was not fully effective.

The wards felt relaxed and comfortable.

Patients told us that they felt safe. Some patients reported that they had witnessed other patients presenting with disturbed behaviour on the wards. However, patients felt that staff did what they could to keep all patients safe.

Safe staffing

Each ward displayed the expected and actual staffing levels. The actual staffing levels matched the expected staffing levels. The number of staff hours planned and the actual hours worked per shift were also published monthly on the trust website. The trust reviewed and adjusted staffing levels to support patient needs and to enable clinical teams locally to provide care that was safe and effective. Wards had recently had their staffing establishment reviewed to ensure that they were operating at safe staffing levels. PICUs had at least two nurses on shift, in line with the National Association of PICU standards. Ward managers told us they were empowered to take professional decisions about the staffing needs of the patients in their care, for example if patients were in seclusion or required higher levels of observation.

The levels of staff vacancies and sickness on the acute wards was high with a vacancy rate of 15% for qualified staff and 13% for non-qualified staff. The ward with the highest vacancy rate was Willow ward, with a vacancy rate of 17%, followed by Brackendale ward with a vacancy rate of 16%. Staffing shortfalls were generally managed through utilising overtime and bank and agency staff, and through the ward manager providing clinical care to manage the need of the wards. On occasions, staffing may have fell slightly below expected levels due to unexpected sickness. When this occurred an incident record was completed to highlight it. Each ward also had designated ward-based occupational therapist staff who helped to ensure that activities and leave were not cancelled due to staffing shortfalls. Patients, at all three sites, told us that there were enough staff on duty to meet their needs.

Staff working within mental health acute wards for working adults including PICU exceeded the trust's target for mandatory training in some areas. For example, health and safety training was 93% completed, medicines

management was 91% completed and record keeping at 94%. There were some mandatory training that fell below the trust's target of 85%, including management of violence and aggression at 82%.

Assessing and managing risk to patients and staff

Staff managed risks through individual assessment. Risk assessments were carried out by staff during patients' initial assessment and reviewed or updated during care review meetings or if patients' needs changed. We looked at care records and saw that each patient had a risk assessment in place. The tool that the trust used to assess and manage risks was the clinical assessment of risks to self and others tool. Some risk assessments were lacking in detail. For example, we looked at six files on Bollin ward that all identified past risk incidents without detailing how current risks would be managed.

There was a clear list of items not allowed on the PICU ward, which were kept in the security cupboard with access to these items under supervision. There was an appropriate balance between managing risks within the PICU environment and an appropriate level of positive risk taking. This was achieved through ensuring proper regard to relational security such as ensuring good knowledge of individual patients and appropriate staffing levels.

We looked at the arrangements for managing medicines. We checked the prescription charts on the wards we visited. The prescription charts were up-to-date and clearly presented to show the treatment people had received. Where required, the relevant legal authorities for treatment were in place and monitored by the ward pharmacist and nurses. The wards were supported by a clinical pharmacist who completed regular checks of the prescription charts and participated in the weekly multi-disciplinary team.

Medicines including controlled drugs were securely stored and emergency medicines were regularly checked to ensure they were available if needed.

During our checks, we found that venous thromboembolism (VTE) risk assessments were completed on admission to ensure that people at risk of thrombosis were picked up and managed. However, on Adelphi ward, reassessments were not clearly documented prior to prescribing VTE treatment in the form of prophylaxis. The junior doctors we spoke with were unclear as to where the VTE assessment should be documented. A datix entry (error report) had also been made by the trust prior to our visit as one patient had missed six doses of medication prescribed for VTE prophylaxis. The take up of mandatory VTE training across the staff on acute wards and PICU was low with only 50% of expected staff attending, against a target of 85%.

However, whilst the management of medicines was largely good across the majority of patient records, we found some minor issues regarding the monitoring of medicines. Monitoring is important to ensure people are physically well and that they receive the most benefit from their medicines:

- On Adelphi ward, we found that a patient's care plan had not been updated to reflect their refusal of therapeutic drug monitoring.
- On most patient notes, comprehensive forms were in place which recorded the prescribing and ongoing monitoring of high dose anti-psychotics, where this was relevant. However, a high dose anti-psychotic monitoring form had not been put in place for one patient whose combined regular and 'when required' medicine was just above the usual maximum.
- On Brooklands ward, we saw that on one occasion a patient had been given both an oral and injected form of the same medicine without explanation in the notes. This meant that they patient had been given more than the usual maximum dose in error.
- We were unable to confirm whether physical observations were being checked often enough for a patient whose medication was being re-titrated (re started) because we could not find a record showing how long the medicine had been missed prior to admission. We advised the ward pharmacist and staff nurse of these findings in order that appropriate action could be taken.

Staff had a good awareness of safeguarding procedures and knew how to raise alerts where necessary when they knew or suspected abuse was occurring. There were information posters for patients informing them about raising safeguarding issues. Staff told us about current safeguarding issues and alerts that had been made to safeguard vulnerable patients.

A high proportion of restraint incidents had involved face down or prone restraint. National guidance states that prone restraint should be avoided where possible. This is

Requires improvement

Are services safe?

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

because there are dangers with prolonged prone restraint such as patients being at higher risk of respiratory collapse. Prone restraint was used 104 times across the acute and PICU wards against a total number of restraints of 223 incidents of restraint between October 2014 - March 2015. This meant that nearly half of restraints involved prone restraint (46%).

The two PICU wards had the highest number of restraints which would correlate to the acuity of patients they were treating. Brooklands Ward reported the highest number of cases of restraint and cases of restraint in the prone position with 34 restraint episodes out of 84 involving prone restraint. Willow ward had 24 restraint episodes out of 35 involving prone restraint. However prone restraint was also used on the acute wards. Two patients on Brooklands ward felt that they were subject to restraint that was excessive for the behaviour they were presenting and restraint was not carried out according to approved techniques.

Restraint records we viewed showed that the full details of restraint were recorded including the reasons for restraint, the position of restraint and for how long restraint was used overall. Most records showed that restraint was used initially in the prone position due to staff following the natural movements when patients were restrained. Records showed that patients were then returned to a non prone position. However many of the records did not indicate the time spent in the prone position to corroborate that prone restraint was used for the shortest possible time.

The majority of expected staff had received conflict resolution and breakaway training (89%). However, the management of violence and aggression and intermediate life support training had only been accessed by 82% of relevant acute ward staff compared to a trust target of 85%.

The trust had initiatives to reduce the numbers of prone restraint through discussions at staff meetings; staff attending human factors training which helped them understand their perceptions and oversight by senior leaders. The trust was also piloting the 'REsTrain Yourself' initiative which was developed by advancing quality alliance (AQuA) in partnership with three north west universities to develop improvement methods and implement core strategies to reduce restraint on acute wards. Staff were aware of these initiatives and all were able to state the risks of prone restraint and how patients should be put in the face up or supine position as soon as possible. Clinical service managers and/or modern matrons reviewed each incident of prone restraint to understand why it was used and reflect with the staff team what could have been done differently.

Records of seclusion showed that many of the safeguards and reviews required when seclusion was used were met. The reasons for seclusion were clearly recorded and observations of patients were recorded every 15 minutes as required. However, it was not clear that the Mental Health Act Code of Practice requirement that a doctor attended within one hour following a period of seclusion was being met. Some of the seclusion records either did not record the time the doctor was informed and attended or did not explain the reasons why the doctor was not able to attend within this time frame. This meant that it was unclear if patients placed in seclusion received a timely medical review.

We also saw that longer term segregation was used for one patient on Willow ward, immediately following a period of seclusion. The patient was nursed in the extra care area and prevented from having contact with his peers. Whilst the rationale for separating this patient from other patients was recorded, there was no clear indication of why segregation rather than seclusion was indicated or how regularly the use of segregation would be reviewed. The patient remained in segregation for over 48 hours without any recorded review occurring.

The wards had systems to deal with foreseeable emergencies including medical emergencies. We saw the emergency equipment were accessible. Records showed that emergency equipment was checked regularly to ensure it was fit for purpose. Equipment used on the wards mirrored the equipment used within the general hospital where the wards were based. This meant that general hospital staff would be familiar with the equipment if they were called upon to respond in an emergency.

Staff were equipped with alarms and would use these to call for assistance from other team members and there were systems in place for responding to an emergency.

The trust had implemented a no smoking policy across all of its services with the aim to promote health and wellbeing amongst patient. Patients were not permitted to

Requires improvement

Are services safe?

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

smoke whilst an in-patient under the care of the trust. Patients were offered support to give up smoking with routine assessment and support with nicotine replacement treatment and counselling to give up smoking.

The practical implementation of the no smoking policy within the trust was causing difficulties for patients and staff. Patients were being asked to hand in any tobacco, cigarettes and lighters and, if searched, these items were being confiscated. These items were not returned until patients were discharged even if patient went on significant periods of leave off the hospital grounds or on overnight leave. The trust should consider whether the current policy and practice of keeping patients' belongings in this way goes beyond the legal powers available to the hospital.

Track record on safety

We looked at the incidents that had occurred recently at this trust. All NHS trusts were required to submit notifications of incidents to the National Reporting and Learning System. Serious incidents known as 'never events' are events that were classified as so serious they should never happen. In mental health services, the particular relevant never events within acute hospital settings was suicide of an in-patient from a fixed ligature point. The trust had not reported any 'never events' on their acute wards and PICUs between April 2014 and March 2015. The environments of the wards were good to prevent any future never events, including unnecessary ligature risks being removed.

There had been two coroner reports to prevent future deaths that involved patients receiving in-patient acute care at Cheshire and Wirral Partnership NHS Foundation Trust. The deaths occurred in 2013, but, due to the ordinary delays in inquests, the reports were not sent to the trust until early 2015. Staff on the acute wards told us about attending the inquests and the support they received from within the trust. Staff were able to tell us what issues were identified and what action had been taken to prevent future similar deaths.

A range of performance indicators were monitored every month and reported centrally. Governance arrangements were in place to ensure there were appropriate reviews of all, serious incidents complaints, and progress on action plan as well as locality risk registers.

Reporting incidents and learning from when things go wrong

The wards had a system in place to capture and report incidents and accidents and to learn from them when things went wrong.

Staff explained to us the process they used to report incidents through the trust's reporting systems. Staff felt that incidents were reduced by the therapeutic relationship they had with patients such as knowing patients well, reducing triggers and identifying early warning signs.

We saw that when incidents occurred there was a debriefing session, which looked at what led up to the incident and helped staff consider issues that had arisen, how staff reacted and how things could be done differently next time.

We saw that lessons had been learnt, for example, following a coroner's ruling which criticised the lack of formal systems for recording the whereabouts of informal patients. Consequently, the wards had developed systems to record this, including the times when patients leave and return to the ward. We saw that managers were reviewing episodes of prone restraint with the aim to reduce the numbers of prone restraints occurring.

Are services effective?

Requires improvement

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.

Summary of findings

Our findings

Assessment of needs and planning of care

We saw well-documented care plans that described how individual needs were met on admission and at each stage of patient care. Care plans were recovery focused and helped patients receive support to address the symptoms of mental disorders. Care plans covered a range of needs that included people's medical needs (physical and mental health needs and medication), nursing needs and interventions, social needs (accommodation, finance, employment and leisure needs), legal status and discharge progress. Feedback from patients across the wards confirmed they felt involved in assessments about their care. Patient needs and care were reviewed on a regular basis at multi-disciplinary meetings.

On Brooklands ward, the pharmacist had advised about physical health monitoring for a diabetic patient. We saw that this advice was being acted upon, although the patients diabetic patient care plan had not been updated to reflect this.

There were systems to ensure patients' physical health needs were met appropriately across the wards. We saw within patients' care records that they had a physical health assessment carried out on admission to the ward.

Best practice in treatment and care

Patients were assessed using the health of the nation outcome scales. These covered 12 health and social domains and enabled clinicians to build up a picture over time of their patients' responses to interventions.

Nurses were using standardised tools to carry out an assessment of the service user to look at the severity and frequency of patients' mental health symptoms, for example the KGV Manchester symptom scale and the personality belief questionnaire provided a cognitive profile identifying specific dysfunctional beliefs of patients.

The malnutrition universal screening tool had been carried out for relevant patients with corresponding care plans. The modified early warning system was used to help monitor patients' physical health care needs.

Staff were following National Institute for Health and Care Excellence (NICE) guidance. For example, safe prescribing was considered resulting in most patients only being given one anti-psychotic. Where it was clinically necessary to give more than one anti-psychotic, there was a comprehensive proforma to complete for the prescribing and ongoing monitoring of high dose anti-psychotics.

Each patient on the ward was fully assessed by an occupational therapist (OT) which included at standardised assessments for considering cognitive ability, levels of anxiety and depression and functional ability. From this and an initial interview, goals were developed, future assessments were identified and a personal activity plan was drawn up with patients.

The PICU staff participated in the National Association of PICU care which meant that staff had an opportunity to share good practice with other PICUs across England.

Skilled staff to deliver care

We spoke with a number of staff including the consultant psychiatrist, ward managers, resource managers, registered and student nursing and non-registered nursing staff and other professionals including the occupational therapists. Staff we spoke with were positive and motivated to provide high quality care.

Staff received appropriate training, supervision and support. Staff on the wards commented favourably on the support and leadership they received from the ward manager. Staff told us that they received supervision which consisted individual management supervision.

Training for staff consisted of mandatory and more specialist training. The trust monitored the staff in relation to compliance with mandatory training. We saw that where staff were overdue training, systems were in place to provide prompts to ensure this occurred.

Multi-disciplinary and inter-agency team work

Patients received multi-disciplinary input from medical staff, registered nursing and non-registered nursing staff and other professionals including occupational therapists. Access to other professionals were via referral, for example dietician or speech and language therapy.

Are services effective?

Requires improvement

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.

Multi-disciplinary meetings occurred on a regular basis, usually every other weekday. At Millbrook, crisis and home treatment teams proactively attended MDT meetings to consider whether patients could be discharged from hospital earlier with input from the staff of the crisis teams.

We observed a multi-disciplinary meeting and a handover. There was comprehensive information on each patient to ensure that all members of the nursing and multidisciplinary team were kept up to date on current issues with patients and to inform decisions about future holistic care needs.

Patients on Beech ward were not receiving regular input from the consultant psychiatrist with some patients not seeing a doctor for significant periods of time. One patient had not seen their psychiatrist for 20 days and another patient had not seen them for five weeks. The consultant psychiatrist for this ward confirmed that they tended not to review patients on a weekly basis.

There was a limited access to psychological interventions available as there was no designated psychology input on the wards. There was access to a trust wide nurse consultant who was trained in cognitive behavioural therapy (CBT) and psychological therapies and to an advanced practitioner who was trained in CBT. There had also been local training delivered by the nurse consultant to enable staff to deliver psychological therapies within inpatient services. Patients did not have direct access to a fully responsive service to access cognitive behavioural and psychological therapies whilst an in-patient on the wards as guided by NICE. For example, guidance for the psychological treatment of a range of mental illness conditions such as psychosis, depression, anxiety and bipolar disorder. We saw that patients were offered psychology input when patients were being considered for discharge. We saw that one patient with a diagnosis of personality disorder was offered dialectical behavioural therapy (DBT) as recommended by NICE guidelines as part of their intended discharge.

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

We reviewed care and treatment of patients detained under the Mental Health Act. We found the service did not always adhere to the Mental Health Act Code of Practice (CoP).

We found there were systems in place to support the operation of the Mental Health Act. However, staff were not completing the appropriate records to evidence adherence to the Mental Health Act. These included:

- A lack of proper recording relating to consent and capacity to consent to treatment for decisions around treatment for mental disorder given to detained patients. For example on Beech ward there was no proper capacity assessments on first administration of treatment on six patient files.
- A small number of patients received treatment without the proper authorisation of medication for mental disorder for detained patients. On Brooklands ward, medicine prescribed for mental disorder was not included on one patient's legal certificate (T2). This was drawn to the prescriber's attention during our visit. One patient on Brooklands ward had his community treatment order revoked and the legal certification for consent for treatment for mental disorder on a T2 form was not completed until eight days after the revocation without explanation. On Willow ward one patient was receiving a combination of anti-psychotic medication above British National Formulary (BNF) limits when the legal certificate stated they should be given within BNF limits.
- Incorrect information about patient's legal status recorded in care notes for example referring to the patient being informal when the patient was detained. On Beech ward, a number of patients were described as detained in care records when they were now informal; for example, on the standard front sheet detailing patient's details or within current care plans.
- Records showed that some patients had been not told about their rights under the Mental Health Act in a timely manner. This could have impacted on their understanding of and ability to exercise their rights, for example, how to appeal against their detention. One patient on a section 2 was not given their rights until six days after their section begun; another patient was not given their rights until nine days after his admission with the rationale given that he was in seclusion. On other records we saw that patients were not offered their rights until two or three days into the admission.
- Where patients did not understand rights, patients were not being revisited on regular occasions to support

Are services effective?

Requires improvement

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.

them to understand their rights. For example we saw on some files that patients who did not understand were given their rights only once per week as a matter of routine. On Adelphi ward, one patient on a section 2 was recorded as being first given her rights after three days. The patient did not understand their rights and it was noted that these would be provided again 11 days after the original section commenced with no explanation why these were not going to be repeated more regularly.

- Adherence to the CoP when patients were recalled on a community treatment order (CTO). For example, one patient who had been recalled to hospital from a community treatment order and their CTO revoked did not have any evidence that they were given their rights when the CTO was revoked. On Beech ward, a patient subject to a CTO was made informal because the legal paperwork revoking the CTO was not completed correctly.
- Some records showed that there had been no appropriate consideration whether specific patients would benefit from the services of an independent mental health advocate (IMHA) to support them to understand their rights. On Adelphi ward, one patient was recorded as lacking capacity on 8 June 2015. There were no entries or consideration of whether the patient would benefit from an IMHA. We saw an example of continued repeating rights for one patient where it was unlikely that the patient would understand their rights in the near future. On this patient's file there was no appropriate consideration of the patient's best interests to assist the patient to exercise their rights and involve independent mental health advocacy services. The IMHA at Bowmere Hospital confirmed that they did not receive referrals for patients who were deemed to lack capacity to understand their rights as detained patients.
- The recording of episodes of seclusion did not always record the time the doctor attended seclusion and the cogent reasons if there was a delay in attendance.
- The limited use of section 17 leave on Brackendale Ward, with only two out of 12 current detained patients having section 17 leave. It was difficult to see if this was clinically appropriate as section 17 leave was not recorded or discussed within many of the review meetings. On Beech ward, section 17 leave was authorised by the responsible clinician without them seeing the patient.

We have found many of these issues before when we carried out MHA monitoring visits and despite promised improvements the same issues kept reoccurring.

Good practice in applying the Mental Capacity Act

Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions in accordance with the Mental Capacity Act. Patients had been encouraged to be involved in drawing up their care plan and subsequently their wishes on future treatment were being respected. This showed that staff ensured they respected patients' capacitated decisions and that staff understood the legal framework to follow to when patients may lack capacity.

Many of the patients were detained under the Mental Health Act (MHA) and treatment decisions for mental disorder were made under the legal framework of the MHA. Staff understood the limitations of the MHA, for example, that capacity assessments were decision specific and the MHA could not be used for treatment decisions for physical health issues.

Informal patients were aware of their right to leave the ward. The trust had produced a leaflet which explained about the locked doors on the ward, how they can exit the ward, how they can refuse treatment and the details of the Mental Capacity Act. One patient was on the PICU as an informal patient. The records showed he was consenting to this but there was no associated capacity to consent assessment to assure staff that he was capable of giving informed consent.

We saw generic consent statements on some files where it was unclear which decision was being referred to and with no corresponding capacity assessment. For example on Brackendale ward, three out of four files we looked at had poor records relating to informed consent. On Adelphi ward, comments were found in the nursing records stating the patient was consenting without any reference to capacity to consent.

We saw decisions being made which may warrant a formal capacity assessment but none was recorded as taking place. For example, one patient was admitted informally to one of the wards and was reported as being confused. There was no capacity assessment to check that the

Are services effective?

Requires improvement

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.

patient was able to give informed consent to their admission. We saw that one patient on Willow ward had an advance statement and although this had been followed largely, staff had not informed or involved the patient's advocate at the earliest stage as stated in the advance statement.

Nursing staff told us that they lacked confidence in assessing capacity and would often defer any such decisions to the doctors. Several staff told us that they felt their training did not support them in building confidence as it was e-learning. Staff were expected to attend Mental Capacity Act training every three years and the current take up of training was 76% which was below the trust's target of 85%.

The trust stated that there were ten Deprivation of Liberty (DoLS) applications made between October 2014 and March 2015 for patients on the acute wards, with seven on Adelphi ward and three on Juniper ward. The trust was notifying us of DoLS applications, as they were required to do. However, the numbers of DoLS applications reported to us between May 2013 and May 2015 did not match the number of applications the trust stated they made. This discrepancy may be because the trust tell us when the outcome of the DoLS application was known and there were frequently delays in the local authority (the DoLS supervisory body) processing applications as a result of the increase following recent court judgements (for example, in a case called the Cheshire West judgement).

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

Most patients were complimentary about the care they received from the staff on the acute wards. Patients told us staff treated them with dignity, respect and compassion. They felt involved in the decisions about their care and treatment. Detained patients were generally aware of their rights whilst being on a section of the Mental Health Act. Two patients on Brooklands ward felt that they were subject to restraint that was excessive for the behaviour they were presenting and restraint was not carried out according to approved techniques. Patients were very complimentary about the activities available during the week run by occupational therapists attached to the wards.

We observed positive interactions between staff and patients. Patients were treated with compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and understanding manner. Staff were knowledgeable about patients' needs and showed commitment to provide patient led care. Wards employed peer support workers so patients were supported by a staff team that included suitable people who had direct experience of mental illness.

The acute in-patient wards scored relatively well in recent patient-led assessments of the care environment (PLACE) annual assessment. These self-assessments are undertaken by teams of NHS and independent heath care providers and patient assessors (members of the public must make up at least 50% of the team). In many areas, the PLACE score were at or above the England average across many areas. The trust's acute services at Bowmere Hospital scored highest and higher than the England average in their PLACE assessment for privacy, dignity and wellbeing. The same location scored substantially lower than the Trust and England averages for cleanliness and ward food. Millbrook at Macclesfield scored substantially lower than the Trust and England averages for ward food. Patients we spoke with at Bowmere Hospital did comment on the reliance on sandwiches for lunchtime meals and at Bollin a limited variety of fruit.

The involvement of patients in the care they receive

The care plan documents across the trust were held in the electronic patient notes system. The involvement of patients in drawing up their care plan was recorded through staff ticking a box within the electronic form. Patients told us that care was planned and reviewed with them. However, in some cases this was not always fully evidenced in the written care plan as it was written from the nurse's perspective.

The trust had a range of meetings in the inpatient services to ensure patients had an opportunity to explore issues and make decisions about their care. Patients were involved in their multi-disciplinary meetings on the ward. However, we saw that patients were not always involved for the full discussion. For example, on Brackendale ward, review meetings were routinely held without patients and relatives for the first part of the meeting and patients were invited in to ask for their views on decisions made.

Community meetings were held regularly on the ward. We saw examples where patients had raised issues or requested specific things and staff had responded to these and made changes where possible.

Patients had regular access to advocacy when they were inpatients, including specialist advocacy for patients detained under the Mental Health Act known as independent mental health advocates (IMHAs). Patients we spoke with were aware of the IMHA service and complimentary of the support received from the IMHA.

There were a small number of comments relating to the acute wards left on the NHS Choices and Patient Opinion websites about people's experiences on the acute wards. These included positive comments about caring, kind and compassionate staff – particularly for those comments made specifically regarding Bowmere Hospital and Millbrook Unit. There were a small number of negative comments on the NHS Choices and Patient Opinion websites regarding poor staff attitudes and alleged instances of complaints being ignored by staff and management. We did not hear these concerns from patients we spoke with on the wards.

The trust had signed up to the 'triangle of care' initiative. The 'triangle of care' approach was developed nationally to improve carer engagement in mental health acute inpatient and home treatment services. Its aim was to

Good

Are services caring?

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

improve service delivery, highlight good practice, ensure consistency of carer involvement across an organisation and build partnership working between statutory and third sector organisations. We saw that patients were asked about the level of engagement they wished their carer or relative had and, where agreed, family members were encouraged to attend MDT reviews.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Access and discharge

Admissions into the acute beds were gate kept by the crisis and home treatment staff within the community teams or out of hours team, or by approved mental health professionals following a Mental Health Act assessment. This ensured that there was proper consideration whether people required treatments as in-patients. Last year, the trust had remained close to the England average for the percentage of patient admissions gate kept by crisis teams.

The wards were operating within safe bed numbers at the time of our visit. The mental health bed occupancy rate for the trust has been consistently below the national average for the last 12 months. The trust target for bed occupancy was 85 % (excluding leave). The mean percentage bed occupancy over the six months between October 2014 to March 2015 showed that five acute wards were meeting the Trust target for bed occupancy with some wards operating below or at 85%. The ward with the highest bed occupancy was Beech ward with 100% bed occupancy when use of beds for patients on leave was included and 96% if this same figure was excluded. This meant that patients could access a bed in their locality.

Admissions into PICU beds were via assessment by the multi-disciplinary team from the PICU wards for patients requiring transfer from the acute wards across the trust. Access into the PICU could also be secured following a Mental Health Act assessment for people in the community. This ensured that there was proper consideration whether patients required being cared for under conditions of psychiatric intensive care. The staff on the acute wards did not raise concern about access to PICU beds.

There were no PICU facilities at Millbrook at Macclesfield. Patients at Millbrook who required a PICU bed had to be conveyed to Bowmere hospital in Chester or Clatterbridge hospital on the Wirral.

The trust had been consistently doing better than the England average for the number of delayed discharges and readmissions within 90 days at the trust. There were two delayed discharges across the acute wards in the 6 months between October 2014 and March 2015. The primary cause of patient delays or delayed days was due to public funding, followed by the wait for nursing home placement or availability. Patients were reported to be appropriately placed with no significant issues with delays on discharge.

There were 113 readmissions in the six months prior to our inspection from 1 Oct 2014- 31 March 2015. The ward with the highest number of readmissions within 90 days was Beech Ward (29). The trust had a complex recovery assessment and consultation (CRAC) team which was a multi-disciplinary team working alongside the acute wards to try and address the readmission rates. The CRAC team worked with patients who repeatedly required acute admissions or whose admission exceeded the expected time in acute care of 40 days. The team looked at why patients' needs were not fully met which led them to requiring readmission or delay in discharge. The team provided specialist feedback, advice and evidence based interventions to aid rehabilitation and recovery, facilitate discharge and prevent readmission.

The facilities promote recovery, comfort, dignity and confidentiality

The ward environment was clean and comfortable. The furniture across the wards was in good condition and comfortable. There were a pleasant assortment of murals and pictures on the walls which made the acute wards feel homely. Patients had good access to outdoor space across the wards.

All the wards were mixed gender. Sleeping accommodation was mainly in single rooms with some double rooms at the Macclesfield location. On most wards, patients were given a magnetic fob, which could be used to open their own bedroom.

The wards had communal areas and other quiet rooms which could be utilised as private interview rooms. There were family visiting areas off the wards with some effort to make the space appropriate for children and family visiting.

Patients had access to a group programme, which contained at least three groups a day. Patients were given a personal activity plan where they could identify their interests and support needs to aid their recovery. Whilst we visited, we saw patients engaging in a varied range of activities that included cheese tasting, discussion groups, and flower arranging. Patients had 1:1 time including access to the community and home visits.

Are services responsive to people's needs?

Good

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

Patients on the PICU had access to the internet via ward-based computers. Patients were given details of useful websites to promote their recovery from mental illness, for example information on treatments, health promotion and national and local mental health charities who could provide more information if required.

Patients had access to their own mobile phones. Individual patients were risk assessed around any items of personal belongings that may need to be considered for confiscation; the need for searching patients was made on an individual basis.

Meeting the needs of all people who use the service

Patients' diversity and human rights were respected. Attempts were made to meet patients' individual needs including cultural, language and religious needs. There were designated multi-faith prayer areas off the ward. The rooms showed patients of Muslim faith, details of the direction towards Mecca to ensure they could pray according to their faith. Staff had an understanding of the implications of Ramadan for patients who were fasting and how the trust needed to adapt to their needs. Contact details for representatives from different faiths were provided and local faith representatives visited patients on the wards.

A choice of meals was available with effort made to ensure a varied range of cultural needs were met representing the needs of individuals and the cultures of the communities the trust serves.

We were told that translation and interpretation service were available. Leaflets provided by the trust informed patients that the leaflet could be translated into different languages on request. One patient on Brackendale ward was French speaking. An interpreter had been booked daily since admission and a French member of staff had transferred wards for some shifts to ensure the ward staff could communicate, assess and treat the patient.

Listening to and learning from concerns and complaints

Patients knew how to raise complaints and concerns. Patients had confidence that the ward managers and senior staff on the ward would take their complaint seriously. Information on how to make a complaint was displayed on the wards. Information on mental health advocacy services were also displayed. Informal complaints were often reported as being raised and resolved at community meetings.

The acute wards for adults of working age and psychiatric intensive care units (PICU) had 28 complaints for the period April 2014 to March 2015. Of these, 10 complaints were upheld; which amounted to 36% of complaints made. The wards with the most complaints were Bollin ward with 10 complaints, followed by Adelphi and Willow wards with 5 complaints each.

The trust produced locality data packs for each ward which showed the number of complaints received and investigated in the previous month.

Are services well-led?

Requires improvement

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

Summary of findings

Our findings

Vision and values

The trust's vision was leading in partnership to improve health and well-being by providing high quality care.

The trust had adopted the six C's as their values. The six C's were a set of core national nursing values for all staff working in the NHS in England as detailed in the Compassion in Practice national nursing strategy. These were:

- care
- compassion
- competence
- communication
- courage
- commitment

The trust had three quality priorities for 2014/5. These were to:

- Achieve a continuous reduction in avoidable harm and make measurable progress to embed a culture of patient safety in CWP, including through improved reporting of incidents.
- Achieve a continuous improvement in health outcomes for people using the trust's services by engaging staff to improve and innovate.
- Achieve a continuous improvement in people's experience of healthcare by promoting the highest standards of caring through implementation of the Trust's values.

The trust's vision and values were displayed on information boards across the wards. The six C's were incorporated into staff supervision to frame discussions. This meant that staff were aware of the values of the trust. Staff on the acute wards showed professional commitment to these values as evidenced throughout our interviews. Patients commented favourably that they received good quality care, which showed staff were working within the stated values of the trust.

Good governance

Each locality had good governance arrangements to ensure that learning was disseminated appropriately, for example learning from incidents and complaints.

Each ward had a locality data pack, which provided information to wards and managers on key indicators. This was a tool developed by the trust, which mirrored the key questions we looked at. This meant that ward managers had access to and could monitor key performance information regarding their wards. This included incidents, complaints, staffing levels and sickness, mandatory training, and rates of supervision and appraisals with staff.

A range of audits were carried out to improve the quality of care and treatment. Action plans were developed and monitored, they are shared across the trust and with service specialties which feed into the zero harm programme. However, whilst the governance systems were largely good, the exception related to the Mental Health Act where we continued to find and report on issues, which the trust told us they were addressing. Despite the trusts' provider action statements provided to us following MHA monitoring visits which prescribed the action the trust would take to address the concerns found, we continued to find similar concerns relating to adherence to the MHA Code of Practice on this inspection which led us to judge that the governance arrangements relating to the MHA were not effective.

Leadership, morale and staff engagement

Ward managers said they had the autonomy to manage the ward. They were supported in the day to day management by a resource manager who managed the non-clinical aspects of running the ward. This enabled ward managers to focus on ensuring the wards provided good quality care.

Staff reported that morale was generally good. Staff told us they felt supported by the managers across the services. We saw evidence that staff at all levels had received regular supervision and appraisals. Staff spoke positively about their role and demonstrated their dedication to providing quality patient care.

Are services well-led?

Requires improvement

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

Commitment to quality improvement and innovation

We saw that there were a number of audits which were carried out which were able to measure standards in terms of development and improvement within the service. This meant that the performance of the service was monitored in order to drive improvement.

The wards monitored their performance against the measures we check using the safe, effective, caring, responsive and well led domains. This information was formulated into locality data packs which provided key details. This meant that the performance of the service was monitored in order to drive improvement.

The wards at Clatterbridge Hospital Psychiatric services had been newly refurbished and one ward was currently closed for refurbishment. This meant that capital investment was occurring to improve the quality of the acute ward environment.

Brooklands Ward was accredited with the Royal College of Psychiatrists' accreditation scheme the accreditation for acute inpatient mental health services on psychiatric intensive care units (AIMS-PICU).

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 **Safe care and treatment** Wards did not always comply with the Department of Health gender separation requirements. This was in breach of Regulation 12 (1) and (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which states that care and treatment must be provided in a safe way and the provider should ensure that premises are used in a safe way. We found at Clatterbridge Hospital Psychiatric Services, Bowmere Hospital and Jocelyn Solly (Millbrook) that there were two acute wards at each site with acute wards being mixed gender. Ward staff attempted to separate patients of the same gender into different corridors, depending on the gender of the patients admitted. However this was not always possible. • On some wards, bedrooms were not ensuite and on some wards, female patients had to pass a male corridor area to access toilet and bathroom facilities and visa versa. • There were blind spots including in corridors with bedrooms where male and female patients were together. • Not all wards had designated female only lounges. • Care plans and risk assessments did not consider providing care in a mixed gender environment. • We observed a male and female patient going into a bedroom area unobserved by staff.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Good governance** We found that the registered person did not operate effective systems to ensure compliance with the regulations. This was due to not acting on feedback from the Care Quality Commission's Mental Health Act monitoring visit reports issued under our duties arising from s120 of the MHA. This was in breach of regulation 17(2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which states that the provider should operate effective processes to act on feedback from relevant persons for the purposes of continually evaluating and improving services. We found at Clatterbridge Hospital Psychiatric Services, Bowmere Hospital and Jocelyn Solly (Millbrook) that: • Despite the trusts' provider action statements provided to us following MHA monitoring visits which prescribed the action the trust has or would take to address the concerns found, we continued to find similar concerns relating to adherence to the MHA Code of Practice on this inspection. This led us to judge that the governance arrangements for oversight of adherence to the MHA were not effective.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Good governance** We found that the registered person did not operate effective systems due to poor recording of responsibilities relating to the Mental Health Act. This was in breach of regulation 17(1) and (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which states that the provider should operate effective processes and maintain an accurate complete and contemporaneous record of decision taken in relation to care and treatment provided. We found at Clatterbridge Hospital Psychiatric Services, Bowmere Hospital and Jocelyn Solly (Millbrook) that:

This section is primarily information for the provider

Requirement notices

• The recording of rights to detained patients included unnecessary delays in giving rights when patients were first detained, did not include timely action taken to revisit the patient or record further action when a patient had refused the explanation.

• The recording of rights to detained patients did not include considering if patients who may not understand their rights would benefit from being referred to the Independent Mental Health Advocacy service to support them.

We found at Clatterbridge Hospital Psychiatric Services that:

• The recording of episodes of seclusion did not always include the time the doctor attended seclusion or the cogent reasons if there was a delay in attendance.

• Episodes of segregation did not indicate how regularly the segregation should be reviewed.