Cheshire and Wirral Partnership NHS Foundation Trust

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

Inspection report

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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inadequate**

Our findings

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

Inadequate ↓↓

We carried out this unannounced focused inspection because we had concerns about the safety and quality of the service. These were specifically about Mulberry ward at Jocelyn Solly (Millbrook) at Macclesfield and Brooklands and Lakefield wards at Clatterbridge Hospital on the Wirral.

The trust has five acute mental health wards for working age adults and two psychiatric intensive care units wards across three locations. On this inspection we only inspected:

- Mullberry ward, a 26-bed ward which was an acute mental health wards for working age adults and older adults with functional mental health problems at Jocelyn Solly (Millbrook) at Macclesfield.
- Lakefield ward, a 20-bed ward which was an acute mental health wards for working age adults and older adults with functional mental health problems at Clatterbridge Hospital Psychiatric Services on the Wirral
- Brooklands ward which was a 10-bed psychiatric intensive care unit at Clatterbridge Hospital Psychiatric Services on the Wirral.

The wards cared for both male and female patients.

We last inspected the trust's mental health acute wards in August 2018 where it was rated good overall and in all key questions apart from the safe key question which was rated as requires improvement. As this was a focused inspection, we did not follow up the shortfalls we found in August 2018 to check whether improvements had been made.

This was a focused inspection which looked at parts of the 'safe', 'caring' and 'well led' key questions. The rating of 'safe' and 'well-led' has changed from requires improvement to inadequate. We issued a warning notice to ensure the trust made appropriate improvements as the environment used for seclusion, seclusion practice, and the governance of seclusion incidents needed significant improvement:

- There was no designated seclusion environment at Jocelyn Solly (Millbrook) at Macclesfield. Patients were secluded in their bedrooms or rooms not designated as seclusion rooms. These rooms were not safe or appropriate environments to seclude patients as they did not fully lock, could be overlooked by other patients and did not meet national guidance.
- The seclusion room at Brooklands ward at Clatterbridge Hospital Psychiatric Services was not fully clean.
- Staff were not recording key tasks when patients were placed in seclusion, so we were not assured that the required safeguards were met for each episode when someone was put in seclusion.
- Staff were not categorising incidents of seclusion properly. The trust's internal safety reviews into seclusion episodes were not always robustly identifying key issues in relation to seclusion incidents.
- Staff did not ensure that a patient who needed to have access to communication cards and tools, always had access to them .

However:

Our findings

- Through observations and speaking to patients, patients were treated with dignity and respect.
- There was no ward manager on Brooklands as the previous manager had resigned but the other ward managers were providing regular input and we did not identify any significant impact. The trust had put a supportive team and improvement plan around the Brooklands ward team.
- In some cases, we saw evidence of learning (especially following serious incidents), and improvements made. The policy and practice of observation had improved with upgraded systems, better observations recording and observing staff wearing tabards so they were not distracted.
- While the layout of Lakefield ward did not fully afford observations across the whole ward, this was mitigated by patient observations, deployment of staff and parabolic mirrors.

This was a focused inspection. Because of its limited scope, we did not set out to rate at this inspection. However, where we have identified a breach of a regulation and we issued a warning notice to an NHS trust, the rating linked to the area of the breach will normally be limited to 'inadequate'. You can view previous ratings and reports on our website at www.cqc.org.uk.

How we carried out the inspection

Before the inspection visit, we reviewed information that we held about the service.

During the inspection visit the inspection team:

- visited three wards and looked at the ward environment
- observed how staff were caring for patients
- spoke with 11 patients and eight carers
- spoke with ward managers or the most senior nurse on duty
- spoke with 18 other staff including nurses, health care assistants, consultant psychiatrists and trainee doctors.
- Reviewed 15 care records of patients and other care related documents
- reviewed fully seven episodes of seclusion
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

What people who use the service say

We spoke with 11 patients and eight carers. Patients told us that the wards were kept very clean. Most patients stated that staff cared for them well and were very friendly. They said staff were very understanding towards patients and helped them as much as they could.

Most patients felt safe and staff helped to keep them safe. One detained patient told us about an incident of restraint but understood why staff needed to restrain them as they were trying to leave the ward. One patient did not have access

Our findings

to communication cards to help them communicate how they were feeling. We passed this on the nurse in charge to ensure that despite any restrictions placed on them, patients were able to use communication aids. Where patients raised less positive concerns, they were in the context of not wanting to be in hospital or they did not provide enough detail for us to pass on to the trust to look into the concerns properly.

None of the current patients we spoke with had experienced being placed in seclusion.

All the carers we spoke to were complimentary about the care their loved one received stating staff were respectful and polite. They stated that staff were responsive when they asked for information. Two carers told us that when their loved one was restrained; they were informed about it soon afterwards. They were not concerned about the restraint episode and said staff were lovely, caring and they could not fault them. One carer told us they felt listened to and their concerns were taken seriously. Some carers said that it was sometimes difficult to speak with staff on the phone on Lakefield ward as the phone wasn't always answered.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate. The trust needed to make significant improvements to the environments used to seclude patients and staff adhering to national guidance when seclusion was used.

Where we have identified a breach of a regulation and we issue a warning notice, the rating linked to the area of the breach will normally be limited to 'inadequate'.

Safe and clean care environments

The main ward areas were clean and maintained. In most instances the wards were designed to reduce the risks to patients, but there were no seclusion rooms at Macclesfield and the seclusion room on Brooklands ward in the Wirral was not fully clean.

Safety of the ward layout

Staff could observe patients in all parts of most wards we visited. The exception was Lakefield ward at Clatterbridge which had more limited lines of sight. This was because the ward was laid out mostly along three corridors in a horse-shoe shape with most of the bedrooms on two long corridors but some bedrooms off a shorter corridor at the back of the ward. Some bedrooms were themselves in a short alcove area off their corridor

While the layout of Lakefield ward did not fully afford observations across the whole ward, this was mitigated by patient observations, deployment of staff and patients, and parabolic mirrors. One member of staff was constantly deployed at the first entrance to all the bedroom corridors on Lakefield ward. Lakefield ward had also reduced bed numbers with 4 beds going to Riverwood ward which helped to improve sightlines. There was no CCTV across the communal areas of Lakefield ward to aid observation, provide a safeguard to patients and assist with post-incident reviews..

The acute ward at Macclesfield no longer had dormitory style accommodation. Mulberry ward opened in December 2019 and offered single bedroom and ensuite accommodation.

Our findings

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The top of the bedroom and bathroom doors across the wards were alarmed to detect any weightbearing and there were daily checks to make sure the alarms were working. Bedroom and bathroom fittings were anti-ligature. On Brooklands ward some of the windows across the ward communal areas were sash type windows but these were locked into position as a safety measure.

Maintenance, cleanliness and infection control

Ward areas were mostly clean and well-maintained but the seclusion room on the Wirral was not fully clean. We found that the ceiling of the seclusion room on Brooklands ward was not fully clean. We saw that the designated seclusion room had two small brown stains on the ceiling. We could not identify the substance causing the stains but it was most likely to be either food or faeces thrown by a patient. The ceiling was at height and could not be reached by the regular cleaning staff that provide routine cleaning across the ward. Staff we spoke with stated that it required either staff from the estates department or a specialist company who were able to work at height to address this.

We highlighted the marks on the first day of our inspection to the most senior nurse in charge and the housekeeper. When we returned a week later to carry on the inspection, we found that the same stains were still there.

This was despite written assurances we received directly by the trust in October 2022 following similar concerns about cleanliness of the seclusion room ceiling. In that response the trust acknowledged similar ceiling debris was noted in May 2022, was removed by the Modern Matron, a deep clean undertaken the following day and systems in place to check the cleanliness.

The main ward area of each ward we visited was fully clean and well maintained with cleaners and housekeepers cleaning during the inspection.

Seclusion rooms

The rooms used to seclude patients at Macclesfield were not safe or appropriate environments. There was no designated seclusion room or appropriate designated safe space for the management of services users displaying severe behavioural disturbance on Mulberry ward, the one acute ward at the Jocelyn Solly which was a stand-alone ward. However, we found that there had been episodes that met the definition of seclusion at the Jocelyn Solly (Millbrook) location at Macclesfield.

There was no other designated de-escalation area at Jocelyn Solly to help staff to manage patients displaying disturbed behaviour which presented a risk to others. There was no other facility on-site such as a mental health-based place of safety and no psychiatric intensive care unit beds in the area. When Mulberry ward opened in December 2019, the trust made an active decision not to have a seclusion room or appropriate designated safe space on Mulberry ward or at any other service at Macclesfield.

The trust's seclusion and segregation policy implemented in May 2019 only identified Brooklands ward (at Clatterbridge Hospital Psychiatric Services) and Willow ward (at Bowmere Hospital) as appropriate seclusion environments available to acute and PICU patients. The trust's policy states that 'The use of a patient's own room should not be considered due to risk of creating trauma related thoughts to that space for the patient'.

Our findings

Records showed that patients had been secluded in rooms that were not designated as seclusion rooms on Mulberry ward for varying periods of time, since the ward had opened in December 2019. This included being secluded in their own bedroom and one of the therapy rooms on Mulberry ward. There had been 10 recorded incidents since November 2021.

Mulberry ward's therapy room and bedrooms were not appropriate environments to seclude patients as they did not meet the environment requirements set out in national guidance, the Mental Health Act Code of Practice. The rooms used did not allow for proper communication, were not robustly constructed, were not free of safety hazards, and had blind spots so did not allow for full observation. The bedrooms included en-suite areas had anti-ligature fittings throughout but there was no discrete observation into the bathroom areas. It was not clear from the records or the reviews whether staff removed any recognised hazards in the bedroom areas prior to seclusion being initiated.

Mulberry ward's therapy room was in a busy area of the ward, looked out on to the internal courtyard area which was accessed by other patients and was not appropriately furnished to be used as a seclusion facility. There was no bed in the therapy room so patients could not sleep if seclusion was used for sustained periods of time. The therapy room was not appropriately heated as there was no heating system or radiator and one of the windows did not fully shut.

As well as failing to meet the environmental standards contained within the Mental Health Act Code of Practice, staff on Mulberry ward were unable to lock the patients inside the bedrooms or the therapy room when seclusion was initiated as a last resort. This was because the doors were operated by magnetic key fob with a door handle on the inside which patients can use to open the door. Therefore, patients were able to use the handle to open the door from inside. There was no function available to staff to override the magnetic fob and door handle arrangement to lock the patients in the room as a last resort to manage disturbed behaviour.

Records showed and staff confirmed that this had led to incidents on Mulberry ward where either staff had to place themselves in the room with the patient exhibiting disturbed behaviour with a risk to others, staff standing in the doorway to prevent patients from leaving or staff holding the door or door handle to keep patients contained within the non-designated rooms for extended periods of time until such time that seclusion could end. For example, one patient had to be restrained by staff while secluded when they had been placed in seclusion due to actual physical aggression to staff. This was because the patient also managed to secrete personal items on their person with the likely intent to self-harm as they were secluded in their bedroom rather than a cleared, safe seclusion room.

The trust's local risk register had highlighted that Mulberry ward does not have a designated seclusion room and the risks to staff and patients from unlockable doors and unsafe spaces to seclude patients. This had been included on the local risk register since June 2020 and initially RAG (Red Amber Green) rated as red with an inherent risk score of 16, reduced to amber and a residual score of 12 with the controls in place. The risk register identified this issue being unresolved and acknowledged that seclusion in non-approved seclusion rooms was still taking place, which was not in line with guidance and best practice. The risk had remained on the register since that time up to and including at the time of our inspection.

Following the inspection, we asked the trust for a response who told us that upgrade works were planned which included, upgraded furniture, upgraded specification of light fittings with anti-damage covers and other adaptions to four bedrooms to make them more suitable. The response did not address the fundamental issues about patient bedrooms being used for seclusion, the rooms not locking and limited observations into the bedroom and en-suite bathroom areas.

Our findings

We issued a warning notice and told the trust it must make significant improvements to any environment used to seclude patients by 30 March 2023.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool. The clinical assessment risk assessment tool was incorporated into the trust's electronic care record system. The trust had recently changed the patient risk tool they used to assess and manage patient risk. The newer risk assessment had greater emphasis on the patients' presenting, predisposing, precipitating, perpetuating, and protective factors to formulate risk. The risk assessments were clear and easy to read.

Most staff had completed training on the new risk process. As of 31st August 2022, the uptake rate for staff completing revised risk assessment and formulation training was 73% compliant. Further training dates were planned to improve the figure further.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Care records included individualised risk assessments, and care plans were developed in response to these. Care plans were detailed, and although some used standard wording, these were personalised to individual patients.

The care plans and daily records of care showed that staff responded to changes in risk, and this included reviewing each patient's level of observation. For example, we saw that one patient's risks were reviewed following a fall and their observations increased. Nursing staff could explain the rationale for higher levels of observations for specific patients.

Staff completed handover sheet that included a summary of risk for each patient. This included the presenting risks and level of observation. Staff including agency staff told us that they received key information about patients risks to manage and mitigate the risks.

Staff completed appropriate observations on patients. The trust had introduced new systems and processes for observing patients. Staff were clear about the changes and were following them. This included revised and improved recording requirements with more detail required about what the patient was doing and how staff were engaging with them at the time of the observations, as well as staff wearing tabards if there carrying out higher levels of observations on specific patients. Records identified that observation levels were regularly reviewed.

Use of restrictive interventions

When a patient was placed in seclusion, staff did not keep clear records and did not follow best practice guidelines.

The trust's own seclusion and segregation policy implemented in May 2019 stated that 'The use of a non–approved room to confine a patient within must only be taken as an emergency measure, be reasonable and proportionate to the harm it is intended to prevent, for the minimum time necessary and supported by implementation of the seclusion policy. The decision to utilise a non–approved room for temporary seclusion must be agreed with the MDT and must only be undertaken whilst awaiting transfer of the patient to a more safer environment with approved seclusion facilities. The use of a patient's own room should not be considered due to risk of creating trauma related thoughts to that space for the patient. In order to identify the most appropriate environment for facilitating temporary seclusion a risk assessment of the environment and patient's needs must be undertaken.' The policy states that consideration must also include certain factors and then goes on to list a prescribed range of considerations.

Our findings

Most of the patients who were secluded on Mulberry ward were secluded in inappropriate environments for significant amounts of time. Following a request for information following the inspection, the trust told us that for the period November 2021 to November 2022, there were 10 seclusion episodes on Mulberry ward involving 7 (or possibly 8) patients secluded – as two episodes were recorded for patients with the same initials but other information led us to believe that this may not be the same patient. Of these episodes all apart from one were seclusion episodes that lasted more than 4 hours in duration. Five episodes were more than 4 hours but less than 24 hours; involving 4 patients. Four episodes lasted over 24 hours - involving 3 or 4 patients. In relation to the episodes of seclusion over 24 hours duration:

- one was in seclusion for 47 hours starting in September 2022;

- one was in seclusion for 52 hours starting in May 2022

- one was in seclusion for just over 72 hours in July 2022 and

- one was in seclusion for over a month starting in August 2022.

All but one episode of these seclusion episodes occurred in a bedroom. One episode (of 15hrs) was carried out in the therapy room. There was also one failed attempt to seclude a patient in an empty bathroom. The records did not fully clarify whether in each relevant instance the patient's own bedroom was used or another bedroom was used to seclude the patient.

Records did not indicate whether staff considered an emergency assessment under the Mental Health Act for one episode of seclusion of a patient who was not detained, contrary to the Mental Health Act Code of Practice. The immediate safety assurance review supplied by the trust for this episode did not identify or indicate that the patient was considered for an assessment for an emergency application for detention under the Act such as whether holding powers or section 4 of the Mental Health Act were considered to meet the Code requirements.

Records indicated that one episode of seclusion was principally to manage a patient’s self-harming behaviour, contrary to the Mental Health Act Code of Practice. The patient was secluded for over a month in their bedroom. The immediate safety assurance review supplied by the trust for this episode did not identify or indicate the patient was a risk to others. The immediate safety assurance review did not indicate which items were removed from the bedroom to fully manage the risks this patient posed to themselves. There had also been previous episodes of seclusion for this patient, but these incidents had not been categorised and reviewed so that learning had been considered prior to further episodes of seclusion.

We found that there were significant shortfalls in the required safeguards when benchmarked against the Mental Health Act Code of Practice and/or no cogent reasons for departing from national guidance were recorded. On the inspection, we reviewed a sample of 4 sets of seclusion records for patients who had been recently secluded on Brooklands and 3 sets of seclusion records for patients who had been recently secluded on Mulberry ward. We identified significant shortfalls across all records we looked.

These included but were not limited to:

- Medical reviews were not always carried out within one hour when seclusion was initiated without cogent reasons contrary to the Mental Health Act Code of Practice.

Our findings

- Nursing review entries did not always identify that a second nurse was part of the two hourly reviews without cogent reasons contrary to the Mental Health Act Code Practice.
- A significant number of entries were retrospective, either medical and/or nursing reviews so it was not always clear when the actual review took place and whether it met the required timeframes as prescribed in the Mental Health Act Code of Practice.
- In many cases the nursing and medical reviews contained little information or explanation to fully understand whether a robust review had occurred.
- Some entries were not clear as to whether the entry referred to a multidisciplinary review, a responsible clinician review, or an independent multidisciplinary review.
- Records of multidisciplinary reviews did not always state who attended, or their role.
- There were gaps in the recording of the required observations or reviews. For example, for one episode of seclusion on 20 September 2022 did not record the 15-minute observations. The independent multidisciplinary reviews at eight hours did not occur for one patient on the seclusion episode of 25 October 2022 event.

The trust's own immediate safety assurance reviews also noted departures from the seclusion safeguards contained within the Mental Health Act Code of Practice without cogent reasons. For example, in one seclusion incident in spring 2022, the trust's own review identified that the nursing review was not robust and the observations were not documented every 15 minutes throughout the seclusion episode and were instead documented hourly.

We issued a warning notice and told the trust it must make significant improvements to seclusion recording and reviews by 28 February 2023.

Track record on safety

Reporting incidents and learning from when things go wrong

Staff recognised incidents but did not always report seclusion episodes appropriately. Managers investigated incidents but they did not review seclusion episodes fully to improve practice. When the most serious incidents occurred, managers shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report but did not always record incidents fully. The trust had an electronic system for reporting incidents which was accessible to all staff.

The trust did not have effective systems and processes to ensure all incidents were reported, reviewed, and investigated appropriately to ensure lessons were identified and shared and to prevent a reoccurrence. The trust did not keep appropriate records in relation to each seclusion episode to provide assurance that the required safeguards were met. The systems and process to manage the cleanliness of the seclusion room were not fully effective.

Staff were not following trust's seclusion and segregation policy to ensure that seclusion episodes in bedrooms were categorised and overseen properly. The trust's own seclusion and segregation policy stated that any incident of seclusion outside of a designated seclusion room must be recorded as a grade B restraint practice incident on the incident recording system and an immediate safety assurance review completed to identify any areas of learning and reflection followed by a debrief for the patient and staff. In seclusion data produced by the trust, this reports that there have been 15 recorded episodes of seclusion in the time period January 2020 to October 2021 on Mulberry ward. The report outlined that there were 15 seclusions for 13 patients in the time-period. A further trawl of incident notifications held by the modern matron identified a further 12 incidents associated with 10 patients where seclusion had been used but the seclusion field had not been checked.

Our findings

Staff continued to incorrectly categorise seclusion episodes in the incident report system, so they were not flagged on the system for appropriate oversight and review. Following a request for information after the inspection, the trust told us that for the period November 2021 to November 2022 there were 10 seclusion episodes, but one patient had been secluded on a number of occasions, but only one incident report noted.

The trust also accepted that not all episodes of seclusion had received an immediate safety assurance review. Following a request for further information after the inspection, the trust provided 7 immediate safety assurance reviews for the period November 2021 to November 2022 but that there were at least 10 seclusion episodes. The trust stated that these incidents would be reviewed at the Immediate Safety Assurance Forum in late November 2022. The trust told us that they would ensure that any future incidents would be categorised as a category B incident and will be reviewed at the Immediate Safety Assurance Forum. In addition, a retrospective review will be undertaken of all incidents relating to seclusion on Mulberry ward over the last 12 months and will be reported through to Immediate Safety Assurance Forum.'

The oversight and review of incidents were not sufficiently robust to ensure that lessons were learnt to prevent a reoccurrence. The immediate safety assurance review supplied by the trust for an episode of seclusion on an informal patient did not identify or indicate whether there was consideration of initiating any such holding power or emergency Mental Health Act application assessment once seclusion had been instigated, either in the body of the description, gaps in care, immediate actions in response or in the learning identified.

The immediate safety assurance review supplied by the trust for an episode of seclusion on a patient that lasted over a month did not identify or indicate the patient was a risk to others. The patient was secluded in their bedroom, but the immediate safety assurance review did not indicate whether all property was removed. The review focused on the decision to seclude the patient but does not provide sufficient detail relating to the timeline of issues relating to ongoing seclusion beyond the 22 August 2022 to provide any detail or assurance around the trust's own policy considerations and to assure any external observer that seclusion was for the shortest possible time.

The trust's immediate safety assurance reviews or the seclusion episodes on Mulberry ward did not benchmark practice against the considerations within their own policy when a non-approved room was used. Many of the reviews did not properly identify how patients were kept within the room for extensive periods of time given the lack of a lockable room. The issue of Mulberry ward using bedroom and other areas has been a known issue since October 2020. While there had been consideration of a draft written protocol, revised admission criteria and a longer term solution, there had been no proper action to address the immediate issues of the current environmental shortfalls on an interim basis until a longer term solution could be agreed and actioned.

When the most serious untoward incidents occurred, managers shared lessons learned with the whole team and the wider service. There was a death in 2018 on Lakefield ward by a patient ligaturing in the bedroom. At the inquest which occurred recently, the coroner identified that the layout of Lakefield ward did not lend itself easily for patient observations with the court expert describing it as 'wholly inadequate'. We saw that there had been changes since the incident including one member of staff constantly deployed at the first entrance to all the bedroom corridors. The ward had reduced in size which also improved sightlines. There had been no further deaths by ligaturing or as a result of the compromised layout on Lakefield ward.

There had also been a serious untoward incident in June 2022 on Brooklands ward which was still under investigation. We saw that improvements had been put in place following the shortfalls identified in the trust's own initial investigation. These included improved observation recording, staff training and staff wearing tabards to identify that they are undertaking observations so as not to be distracted.

Our findings

Is the service caring?

Inspected but not rated

We did not rerate caring at this inspection. This was a focused inspection and we did not look at the whole key question.

Kindness, privacy, dignity, respect, compassion and support

Staff were discreet, respectful, and responsive when caring for patients. We spoke with 11 patients and eight carers. Most patients stated that staff cared for them well and were very friendly. They said staff were very understanding towards patients and helped them as much as they could. We observed care and saw staff responding to patients quickly and speaking with patients with dignity and respect.

Patients and carers said staff treated patients well and behaved kindly. All the carers we spoke to were complimentary about the care their loved one received stating staff were respectful and polite. They stated that staff were responsive when they asked for information. One carer summed this up by stating they felt listened to and their concerns were taken seriously. Some carers said that it was sometimes difficult to speak with staff on the phone on Lakefield ward as the phone wasn't always answered.

Staff understood and respected the individual needs of each patient. Patients reported that their needs were understood and met. One patient did not have access to communication cards to help them communicate how they were feeling. We passed this on the nurse in charge to ensure that despite any restrictions placed on them, patients were supported to be able to use their communication aids.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Most patients felt safe and staff helped to keep them safe. Two carers told us that when their loved one was restrained; they were informed about it soon afterwards. They were not concerned about the restraint episode and said staff were lovely, caring and they could not fault them. One detained patient told us about an incident of restraint but understood why staff needed to restrain them as they were trying to leave the ward. Where patients raised less positive concerns, they were in the context of not wanting to be in hospital or they did not provide enough detail for us to pass on to the trust to look into the concerns properly.

None of the current patients we spoke with had experienced being placed in seclusion. When patients were placed in seclusion at Macclesfield, staff recorded an appropriate rationale for why seclusion was necessary to keep patients and staff safe for patients presenting with serious physical aggression. While records showed staff tried to maintain patients' dignity and respect when responding to and during seclusion episodes, this was not always possible due to the limitations of the environment at Macclesfield.

Is the service well-led?

Inadequate ↓↓

Our findings

Our rating of well-led went down. We rated it as inadequate as the trust needed to make significant improvements to governance arrangements around seclusion. Where we have identified a breach of a regulation and we issue a warning notice, the rating linked to the area of the breach will normally be limited to 'inadequate'.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. However leaders had not acted quickly enough to oversee and improve seclusion practice.

The wards were managed locally by competent and experienced band 6 and 7 nurses, clinical service managers, modern matrons and ward managers who had many years' experience of working in, and managing, inpatient adult mental health wards.

At the time of the inspection, there was no ward manager on Brooklands ward at Clatterbridge but the other ward managers at Clatterbridge Hospital Psychiatric Services were providing regular input. The trust had also put in a team around Brooklands ward to support the staff team. We did not identify any significant impact and staff felt well supported and continued to receive support and supervision.

The trust did not now routinely produce locality data packs which gave high quality data on the ward performance as their production had been paused. The trust were developing a revised format for reporting ward performance.

The ward managers and senior nurses had a good understanding of the wards they managed. They could explain clearly the service offered, what the ward team did well and what they felt needed improving.

Patients and staff knew who the leaders were, could approach them and saw them often in the service. Patients told us that the ward managers attended the community meetings where possible and felt confident approaching them if necessary. Staff felt well supported by the ward managers and their supervisors. One patient told us that the director of nursing had recently been to visit their ward.

Leaders had not acted robustly enough to oversee and improve seclusion practice.

The controls arising from the risk register entry around seclusion practice focused on post-incident review rather than addressing fully the environmental shortfalls to ensure there was an appropriate space to seclude patients. Several senior leaders discussed seclusion practice at the trust's regular leaders clinical practice and standards subcommittee but the focus for many months was reviewing seclusion incidents and developing a protocol which was not adopted. The action did not address or resolve the lack of an appropriate or safe environment for secluding patients. Following the inspection, we asked the trust for a response around their plans to improve the environment for secluding patients at Macclesfield. Leaders told us that upgrade works were planned which included upgraded furniture, upgraded specification of light fittings with anti-damage covers and other adaptions to four bedrooms to make them more suitable. The response did not address the fundamental issues about patient bedrooms being used for seclusion, the rooms not locking and limited observations into the bedroom and en-suite bathroom areas.

Culture

Staff felt respected and valued, and could raise any concerns. Staff told us that they did not face bullying or harassment on the wards, and that they felt valued and respected. Staff felt able to speak out about their concerns.

Our findings

Staff told us they felt confident that managers would listen to and address any concerns that compromised good quality patient care. For example, following instances of some staff being found on their mobile phones while working on one ward, managers had raised this as a concern and it was mentioned routinely at handover. As a result, it was reported there had been fewer incidents.

Staff felt respected, supported and valued by their peers and managers. Staff reported morale was good within the ward teams despite the challenges they faced. These challenges included higher levels of acuity of patients following the pandemic and staffing challenges. Staff were committed to working as an effective multidisciplinary team.

Staff told us they liked to work for the trust. Through conversations with staff and observing care, we saw staff had a commitment to ensure patients received good quality care. Specific training has been developed by the complex needs service for staff about better supporting patients with complex needs and personality disorder which was being rolled out to staff.

Brooklands ward was subject to an improvement plan following leadership changes and incidents on the ward. Managers were engaged in the process of a range of support to improve the leadership, team culture, reduce agency use and improve patient safety. Managers had used tools to assess and monitor the progress of improvement including the 15 steps challenge which identifies initial impressions when walking onto the ward to assess how patient focused the report. An improvement plan was developed from this. The improvement plan was reviewed weekly at the local business meeting and overseen at operational committee. Staff on Brooklands ward told us they felt supported by the support they had received form the trust.

Governance

Our findings from the other key questions demonstrated that the trust's governance processes were not always followed effectively. The trust identified shortfalls themselves where improvements needed to be made but then staff had not acted quickly enough to mitigate the risks of the shortfalls.

Our findings from the other key questions showed that governance processes needed to improve further to keep people safe and provide good quality care and support.

Managers had put improved measures in place, but these were not always fully effective. For example, managers told us that they had put improved systems in to manage the cleanliness of seclusion facilities, but we found that these were not fully effective. We received assurances directly from the trust in an email in October 2022 that measures had been put in place to address the cleanliness of the seclusion room on Brooklands ward, the psychiatric intensive care unit at Clatterbridge Hospital Psychiatric Services. However, we found that it was not fully clean and was not cleaned when we returned even though we pointed it out on the first day of the inspection.

Managers were not taking sufficiently robust action to address the shortfalls they had identified through their own systems. For example, the trust did not have appropriate systems and processes to fully record and monitor seclusion and its safeguards. The trust recognised that staff were not categorising seclusion episodes properly but did not address take action to address this issue fully as there were further episodes where staff did not record or categorise seclusion episodes. The wards did not have a central list or register of seclusion episode. Following the trust's submission about seclusion episodes on Mulberry ward, we had to request further information to get a fuller and better picture of seclusion practice as the trust's initial responses had gaps in the information and they recognised there were further episodes of seclusion which had not .

Our findings

We found that some audits were limited in scope and failed to fully address issues we found on inspection or did not consider the specific needs of the people using the service. For example, staff were not always recording that the safeguards in relation to appropriate observations, professional and independent reviews had been carried out when patients were placed in seclusion. These shortfalls continued even though some initial patient safety reviews identified similar shortfalls.

Managers had not taken enough action to manage the risks and develop and improve the service. The trust's local risk register around the lack of the designated seclusion room on Mulberry had been included on the local risk register for 18 months since June 2020 up to and including at the time of our inspection. The trust initially RAG (Red Amber Green) rated this issue as red with an inherent risk score of 16, reduced to amber and a residual score of 12 with the controls in place. The controls were not fully effective. For example, the risk register identified this issue being unresolved and acknowledged that seclusion in non-approved seclusion rooms was still taking place, which was not in line with guidance and best practice. Managers held regular meetings about it but did not fully mitigate the risks in the short term or longer term. All of these were all identified as ongoing with no finite completion date

We issued a warning notice and told the trust it must make significant improvements to governance arrangements around seclusion recording and reviews by 28 February 2023.

Our findings

Areas for improvement

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

Action the trust MUST take to improve

- The trust must ensure that premises used to seclude service users are secure and suitable for the purpose for which they are being used (Regulation 15(1)(b) and (c)). We have issued a warning notice to the trust telling them that they must improve in this area by 30 March 2023.
- The trust must ensure that they effectively or appropriately mitigate the risks relating to the health, safety and welfare of service users and who present with severe behavioural disturbance warranting seclusion. (Regulation 12(1)(2)(b)). We have issued a warning notice to the trust telling them that they must improve in this area by 28 February 2023.
- The trust must ensure that have effective systems and processes to ensure incidents are reported, reviewed, and investigated appropriately to ensure lessons are identified and shared and to prevent a reoccurrence. The trust must ensure that the systems and process to manage the cleanliness of the seclusion room are fully effective. (Regulation 17(1)(2)(a)(b)). We have issued a warning notice to the trust telling them that they must improve in this area by 28 February 2023.
- The trust must ensure they keep appropriate records in relation to each seclusion episode to provide assurance that the required safeguards are met. (Regulation 17(1)(2)(c)). We have issued a warning notice to the trust telling them that they must improve in this area by 28 February 2023.

Our inspection team

The team that inspected the service comprised two CQC inspectors, two CQC Mental Health Act reviewers, a specialist advisor and an expert by experience.