Greater Manchester Mental Health NHS Foundation Trust

Inspection report

Prestwich Hospital
Bury New Road, Prestwich
Manchester
M25 3BL
Tel: 01617739121
www.gmmh.nhs.uk

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Ratings

Overall trust quality rating	Inspected but remains suspended
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive?	Requires Improvement
Are services well-led?	Inspected but remains suspended

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Overall summary

What we found

Overall trust

We have suspended the trust-wide well-led rating and the overall trust rating. This is because of concerns that have come to light since we completed our well-led inspection.

We carried out an unannounced inspection of three mental health core services provided by this trust because we received information giving us concerns about the safety and quality of the services. We also carried out an announced inspection of the well-led key question for the trust overall.

As part of our continual checks on the safety and quality of healthcare services at our last inspection we rated the trust overall as good. Since our last inspection of the trust, we have carried out four focused responsive inspections in three of the trust's core services. We inspected acute wards for adults of working age and psychiatric intensive care units twice, but we did not re-rate any of the key questions with safe remaining requires improvement. We inspected and rated child and adolescent mental health wards as good overall and rated community mental health services for adults of working age as inadequate in the safe key question.

During this inspection, we inspected 3 mental health core services including:

- acute wards for adults of working age and psychiatric intensive care units
- forensic inpatients/secure wards
- mental health crisis services and health-based places of safety.

We did not inspect the following 7 core services at this inspection:

Our findings

- wards for older people with mental health problems
- community-based mental health services for adults of working age
- specialist community mental health services for children and young people
- long stay/rehabilitation mental health wards for working age adults
- child and adolescent mental health wards
- community-based mental health services for older people
- substance misuse services.

Following the inspection, we took enforcement action against the trust. We served the provider with a Section 29A Warning Notice and served a further Section 29A Warning Notice at provider level following the well led inspection. We served Section 29A Warning Notices because the quality of health care provided required significant improvement in some areas identified during the inspection. The Warning Notices set out a legally set timescale for the provider to become compliant. A further inspection will be carried out to ensure action has been taken to comply with the Warning Notices. We will continue to monitor the progress of other areas of improvement to these services and will re-inspect them as appropriate.

- We rated 2 of the trust's 10 core services as inadequate and 2 as requires improvement. We rated 5 of the trust's services as good and 1 as outstanding. In rating the trust, we took into account the current ratings of the 7 services not inspected this time.
- We rated safe as inadequate, effective as requires improvement, caring as good and responsive as requires improvement. We suspended the rating for well led.
- The trust governance systems and processes did not ensure that all services provided safe and good quality care. Information and data being received by board did not provide sufficient detail to enable the board to have full oversight of the risks which were present within clinical areas and their impact on patient care. This meant that effective action to address and mitigate risks was not taken by the trust.
- The trust did not provide safe care. The ward environments were not all safe, clean, maintained or well presented. We had significant concerns about fire safety in the acute wards. Ligature audits were poor because they did not identify all risks or effectively mitigate these. The environment was dated, and maintenance were slow to react to requests.
- The service did not have enough registered nurses and healthcare assistants to ensure that patients got the care and treatment they needed. Staff frequently worked under the minimum staffing establishment levels, wards had unfilled shifts and there was not always a registered nurse present.
- Dormitory accommodation remained in place in some services and this did not protect the dignity, privacy and safety of patients. We had significant concerns about the sexual safety of patients on mixed sex wards.
- Managers had not identified that the mandatory training program did not meet the needs of all patients and staff. Training figures were poor in some areas and the trust had not ensured that enough staff were adequately trained in fundamentals when providing patient care, including fire safety, safeguarding, basic and immediate life support, the Mental Health Act and Mental Capacity Act.
- Clinic rooms were not all fully equipped, and staff did not check, maintain, and clean equipment consistently. Clinic room temperatures and medicines fridge temperatures were not always checked, and staff did not consistently act when issues were identified.

Our findings

- Systems were not effective for the proper and safe management of medicines. Physical health observations to review the effects of medicines were not continuously completed and documentation was not always available.
- The trust did not always provide effective care in all services. Paperwork for consenting to, or not consenting to medicines, was not always accurate or available. Staff in the acute wards did not always ensure that informal patients were aware of their rights.
- Services were not always caring, some patients told us that wards were noisy and chaotic, and that they did not always feel safe.
- The trust did not provide responsive care in all services. Bed occupancy often exceeded 100% and patients did not always have a bed when they returned from leave. The acute wards regularly used rooms designed for other purposes as patient bedrooms.
- Patients told us about a lack of therapeutic activity.
- Not all staff were receiving effective, regular supervision and appraisal.
- We found that the quality of services at the point of delivery was not reflected in the executive teams understanding of the services.
- Services were not well led, and the governance processes did not ensure that wards were safe. Ward based audits were undertaken by managers and matrons, but the results were not always acted on. Named nurse audits highlighted areas for improvement, but actions were not taken to make sustained improvement, this was exacerbated by ward acuity and staffing. Managers noted a lack of information coming back to ward and service level, for example, managers relayed information about restrictive interventions to the trust, but no results were fed back down.
- Services in Wigan and Leigh used a different electronic records system to services in the rest of the trust. The Wigan and Leigh services were due to migrate to the trust system in October 2022.
- Leaders had not ensured that where concerns and risks were present, swift action was taken to monitor, mitigate and remove risks.

However:

- We rated five of the trust's services as good and one as outstanding. In rating the trust, we took into account the current ratings of the seven services not inspected this time.
- Staff working for the mental health crisis teams developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Overall, patients told us that staff treated patients with compassion, kindness and they understood their individual needs.

Our findings

- The mental health crisis service and the health-based places of safety were easy to access. Staff assessed patients promptly. Those who required urgent care were taken onto the caseload of the crisis teams immediately. Staff and managers managed the caseloads of the mental health crisis teams well. The services did not exclude patients who would have benefitted from care.
- Staff felt supported and respected by their immediate line managers.

How we carried out the inspection

During this inspection we:

- talked with 112 patients, service users and their carers about their experience of using these services
- toured nine of the 17 environments on the forensic inpatient / secure wards and all the acute wards and psychiatric intensive care units
- visited seven crisis teams and 5 health-based places of safety
- spoke with a variety of staff in face to face or virtual meetings including; health care assistants, nurses, doctors, allied health professionals, advocates, managers, executive directors, non-executive directors and governors
- reviewed a number of records relating to the care and treatment of patients
- reviewed a variety of documents relating to the management of the trust and the services it delivers
- held focus groups with external partners and staff side
- reviewed a variety of information we already held about the trust
- sought feedback from a number of the trust's stakeholders such as NHS England and clinical commissioning groups.

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

What people who use the service say

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

We spoke to 62 patients during this inspection and collected 48 comment cards.

Patients said staff mostly treated them well and behaved kindly. Most patients spoke positively about staff who they worked with. Staff were described as supportive, kind, respectful and caring. Patients were also positive about support they received from volunteers and peer support workers across the services.

However, patients were concerned about staffing levels in the service. They told us that the high use of temporary staff meant that there was a lack of consistency and that there was less interaction with them. Patients at Bolton, Trafford and Park House spoke specifically about night staffing issues, noting night staff as being unapproachable, rude and dismissive at times.

Patients also raised concerns about the ward environments, particularly about feeling unsafe in some wards and in dormitory accommodation.

Our findings

Feedback about activities was mixed. At Bolton and Park House some patients mentioned there was limited choice and no activities at weekend. Most patients noted some activities taking place during the week and there was positive feedback for psychology led groups where these were running.

Forensic inpatient or secure wards

We spoke with 18 patients, 6 carers, families or relatives and 2 advocates that worked into the service.

Most patients felt safe and listened to on the wards. Patients said staff looked after them well and they described staff as polite, respectful and caring. Most families and carers felt informed and involved but told us that making telephone contact with wards was difficult. They described regular staff as amazing. Advocacy said that the service took a patient-centred approach and that patients were given opportunities to participate in their own care, treatment and recovery.

Patients and their carers or relatives raised concerns with us about staffing. Advocates also raised staffing as a concern. Patients told us that staffing levels made them feel unsafe at times and that their leave or activities had to be cancelled due to staffing levels.

Patients said there were not a lot of activities on the wards other than television. Patients said food portions were small and that the food was unpleasant.

Mental health crisis services and health-based places of safety

We spoke with 12 patients who used the service. Patient feedback about staff was positive. Patients viewed staff as kind, caring and considerate. They felt that staff were responsive and interested in the patients' health and well-being. However, we spoke with four patients who were on the Safire Unit. They raised concerns over the dormitory facilities on the unit and the impact upon their privacy and dignity.

Outstanding practice

Mental health crisis services and health-based places of safety

We found the following outstanding practice:

- The service had strong and effective working relationships with relevant services outside the organisation. The Trust was delivering a transformation programme for its crisis services and pathways. Plans had been developed collaboratively with local NHS bodies, healthcare providers, third sector organisations and other services including local police forces. There was evidence of pro-active multi-agency working in the delivery of care and regular multi-agency meetings designed to support pathways and reduce admissions
- The trust had set up community-based crisis cafes within each locality. Some of these had been developed and were delivered in conjunction with third sector organisations.

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:

We told the trust that it must take action to bring services into line with six legal requirements. This action related to two services and the trust overall.

Trust wide

- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed on each ward to keep patients' safe and meet their needs. This includes ensuring staff receive appraisals, supervision and the training they require. (Regulation 18)
- The trust must ensure it has effective governance systems and processes to ensure board have effective oversight of quality, risk and safety concerns and that these are being managed effectively. (Regulation 17)

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

- The trust must ensure there are systems and processes in place to effectively assess, monitor and mitigate environmental risks related to fire safety, ligature risks and blind spots on all wards. (Regulation 12)
- The trust must ensure there are patient alarm systems at every hospital site. (Regulation 12)
- The trust must ensure that patients physical health needs and risks are appropriately assessed, recorded, monitored and action is taken to mitigate any such risks in line with trust policy and national guidance. (Regulation 12)
- The trust must ensure that there are effective systems in place for the proper and safe management of medicines. This must include the storage, recording and administration of medicines, including those prescribed under the Mental Health Act. (Regulation 12)
- The trust must ensure that staff accurately report the use of prone restraint. (Regulation 12)
- The trust must ensure that patients on mixed sex wards are protected from the risks of sexual assault, abuse or harassment. (Regulation 13)
- The trust must ensure that service users are protected from abuse or improper treatment. (Regulation 13)
- The trust must ensure that informal patients are informed of their rights and information is displayed making this clear. (Regulation 13)
- The trust must ensure that all ward premises, fittings and fixtures are clean, properly maintained and suitable for the purpose for which they are being used. This includes the use of 'surge beds'. (Regulation 15)
- Equipment at the Meadowbrook site must be stored appropriately. (Regulation 15)
- All patients must have access to lockable storage for their belongings. (Regulation 15)
- All staff must have access to electronic systems and technology they require to fulfil their role. (Regulation 15)

Our findings

- The trust must ensure there are effective systems and governance processes in place to assess, monitor and improve the quality and safety of services provided on the wards. (Regulation 17)
- The trust must seek and act on feedback to improve services. The trust must ensure that staff are supported in raising concerns about the trust culture, staffing levels and change being introduced, particularly at Atherleigh Park. (Regulation 17)
- The trust must work to improve morale amongst ward based teams. (Regulation 17)
- The trust must ensure that meaningful action is taken to address concerns in a timely manner that are added to directorate risk registers. (Regulation 17)
- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed on each ward to keep patients' safe and meet their needs. This includes ensuring staff receive appraisals, supervision and the training they require. (Regulation 18)

Forensic inpatient or secure wards

- The trust must ensure that all environmental risks are identified, acted on and updated to make environments safe and that staff are aware of these. (Regulations 12)
- The trust must ensure that there are effective systems in place for the storage and safe management of medicines. (Regulation 12)
- The service must ensure that all records relating to capacity and self-medication are completed and that physical health monitoring is personalised to the patients' needs and completed to the prescribed timescales to keep patients safe. (Regulations 12)
- The trust must ensure that all ward premises, fittings and fixtures are properly maintained and suitable for the purpose for which they are being used. (Regulation 15)
- The trust must ensure there are effective systems and governance processes in place to assess, monitor and improve the quality and safety of services provided on the wards and that performance and risk are managed well. (Regulation 17)
- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed on each ward to keep patients' safe and meet their needs. This includes ensuring staff receive appraisals, supervision and the training they require. (Regulation 18)

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure it delivers on its estate strategy to remove the use of dormitory accommodation.

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

- The trust should ensure that there is a clear framework of what must be discussed at a team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, is shared and discussed.

Mental health crisis services and health-based places of safety

- The trust should ensure it delivers on its estate strategy to remove the use of dormitory accommodation.

Our findings

- The trust should ensure that services based in Wigan and Leigh are transferred to the PARIS electronic records system as planned.
- The trust should ensure that it continues to effectively manage staffing resources and continues to recruit to vacancies.
- The trust should ensure that patient risk assessments are updated regularly and are captured on electronic care record systems.
- The trust should ensure that care plans and holistic and personalised.

Forensic inpatient or secure wards

- The trust should ensure that all patients have positive behaviour support plans that are used by staff and that all care plans contain personalised patient goals.
- The trust should ensure that they have complete oversight and regular reviews of all restrictions placed on patients.
- The trust should ensure that they have an accurate and complete picture of all long-term segregation used in the service.
- The trust should ensure that reporting processes enable staffing issues to be reported by ward staff (including when the service cannot meet the planned skill mix and staffing numbers) so that the trust has an accurate reflection of staffing. The service should also provide learning from incidents, internal and external to the service..
- The trust should ensure that requests for opinions from Second Opinion Appointed Doctors are completed a timely way.
- The trust should ensure there are enough ward-based activities for patients to participate in.
- The trust should consider implementing a set structure for team meetings to ensure all information is consistently shared and discussed with staff.

Is this organisation well-led?

We have suspended the trust-wide well-led rating because of concerns that have come to light since we completed our well-led inspection.

Leadership

The trust board had the appropriate range of skills, knowledge and experience to perform its role. The board comprised of seven executive directors including the chief executive who had been in post since April 2018. The executive directors included a chief nurse, director of human resources who also held the deputy chief executive role, director of performance and strategic development, chief operating officer, medical director and a director of finance, information management and technology. All the executive directors had been in post at our last inspection with the exception of the medical director who was appointed from October 2019 and the director of finance and information management and technology who had joined the trust in August 2020.

Our findings

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. All members of the senior leadership team had significant experience of working in healthcare in senior roles. The trust had eight voting non-executive directors including the chair and one non-voting non-executive director. The chair had been in post since 2016. The non-executive directors had diverse backgrounds including nursing, legal, higher education, voluntary sector, finance, NHS Confederation and planning inspectorate.

The executive board had no black and minority ethnic members. Five of the members were female and two were male. The non-executive board had two black and minority ethnic members and five of the nine were women.

The members of the trust board and senior leadership team we spoke with were clear about their areas of responsibility. As part of the inspection we received feedback from external partners, stakeholders and commissioners. We also interviewed members of the senior leadership team about the capability of senior leaders. All the people we spoke with told us they had confidence in the senior leadership teams' ability to perform its function effectively.

The trust reviewed the leadership capacity and skills on a regular basis and targeted recruitment to ensure that the board had the range of skills and knowledge required to provide leadership across the organisation. The trust had identified that further leadership capacity was required across the organisation and had formed four care groups with a senior leadership team in each. At the time of inspection these care groups had recently been formed and were being supported to develop and take on the expected leadership responsibilities. As a result of the stage of the implementation of the care groups it was too early to be able to see the impact of this additional leadership and governance capacity.

The trust had 30 seats on its Council of Governors, of which 24 were elected seats and six were appointed to by trust partners. The elected governors represented public constituencies across the five areas within the trust footprint, a service user/carer constituency and trust staff. At the time of inspection, 22 of the elected seats were filled and five of the partner seats were appointed to making a total of 27 governors. Of these, four were elected public service user/carer governors and seven were elected staff governors.

Governors were active within the trust and had representation at board meetings which was evidenced through meeting minutes we reviewed and from speaking with eight governors who attended a focus group we held. Governors told us that the board members worked well together and functioned effectively as a board. The governors were scheduled to meet five times in 2022/23 and reported they met regularly with the chair of the board. They also provided feedback to the non-executive directors as part of the annual appraisal process.

The board provided training to the governors to equip them with the skills and knowledge to undertake their roles. The governor development programme included masterclasses covering topics such as finance and was led by board members and other senior leaders. The chair and chief executive also provided briefings to the governors which covered changes in the national, regional and local operating landscape, trust performance and key developments to ensure they were kept up to date.

The trust had a corporate lead for child and adolescent mental health, a lead for learning disability and autism and a lead for safeguarding and physical health. The lead for safeguarding was supported by a deputy lead nurse and safeguarding leads in each locality to align with the local authorities. The trust had established safeguarding policies and procedures in place. Since our last inspection, the trust had commissioned an independent audit by an external provider to assess the strength of their governance in relation safeguarding which concluded there was substantial assurance in place.

Our findings

The trust had a strategy for meeting the physical healthcare needs of patients. The head of physical health care was supported by locality physical healthcare leads.

Fit and proper person checks were in place. A system was in place to ensure that the required checks were carried out on appointment and during employment. We reviewed the five personal files of board members who had joined the board since our last inspection and found evidence of the checks in place.

All the senior leaders we spoke with were able to discuss the trusts' identified priorities and the challenges the trust faced in achieving these. Leaders were transparent and open when discussing the challenges and risks were captured within the board assurance framework. However, although the leadership team had identified the significant challenges, actions taken had not ensured that the quality and safety of all services were maintained.

Senior leaders were each able to explain in detail how the overarching strategic plans, programmes and workstreams which were relevant to their area of accountability and responsibility had been developed to address the key priorities and challenges they faced over the next 2-3 years.

The trust had a programme of board visits to services however; due to restrictions imposed during the Covid-19 pandemic, these had been mostly suspended but they were reintroduced once restrictions had eased. Senior leaders who had a clinical background, had provided on-site support to some front-line staff teams during the pandemic including the chief nurse.

Staff and leaders in roles directly supporting the senior leadership team described senior leaders as approachable and visible. However, staff we spoke to in the core services told us that senior managers and leaders were not visible in their services.

Leadership development opportunities were available, including opportunities for staff below team manager level. The trust ran a series of leadership programmes for staff in leadership or managerial roles through their leadership lenses-collective leadership programme which was underpinned by a coaching model approach which aligned to the trusts' values. The programmes provided a safe space for managers across the trust to interact with one another and build up a supportive network of peers who could learn from each other's experience. The model outlined a set of behaviours leaders were expected to demonstrate which the trust had integrated within the recruitment process for managers roles going forward. All leadership development programmes had a minimum of 20% of places protected for black, Asian, minority ethnic members of staff.

The trust also provided apprenticeship training courses to 224 apprentices, support for over 700 volunteers and both accredited and non-accredited courses for all levels of staff within the trust.

The trusts NHS staff survey results for 2021 scored the trust as 6.5 against a national average of 6.6 for the statement, 'We are always learning'.

When senior leadership vacancies arose the recruitment team reviewed capacity and capability needs. The trust reviewed leadership capacity and capability on an ongoing basis and succession planning was in place throughout the trust.

The trust had recently established a workforce development committee with the aim of developing three subgroups which would report to the workforce development committee which were:

Our findings

- staff experience working group
- workforce supply working group
- training and education working group.

The overarching aim of the committee was to ensure the implementation of the trusts' people plan. The people plans' strategic objectives were focussed on improving staff health and wellbeing, retention and growth of the workforce, streamlining access to training and education and improving access to key workforce data.

Vision and Strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities.

There was a clear strategy for achieving trust priorities and developing good quality, sustainable care. The trust's five-year strategy 2019 - 2024 ('Delivering Excellent Care and Supporting Wellbeing') set out the trust's strategic vision - 'Working Together to Improve Lives and Support Optimistic Futures' and future direction of travel.

The vision was underpinned by five overarching values which were launched in September 2017 following extensive engagement with service users, carers, staff and governors.

Each of the five values was supported by a set of five associated behaviours which all staff were expected to demonstrate through their everyday work. The trust's vision and values were displayed throughout the trust on staff lanyards, posters, corporate information and on the trust website.

Staff at all levels within the trust demonstrated a good understanding of the values and vision of the trust and were able to articulate how these linked to their work. The trust values were embedded within all levels of the trust from staff induction, the recruitment process, policies, appraisal system, board assurance framework and board meetings.

To deliver the trusts' vision, the trust had five key strategic objectives which were aligned to strategies and programmes of work. The trust had identified overarching goals in the delivery of these objectives. These were:

- Individuals who need mental health/substance misuse support to have timely access to services that are personalised, integrated and close to home.
- Our staff and services to be recovery-focused, building individual and community resilience.
- The services we provide to be evidence-based, offering high quality care by compassionate and capable staff in fit for purpose environments
- Our staff to be happy and motivated.
- Anyone with a mental health or substance misuse issue to be treated equally and be supported to challenge stigma that they may face in their lives.

The trusts' strategic plan demonstrated the trust's commitment to working in collaboration with partners to deliver system wide transformation within the Greater Manchester footprint.

Our findings

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans supporting the parity of mental health and wellbeing alongside physical health. Board members were able to describe how the strategic plan focussed on supporting partnership working with stakeholders to ensure the delivery of sustainable care which was responsive to the local populations needs.

The trust was part of the Greater Manchester Health and Social Care Partnership and developing Integrated Care System which was formed in July 2022. The partnership brings together NHS providers and commissioners from across the region with local authorities and other local partners, including the voluntary sector, to collectively plan and deliver joined up health and care provision within the Integrated Care System.

From October 2021, the responsibility for planning secure services for adults with mental illness and/or learning disabilities transferred from NHS England to the Greater Manchester Adult Secure Provider Collaborative. The trust was appointed as the lead provider of the collaborative, working in partnership with neighbouring trusts and independent health providers. The trust was also working together with service users, carers, system partners and other local stakeholders to make sure that by working together on the design and delivery of services, they were able to meet the needs of the population of Greater Manchester. As lead provider, the trust had oversight of the whole adult secure care pathway in Greater Manchester and the trust aspired that the close working relationships between all providers would mean that everyone was working together to ensure that service users were in the right place, at the right time, with the right level of support.

Throughout the COVID-19 pandemic, the trust had worked closely with the police, voluntary agencies, acute hospital trusts and other stakeholders on a range of transformation programmes to support service users to access community services and improve clinical outcomes. These included:

- The healthier patient pathways resulting in a number of improved clinical outcomes for patients through a 36% increase in discharges during 'perfect week' events, a reduction in length of stay by 3.4 days and a 52% reduction in delayed transfers of care.
- The community transformation, the remodelling of primary and community mental health care through the delivery of phase 1 and phase 2 of the Salford Living Well (National Vanguard Site), which focused on adults too complex for primary care and psychological therapy services, but who did not meet the threshold for secondary care. The programme was independently evaluated, and interim findings of the report noted a high proportion of people showed significant improvement in personal safety, leisure and community activities, jobs/occupation and quality of life scores. The trust established living well collaborative design groups to support the implementation of the 'Living Well' development programme working collaboratively with Greater Manchester Health and Social Care Partnership, Innovation Unit, voluntary sector, those with lived experience and the clinical commission groups.
- Trust staff provided additional support to paediatric wards to support in the assessment and management of young people with mental health needs, including eating disorders.
- Delivering improved access and earlier interventions by establishing 24/7 open access crisis lines across all localities and, in collaboration with Greater Manchester Health and Social Care Partnership and other partner agencies, and the Greater Manchester Clinical Assessment Service linked to the crisis line.
- Establishing an all age accident & emergency / liaison mental health services across all acute hospitals within Bolton, Salford, Manchester and Trafford and urgent care centres in Bolton and Salford.

Our findings

- Developing overnight crisis cafes and alternatives to admission across all localities and working collaboratively with partners to create Safe Havens in Trafford and Wigan. Development of open access day services and recovery colleges for all localities.
- The trust had also responded quickly providing clinical support services when requested by NHSE and clinical commissioning groups to support the local system where providers had failed to meet patients' needs adequately.

The trust had developed an estates strategy 2022-2025 which included productivity and development of an infrastructure strategy, rationalisation and capital improvements. The trust had successfully completed the full business case for the replacement of Park House which was approved by HM Treasury in November 2021 securing capital investment of £91.3m. Work on the new inpatient accommodation in North Manchester had recently commenced and was due to be completed in the next two years.

Culture

Staff did not always feel respected, supported and valued.

In all three services we visited during the inspection, staff told us that they felt supported by their direct line managers and that they were able to raise concerns about practice without fear of reprisals. However, in all services staff told us that they felt a disconnect with the senior leaders of the organisation. They told us that they did not always feel involved in change and the future direction of the organisation and they did not always feel listened to by senior managers. This was particularly a theme where the trust had taken on new services, such as in Wigan.

We reviewed the latest staff survey results for the trust from 2021 which 2,916 staff completed (47%). The survey compared trust staff responses to nine statements against the national average. Of the nine statements, the trust scored in line with the national average for one of the statements, and below the national average for the other eight statements.

The trust scores related to compassionate culture, being recognised and rewarded, team working, and health and safety climate went down from the 2020 survey. However, the scores related to we have a voice and morale had increased in this year's survey. The percentage of staff who reported that they looked forward to going to work was 51.6% which was lower than the average of 56.7% and 31% of staff expressed their desire to leave the organisation. The percentage of staff who would recommend the trust as a place to work was 56% against an average of 63.2%.

The 2021 NHS staff survey results showed that the trust's score for staff engagement was 6.8 which was slightly below the national average of seven. The staff engagement score had reduced from the previous year.

The trust had experienced a rise in staff leavers over the past 12 months which they had acknowledged. The total staff turnover figure was 14.02% in June 2021 rising to 16.29% in May 2022. The trust had commissioned an external company to collate information from employees leaving the trust and develop a report from the data. We reviewed the annual report for all 336 leavers between June 2021-2022. Overall, 120 (36%) were classed as, 'happy leavers' and 216 (64%) were classed as, 'unhappy leavers' in the report. Sixty three percent stated they would work for the trust again and 57% would recommend the trust as a place to work. Sixteen percent of leavers had left within 0-6 months, 31% had left within 12 months of starting and 53% had left within two years. This meant that although the trust were able to recruit staff, they had significant issues in retaining these staff. The trust had various workstreams in place underpinned by the recently established workforce development committee with the aim of improving staff health and wellbeing, retention and growth of the workforce.

Our findings

The trust's strategy, vision and values underpinned the aim to have a culture which was patient centred. Since our last inspection, the trust had developed a Greater Manchester Mental Health Together Strategy 2022 to 2025 to bring together the previous two separate carer and service user engagement strategies they had implemented between 2018-21. Underpinning the new strategy was a focus on how the trust aimed to work in collaboration with everyone including the wider community to meet service users and carers needs. The strategy was co-produced following extensive engagement with service users, carers, families, staff and external agencies with the pro-active involvement and support of the trust's service user and carer governors.

The trust recognised staff success by staff awards and through feedback. The trust held annual awards for which staff could be nominated. The trust had staff who were nominated for national awards in the twelve months prior to the inspection. However, there had been a significant decrease in the amount of staff who felt they were recognised and rewarded by the organisation from the 2020 to the 2021 survey. For example, in 2020 52% of staff felt that the organisation valued their work, this had reduced to 47% in 2021.

Some wards had introduced ward based staff recognition and star of the week. In acute services, staff had worked on a working better together board with information about different countries and cultures that reflected staff backgrounds and celebrated these.

We held a focus group with a range of trade union representatives who told us that the trust worked appropriately with trade unions. They provided positive feedback about the changes the trust had made with the introduction of the new staff wellbeing policy and praised how senior leaders had communicated with staff throughout the pandemic although they stated this had not been as good more recently. Some members also commented that although the trust had a number of strategies in place, these were often, 'lost' at middle management level creating a disconnect of information from the board down to staff in the teams/wards. This mirrored what staff working in services had told us.

Managers took action to address the poor performance of staff where this was identified and needed. A policy was in place to provide guidance to managers on the expected approach and actions. We reviewed five staff records where staff had been subject to disciplinary procedures and saw evidence that trust policies and procedures were followed in these cases.

The trust had effective processes in place to verify that staff had a current professional registration and valid disclosure and barring service where required.

The trust had a freedom to speak up guardian who was supported by a full-time deputy.

They were provided with sufficient resources and support to help staff to raise concerns. The freedom to speak up guardian had direct access to the chief executive and wider executive colleagues. They met with the chair, chief executive, deputy chief executive / director of human resources and non-executive director lead for freedom to speak up to summarise activity and discuss high level details into case management and ongoing cases on a quarterly basis. They also submitted a bi-annual report to the board.

The number of staff who had raised a concern through the freedom to speak up guardian in the year 21/22 was 96, four of which were raised anonymously. This was a 35% increase from the previous year. The themes from these concerns were similar to the previous year with the majority of cases related to personal grievances, followed by cases relating to bullying or harassment or working practices. Elements of patient safety were present in four cases.

Our findings

Overall, staff we spoke with on inspection told us they felt able to raise concerns without fear of retribution however, seven staff who had raised a concerns through the freedom to speak up guardian reported they felt they had suffered detriment by speaking up. Some staff within the wards we inspected also told us that they did not raise concerns as they did not feel they were heard or that action would be taken in response to them raising concerns.

The trust had a guardian of safe working hours who provided annual and quarterly reports to the board in line with the requirements of the 2016 terms and conditions of service for junior doctors. Reports included data on exception reports, details of fines levied against departments with safety issues, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting good practice and/or persistent concern.

Between February and April 2022, there were 23 exception reports, three of which had been carried over from the last report. Themes around the reports included out of hours cover and trainees struggling to take breaks in addition to workload. The trust had taken action by introducing a trust-wide out of hours rota in February 2022. The rota was for higher trainees covering general adult and later life services and was monitored through review meetings held with trainee representatives, senior medial leaders and the guardian of safe working hours. There continued to be issues with out of hours cover in the Wigan child and adolescent and adult services however, which were covered by locums.

The trust applied duty of candour appropriately. The trust had a policy which met the duty of candour requirements of the regulation. The policy was being reviewed at the time of our inspection to make it clearer when duty of candour applied and how this could be evidenced.

There was also a programme of training being rolled out within the trust and being open and duty of candour had been the focus of one of the, '7 minute briefing papers' and spotlight on patient safety newsletters which all staff had access to.

Staff had the opportunity to discuss their learning and career development needs at appraisal. Staff appraisal rates overall were 84% at the time of inspection however; there were pockets where this figure was much lower.

Trust wide staff compliance rates for clinical supervision and line management supervision were 75% and 78% respectively as of June 2022. Whilst trust level compliance in relation to supervision, appraisal and mandatory training were above 75%, we found that on some wards, figures were much lower. For example; on Priestner unit, the overall compliance rate for appraisals was 21%.

The trust had an annual mandatory programme in place for staff and as of June 2022 the compliance at trustwide level ranged from 75-96% depending on the course. Mandatory training included safeguarding adults and children, basic life support, information governance, infection prevention, health and safety, fire safety, equality, diversity and human rights, Mental Capacity Act and Mental Health Act, PREVENT, conflict resolution and prevention management of violence and aggression.

Whilst trustwide compliance levels were higher, in some services and wards, compliance levels were very low. We raised concerns about this in our inspections of the forensic inpatient and acute/PICU wards. It was not evident that the senior leadership team had identified and taken robust action to address the low levels of supervision, appraisal and training in some services.

Our findings

Intermediate life support was not considered mandatory training for all clinical staff. Given the type of services being provided, the presence of staff with immediate life support training is expected. Whilst the trust had a process in place to identify staff with intermediate life support training on each site there were many clinical staff who did not have these skills and we were therefore not assured there were enough staff to respond in the event of an emergency.

Volunteers we spoke with in a focus group told us that they were supported to further their skills, training and careers in a way they felt comfortable with and which met their needs.

Staff had access to support for their own physical and emotional health needs through occupational health. The trust launched a new wellbeing policy on the 1 April 2022 which had a much greater emphasis on providing a person-centred approach to supporting staff wellbeing. To build on the home working hybrid approach some staff had worked during the pandemic, the trust had developed a homeworking deal to support staff in attaining a healthy work/life balance.

Staff had access to occupational health and external counselling service to support their wellbeing.

Sickness and absence figures were not outliers. Staff sickness and absence figures had been significantly impacted by the pandemic over the past two years however; these had gradually reduced and stabilised over the previous months. Staff sickness levels in February 2022 had reduced from 8.7% to 6.5% of which 1.1% was Covid-19 related.

Staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression. The trust scored 7.4 against an average of 7.5 in the staff survey 2021 for the statement, 'We are compassionate and inclusive'.

The trust had launched a new Advancing Equalities Strategy 2022 to 2025 in the week prior to our inspection which set out four objectives to achieve over the following three years. These were:

- reduce inequalities in health and employment by using data and intelligence to assess impact, guide activity and monitor performance
- reduce health inequalities by working with community partners and experts by experience to co-produce inclusive integrated services that improve outcomes
- reduce workforce inequalities by working collaboratively to create a culture of conscious inclusion where diversity is valued and nurtured
- increase people's sense of belonging by creating inclusive and accessible environments where people feel respected and safe.

The trust had a previously established strategic equality, diversity and inclusion group chaired by a non-executive director through which the Advancing Equalities Strategy was developed. The advancing inequalities forum was established to support the implementation of the strategy. Each objective had three priorities for action which the trust planned to reflect in an associated advancing equalities action plan 2022-25 which would be used to support the monitoring and reporting on progress of the strategy to the board.

Although the trust had made some progress in reducing inequalities within the workforce, it acknowledged that more targeted work needed to be done.

Our findings

The trusts' workforce race equality standard showed that in 2019 the trust had 14.7% of staff from a black and minority ethnic background which increased to 15.9% in 2020 and 16.3% in 2021. The likelihood of white staff being appointed from shortlisting was 1.57 times greater in 2019. This reduced to 1.47 in 2020 and 1.3 in 2021.

The number of staff from a black and minority ethnic background entering a formal disciplinary process had also reduced year on year.

The relative likelihood of white staff accessing non mandatory training was higher by 1.3 than that of staff from a black and minority ethnic background.

The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in 2021 (based on data from the 2020 staff survey) was 29% for white staff and 36% for staff from a black and minority ethnic background. Figures for staff experiencing harassment, bullying or abuse from staff were similar for both staff groups at 21% and 22% respectively.

However; the percentage of staff from a black and minority ethnic background who had experienced discrimination from managers was higher at 16% compared to 7% for white staff and white staff reported more opportunities for career progression/promotion at 87% compared to 75% of staff from a black and minority ethnic background.

Staff networks were in place promoting the diversity of staff. The trust had three established staff networks which were the black, Asian and minority ethnic group network, a staff disability network and a LGBT+ network. The non-executive director for equality and diversity told us that there were plans to develop a staff network for staff from a Jewish heritage. They also told us of plans to move the networks to a hybrid model where staff could join meetings via teams as this had improved attendance through Covid-19 restrictions by being more accessible to staff. Staff were supported by managers to attend meetings in work time.

Local teams we visited during the inspection worked well together and told us that managers had acted when conflicts or concerns about behaviours within a team had developed. The trust scored 7.0 against an average of 7.1 in the staff survey 2021 for the statement, 'We are a team'.

Governance

Our findings from our inspection activity showed that governance systems and processes were not always effective in ensuring that patients received safe and effective care in appropriate environments.

The trust had structures, systems and processes in place to support the delivery of its strategy from the board to sub-board committees. However, below this level these systems and structures were not always effective in identifying concerns regarding the quality and safety of services and ensuring effective action was taken to make improvements and ensure the delivery of high quality patient care.

The trust had revised and made changes to the board governance structure which was approved by the executive management team on the 6 April 2022. The new structure had seven sub committees and a strategic equality and diversity working group which fed directly into the board. The sub committees included: workforce development, finance and investment, charitable fund, commissioning, quality improvement, audit and remuneration and terms of service committee.

Our findings

Each committee chair presented the board with a comprehensive up to date progress report. This was linked to the key priorities of the committee and identified challenges faced and plans in place to address these. Each of the committees had specific groups/sub-committees which linked into them to support the delivery of the trust's strategy. The structure from the board to the groups/sub-committees was displayed on a single sheet which provided a clear overview of the board's overarching governance structure.

Non-executive and executive directors were clear about their areas of responsibility. They were each able to explain in detail how the overarching strategic plans, programmes and workstreams which were relevant to their area of accountability and responsibility had been developed to address the key priorities and challenges they faced over the next 2-3 years.

The chair invited each non-executive director to present on their area of expertise to the board. The board assurance framework was reviewed by the board at each meeting.

We attended both a board and quality committee meeting and reviewed a range of minutes from the board and sub-committee meetings. Papers to inform the meeting were circulated in good time and contained clear, relevant information in relation to the meetings. There was consistency among all board members regarding the priorities and challenges the trust faced which was further evidenced through the interviews and focus groups we held. Members of the board demonstrated collective accountability, transparency and integrity within the meetings. We observed board members providing respectful, appropriate challenge to other members when clarity or further assurance was sought regarding a particular issue. However, this review by board did not identify if there were services which faced particular challenges such as reduced staffing, staff training, supervision or environmental issues.

The board of directors were open and honest about the challenges faced by the trust. They described the trust as being on a journey to improvement, particularly in relation to strengthening governance structures and systems to provide assurance. With the establishment of the care group structure within the trust, the trust had commissioned external independent support, to review and develop the governance structure around the new care groups and accountability framework. This work was concluding at the time of our inspection.

Since our last inspection, the trust had recognised that with the acquisition of new services and subsequent expansion of the trust, that the existing governance structure needed to be reviewed and realigned to strengthen the lines of accountability and responsibility from the board to wards/teams. They had completed a programme to redesign their operational delivery model in April 2022. The model was implemented by the introduction of four collaborative leadership teams across the divisions which directly reported to the deputy chief operating officer.

The teams were supported clinically by the deputy chief nurse and deputy medical director. The four teams were accountable and responsible for the delivery of services with the following care groups: specialist services, Wigan and Bolton, Salford and Trafford and Manchester. Each team had an associate medical director, associate director of operations and an associate director of health professionals and quality. Under each team there were three distinct divisions which were split by service or geographical location. This meant that there were clearer lines of accountability and responsibility from the board to wards and teams.

At the time of our inspection, these new structures were not effective and embedded. There were a number of significant safety issues we found in the services we inspected which had not been identified or addressed. This

included serious concerns about; medicines management and pharmacy oversight, mandatory training levels, staffing and retention, fire safety, sexual safety, dormitory accommodation and environmental risks and safety. The trust were aware of a number of these risks but there was not evidence that action had been taken to monitor and mitigate the risks presented.

The trust had recently implemented a new governance framework which was supported by an interim care group accountability framework. However; we found that service level meetings had inconsistent agendas, low attendance and that learning from incidents was not always shared.

Governance arrangements were in place in relation to Mental Health Act administration and compliance. Staff were aware of who the Mental Health Act administrator was for their clinical area and how they could contact them if required.

The chief nurse was the executive lead for the Mental Health Act and the trust had a head of mental health legislation and policy. A Mental Health Act compliance committee met bi-monthly and provided assurance to the board on trust compliance with the Mental Health Act, the Mental Health Act Code of Practice and the Mental Capacity Act through the quality improvement committee. Outcomes of Mental Health Act monitoring visits were reviewed for any themes.

Staff reported episodes of restraint, seclusion and rapid tranquilisation were recorded as incidents on the trusts' reporting system. These were reviewed by managers and centrally within the trust by the Positive and Safe group. The positive and safe group was a sub-group of the quality improvement operational delivery group. The trust also participated in safewards, a model which seeks to reduce conflict in ward environments. The trust has an identified clinical lead responsible for the implementation of the safewards model.

The trust had a restrictive interventions reduction programme in place, which met best practice standards. The trust had started to consider the Mental Health Units (Use of Force Act) 2018 but had not made significant progress in its implementation. The chief nurse was nominated as the responsible person to ensure accountability with the medical director as nominated support in the chief nurses' absence.

There was no overall implementation plan or strategy for the organisation to be compliant with the Act and its statutory guidance other than for training. The organisation was on the 'working towards certification' list on the Restraint Reduction Network website. The training self-assessment document was RAG rated but had no implementation or target dates, there were also gaps and no supporting documents. There was no up to date policy which included the Mental Health Units (Use of Force) Act.

The trust had recently completed phase 1 of a quality improvement project specifically aimed at reducing restrictive interventions which was part of the Breakthrough Series Collaborative. The aim of the project was to decrease the use of restrictive interventions by 5% by 30th November 2021 across innovation wards. The result at the end of the project was a reduction of 7.5% in the use of restrictive interventions. Further broken down, this was a reduction of 15% in the use of restraint and 6% reduction in the use of seclusion however, there was a corresponding increase in the use of rapid tranquillisation by 15% which was being further explored.

The trust treated concerns and complaints seriously and investigated them. The trust had introduced a triage process to their complaints structure, giving service users and carers a choice about whether they want to make a complaint or raise a concern. Where people wished to make a complaint, they were supported to do so by staff, and these were investigated in line with trust policies and procedures. However, if people choose to raise a concern, the customer care

team contacted the respective service to try to resolve things as quickly as possible. There had been a subsequent decrease in complaints during 2021/2022 with a corresponding increase in concerns logged of which 93% were resolved to the satisfaction of the service user or carer raising the concern. However, the trusts' complaint policy had not yet been updated since the implementation of this new way of managing concerns to reflect the change.

In the services we inspected information on raising complaints and concerns was available to patients, their relatives or carers and staff understood their responsibilities in handling complaints or concerns. However, the learning from complaints or concerns was not consistently shared and acted upon in two of the three core services.

Managers did not always share learning about serious incidents with their staff and across the trust. Some staff said that information was shared with them at team meetings or via emails, but others said they did not receive information. We reviewed team meeting minutes and saw no learning shared from other parts of the trust. The trust said that information was shared via multiple mechanisms including safety alerts, newsletters, trust wide learning events etc.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. However, staff we spoke with told us that they did not always receive feedback when they raised concerns and shared ideas and felt despondent about continuing to do so due to a perceived lack of action from senior leaders.

Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. Learning from these was shared trust wide via bulletins, emails and newsletters. However, there was no monitoring of the impact on practice of the information shared by these bulletins, emails and newsletters.

The trust had an established mortality group and suicide prevention group which were led by the medical director who provided a summary of the learning from deaths report to the quality improvement sub-committee. The reports included an analysis of themes, trends and learning to improve practice across the trust. These processes had recently been revised and had not been fully embedded at the time of inspection.

The trust held a weekly serious incident panel where serious incidents were discussed, and reporting timescales agreed and reviewed.

The trust had commissioned an independent audit and review to assess the strength of their governance in relation to serious incidents which was completed in November 2021. The report concluded there was substantial assurance that the trusts' systems and processes were operating effectively.

However, at service level we could not see how learning was shared and changes made to make improvements. Staff and service level meetings did not always discuss learning from incidents, complaints and safeguarding concerns.

Senior management committees and the board reviewed performance reports and the trust shared performance with those who commissioned their services. Performance information was regularly reviewed by leaders to support the management of both current and future performance.

Outcomes of clinical and internal audits were included within the governance systems and processes. Whilst we could see evidence that improvements had been made as a result of audits linked to trust-wide quality improvement programmes, there was a lack of evidence to demonstrate that changes were made as a result of local audits on the wards we visited.

Our findings

The trust had a board assurance framework for 2021/22 which had 15 risks as of February 2022 which were all linked to a strategic objective. Nine of these were classed as high risks and six were classed as extreme. The extreme risks related to workforce, performance, Covid-19, future commissioning and financial sustainability. Some of the risks had been open for several years. The board assurance framework was reviewed in each board meeting.

Each risk within the board assurance framework had a designated executive director lead, whose role included routinely reviewing and updating the risks, and a designated lead committee with responsibility for testing the accuracy of the current risk score based on the available assurances and/or gaps in assurance, monitoring progress against action plans designed to mitigate the risk, identifying any risks for addition or deletion and where necessary, commissioning a more detailed review or 'deep dive' into specific risks.

Senior leaders were able to discuss the key risks identified in the trust and the actions being taken to mitigate these. However, this oversight had not identified the impact of these risks on the quality and safety of patient care in all services and had not always resulted in effective and proactive action being taken to make improvements. Where CQC has taken enforcement action the trust has provided plans to make improvements within required timescales.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. Staff concerns matched those on the risk register however, actions to reduce or effectively mitigate these risks had not always been taken and some of the risks had been on the local risk registers for several years.

The trust had plans in place for emergencies and other unexpected or expected events. For example, adverse weather, a flu outbreak or a disruption to business continuity.

The trust had a divisional business continuity plan dated March 2020. The trust had invoked its emergency and service continuity plans to maintain delivery of critical services during the pandemic. Gold command and control structures had been put in place to provide executive oversight and assurance to the board.

In the focus group we held with staff side, they were very positive about the commitment and drive the chief nurse had shown when leading the roll out of the flu vaccination programme and the communication arrangements that the trust had in place throughout the pandemic.

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. Where cost improvements were taking place, they did not compromise patient care. Financial planning was carried out with decisions being agreed locally, regionally and nationally.

Information Management

The trust's Digital Strategy 2019-2022 established a vision to adopt digital technologies that enhanced patient and service user experience, whilst ensuring the trust used its resources to maximum effect. The Digital Strategy aligned with the direction of travel set out in the NHS Long Tern Plan, which advocates digital innovation to support the NHS' long-term future whilst ensuring digital inclusion for all. Five key ambitions were set out for delivery over the three-year period:

1. Improving the experience of our services for patients, service users and carers

2. Having the ability to connect our organisation across the health and social care partner footprints

Our findings

3. Improving our ability to make informed and intelligent decisions

4. Improving the efficiency and digital safety of our organisation

5. Supporting our workforce to become digitally enabled.

Delivery of elements of the trusts' Digital Strategy were accelerated in response to COVID-19 to enable the adaptation of care models and to support the necessary delivery of digitally enabled services. The use of digital technologies during the pandemic had supported business continuity with minimum use of the trust's corporate and community estate during the period. Services such as access to psychological therapies quickly switched to a remote, digital offer, whilst approximately 1,200 members of staff were supported to work from home through the procurement of additional servers and other hardware and the embedding of virtual meeting software.

The board received a range of data to support the oversight of trust performance and quality. Team managers continued to have access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Quality performance indicators data were reported to the trust board including quality, workforce, finance, and performance following scrutiny within the governance framework but this had not supported the identification and effectiveness of the boards oversight and response to areas of concern identified prior to and during our inspection.

The trust has experienced issues with the role out of electronic prescribing of medicines. Services which had been transferred to the trust since our last inspection used different electronic patient record systems. The trust was looking to implement a consistent records system in the autumn of 2022. Some staff reported delays in accessing training to gain access to the electronic records system and some bank and agency staff did not have access to the system.

In the core services we inspected staff reported and we saw that computers could be slow when being used by staff, some staff reported that there were issues with the telephone system and with the availability of computers in ward areas.

The trust was proactive in working with commissioners and regulators and had mature and open discussions where issues arose. The trust submitted required notifications and shared information of concern with CQC and commissioners.

The trust had appropriate information governance systems in place including protecting the confidentiality of patient records. Staff received information governance training as part of the mandatory training programme.

The trust had completed the Information Governance Toolkit assessment which was assessed by an independent team in June 2022. The team reported that the trust had demonstrated that a robust framework was in place in relation to data security and protection, with clear commitment and support by senior management and that there was a well-defined organisation structure with associated groups and supporting policies and procedures. The report concluded that the trust had substantial assurance with regards to the management of information governance.

The trust had identified both a Caldicott guardian and a senior information risk owner. The lead for cyber security was the head of ICT supported by the ICT security manager. The trust had reported no network security incidents since the last inspection.

Our findings

Engagement

The trust had a structured and systematic approach to engaging with people who use services,

those close to them and their representatives. Since our last inspection, the trust had developed a

Greater Manchester Mental Health Together Strategy 2022-25 to bring together the previous two separate carer and service user engagement strategies they had implemented between 2018-21. Underpinning the new strategy was a focus on how the trust aimed to work in collaboration with everyone including the wider community.

The new strategy was aligned to the 2019 NHS 10 Year Long Term Plan which had a renewed focus on the NHS working hand in hand with the voluntary sector and local authorities with a commitment to supporting local areas to redesign and reorganise core community mental health teams to move towards a new place-based, multidisciplinary service across health and social care. The strategy was co-produced with extensive engagement with service users, carers, families, staff and external agencies with the pro-active involvement and support of the trust's service user and carer governors.

The four key ambitions of the strategy emphasised the principles of working together to meet people's needs, listen to what people have to say and working together to improve services and support for people's mental health.

The trust planned to monitor progress against local service and corporate action plans through the trust's service user and carer engagement forum which met quarterly. The trust's service user and carer governors were key members of the forum which reported directly to the trust's quality improvement committee.

The trust supported service users and carers to be actively involved in several initiatives including recruitment panels, education and research activity throughout the trust.

The trust supported the continued achievements of their recovery academy which was established in 2013. The academy was run by and for those with lived experience of mental health or substance misuse problems. The academy offered a range of free courses to support recovery and break down mental health related stigma and discrimination. Many courses were accredited by or delivered in partnership with professional organisations. The academy had supported over 7000 registered academy students.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The trust had launched a new feedback process alongside their share your views campaign. The campaign had seen a three-fold increase in service user/carer feedback in the first six months of 2021. Alongside service user/carer satisfaction surveys, people could also access share your views from the text messages they were send and via appointment letters containing a QR code. This had significantly increased feedback the trust received to over a thousand pieces of feedback monthly. Eighty six percent of responses reported a positive experience. However, themes were emerging in relation to support for people's wider health and wellbeing needs, and this was being fed through to the trusts' workforce strategy group and community transformation meetings at both a local and trust wide level.

The trust submitted monthly friends and family test data to NHS England. They scored 84.4% in January 2022 which was below the England average of 86.3%.

In the core services we inspected we saw that patients were able to give feedback about the services through the concern's complaints process but also through patient community meetings on wards.

Communication systems such as the intranet and newsletters were in place to ensure staff,

patients and carers had access to up-to-date information about the work of the trust and the

services they used. The trust used several ways to communicate information to service users and their carers. For example: they had co-produced a range of resources for carers with carers, including an information sharing form for carers to share information with staff about the person they care for, a carers information pack and resources highlighting the support available. All of these resources were on the trust website and available in printed format for carers.

The trust had also arranged a carers learning event focusing on lessons to be learned from serious incidents where carer contact, and engagement had been poor.

Staff at Park House told us they had been involved in service planning and meetings about the new service being built. However, staff at Wigan who had transferred over into the trust from another provider did not feel that good practice they had in place was valued or supported and they did not feel involved in changes that had taken place in the service.

In the focus group we held with staff side representatives, they reported that some staff teams did not feel heard or supported when they raised issues such as staffing and the level of need patients had, particular on the acute wards but also within some of the community mental health teams and that ideas staff had put forward to drive improvement were not acted upon. Some staff in the core services we inspected also told us that managers did not always act on information they received or provide feedback to them.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trusts' strategic plan demonstrated the trust's commitment to working in collaboration with partners to deliver system wide transformation within the Greater Manchester footprint.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. Board members were able to describe how the strategic plan focussed on supporting partnership working with stakeholders to ensure the delivery of sustainable care which was responsive to the local populations needs.

Learning, continuous improvement and innovation

The trust actively sought to participate in national improvement and innovation projects. The trust had a quality improvement committee which was chaired by a non-executive director and supported by the chief nurse. A quality improvement strategy was in place which included eight agreed quality improvement projects at the time of inspection including improving access and quality of supervision, reducing falls, building an improvement culture and reducing restrictive practices.

Staff had training in improvement methodologies and the use of standard tools and methods. The trust had supported 500 staff to be trained in their quality improvement methodology and further training was planned to increase the number of staff who understood the approach and were able to support quality improvement initiatives. In the services we inspected we saw evidence of staff involved in local quality improvement projects alongside participation in wider trust projects.

Our findings

The trust had a planned approach to taking part in national audits and accreditation schemes and shared learning. The trust had invested heavily in research with the establishment of 10 research units to support the delivery of their research and innovation strategy. These included a youth mental health research unit, equality, diversity and inclusion research unit, dementia research unit and psychosis research unit for example. The trust had identified 68 clinical research studies/programmes staff were involved in trust-wide for 2022/23.

In 2021-22 the trust was the highest recruiting trust within Greater Manchester into Clinical Research Network studies with 14,679 participants. We saw evidence that quality improvement initiatives had improved patient outcomes. For example; the reducing falls project had resulted in a reduction in fall by 23% across eight wards.

External organisations had recognised the trust's improvement work. The trust had received positive feedback from the UK research and development external peer-review team in October 2021 particularly in relation to the development of service user/carer researchers within the trust which it recommended as a model that should be adopted more widely. In the trusts' psychosis research unit, 38% of staff were employed on the basis that they had lived experience of psychosis.

The trust had been named as a Veteran Aware Trust from the Veterans Covenant Healthcare Alliance in recognition of its commitment to improving NHS care for veterans, reservists and members of the armed forces and their families.

The trust was also one of four national pilot sites working on the first ever 'Patient and Carers Race Equality Framework (PCREF)' which was a tool to enable organisations to understand what steps they needed to take to achieve practical improvements for individuals from diverse ethnic background.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ↓ Nov 2022	Inspected but remains suspended	Inspected but remains suspended

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based mental health services of adults of working age	Inadequate Jun 2022	Good Jan 2020	Good Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Requires improvement Jan 2020
Long stay or rehabilitation mental health wards for working age adults	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Mental health crisis services and health-based places of safety	Good → ← Nov 2022	Good → ← Nov 2022	Good → ← Nov 2022	Good → ← Nov 2022	Good → ← Nov 2022	Good → ← Nov 2022
Wards for older people with mental health problems	Good Feb 2018	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Child and adolescent mental health wards	Good Apr 2022	Good Apr 2022	Outstanding Apr 2022	Good Apr 2022	Good Apr 2022	Good Apr 2022
Forensic inpatient or secure wards	Inadequate ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Inadequate ↓↓ Nov 2022	Inadequate ↓↓ Nov 2022
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Inadequate ↓↓ Nov 2022	Inadequate ↓↓ Nov 2022
Community-based mental health services for older people	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Substance misuse services	Good Feb 2018	Good Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018
Specialist community mental health services for children and young people	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Mental health crisis services and health-based places of safety

Good

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

Safe and clean environments

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environments of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

Staff on the Swift Assessment for the Immediate Resolution of Emergencies (SAFIRE Unit) and within health-based places of safety completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. The SAFIRE unit provided support to people in mental health crisis. It was a nine-bed unit used as alternative to inpatient admission for further assessment. Staff had access to copies of ligature risk assessments on site. Staff using interview rooms within community settings had access to alarms and staff available to respond.

Clinic rooms had the necessary equipment for patients to have thorough physical examinations.

Clinical premises where patients received care were generally safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice. Mental Health Liaison Teams had access to appropriate assessment rooms within accident and emergency departments.

However, the SAFIRE Unit included dormitory accommodation. There were two four-bed dormitories and one single occupancy room. The unit was a single sex adult unit. Staff followed policies and procedures in the management of the dormitories to mitigate risk. We reviewed adverse incidents submitted by the SAFIRE Unit during the period May 2021 to May 2022. We did not see any incidents directly related to the use of dormitories. The trust was in the process of building a replacement facility which would provide single occupancy bedrooms throughout. The new facility was expected to be completed in 2024

Services we visited were clean and well maintained. Cleaning records were up to date. Staff followed infection control guidelines including those related to the COVID-19 pandemic such as the use of appropriate personal protective equipment in clinical areas. Staff made sure equipment was well maintained, clean and in working order.

Safe staffing

The service ensured that it provided enough staff to keep people safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Most staff received basic training, however training rates for safeguarding level three and basic life support were low.

Nursing staff

The service had a high vacancy rate. Across this service, the vacancy rate was 20%. The service managed this using overtime, bank and agency. Although the services had vacancies, the teams had enough nursing and support staff on duty to keep patients safe and to meet their needs. Staff we spoke with acknowledged that staffing could feel stretched, but they felt they were able to meet the needs of service users.

Services had systems in place to monitor staffing and respond to increases in demands for services. Community-based services in each locality had daily safety huddles to review clinical activity and staffing. Where required staff could be redeployed from a team to support other teams. We observed a safety huddle call for the Wigan and Leigh services. The call was well structured and reviewed the daily position within each team to ensure scheduled activity could be delivered. The SAFIRE Unit was part of the daily safety huddle with the acute mental health wards at Park House where it was located.

Staff caseloads were reviewed regularly. The services in the Wigan and Leigh locality had reviewed caseloads. They had ensured that referrals were appropriate and transferred or discharged patients to the most appropriate services to meet their needs.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Managers utilised regular bank and agency staff to promote consistency. Bank and agency staff that we spoke with told us they felt integrated into teams and demonstrated a sound knowledge of both the team and the patient base.

Sickness and turnover rates varied between services and locations. Across the service sickness and staff turnover was reducing. Managers used bank and agency staff to cover sickness. A programme of recruitment was ongoing.

Medical staff

The service had enough medical staff to keep patients safe and meet their needs. Each team had access to medical staff and could access a psychiatrist quickly when they needed to. Staff we spoke with told us doctors were generally available when required.

Managers could use locum doctors when they needed additional support or to cover staff sickness or absence. Managers made sure all locum doctors had a full induction and understood the service.

Mandatory training

Staff had mostly completed and kept up to date with their mandatory training. Overall staff had undertaken 88% of the various elements of training that the trust had set as mandatory. However, there were two courses where compliance was below 75%. These were basic life support (69%) and safeguarding adults level three training (63%). In addition, immediate life support was not included within mandatory training for staff. Immediate life support was identified as essential for specific staffing roles. Staff on the SAFIRE Unit worked with other wards in their building as a ‘cluster’ to ensure that there was appropriate levels of staff trained in basic and immediate life support who were able to attend the unit in the event of an emergency. Staff were able to access support around safeguarding from a dedicated trust team.

The mandatory training programme was comprehensive and met the needs of patients and staff. The programme included training on infection control, information governance and conflict resolution.

Although managers monitored mandatory training and alerted staff when they needed to update their training, there were two courses with low completion rates.

Mental health crisis services and health-based places of safety

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 72 care records. We found that most patients records contained an up to date risk assessment. However, at Wythenshawe Home-based Treatment team, five out of eight patients' records did not have an up to date risk assessment. In those records, information on risk was recorded in daily progress notes but was not always reflected in formal risk assessments.

Staff used a recognised risk assessment tool. Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. We saw examples of crisis plans within the records that we reviewed.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. Teams discussed patients who were awaiting assessment daily to monitor risk and respond to increased need.

Staff followed clear personal safety protocols, including for lone working.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff were up to date with training on how to recognise and report abuse and they knew how to apply it.

Staff mostly received training on how to recognise and report abuse, appropriate for their role. Staff mostly kept up to date with their safeguarding training. However, only 63% of eligible staff had completed and kept up to date with safeguarding level three training. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Records we reviewed included relevant safeguarding information and evidence of the ongoing management of safeguarding concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, information was stored inconsistently on the system used in the Wigan and Leigh services.

Mental health crisis services and health-based places of safety

Patient notes were generally comprehensive, and all staff could access them easily. However, staff within the crisis service were using two different electronic record systems. Staff based in the Wigan and Leigh locality were using the electronic record system they used whilst they were under a previous NHS Trust. The information stored on that system in relation to risk was not always easy to find as it was stored in different places. There were plans in place to migrate Wigan and Leigh services onto the electronic records system used by the rest of the trust in October 2022.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's mental and physical health.

The service used systems and processes to safely prescribe, administer, record and store medicines. Community-based services did not store medication on site. Staff on the SAFIRE Unit stored and managed medication safely. There were regular audits of medication on the SAFIRE Unit including stock checks and fridge temperatures.

Staff followed systems and processes to prescribe and administer medicines safely. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up to date.

The service had non-medical prescribers in place to support patients. There were good links with the Trust pharmacy team who provided support, advice and assurance through audit.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff had access to an electronic incident reporting system. Staff knew what incidents to report and how to report them. Staff told us they reported all incidents and near misses in line with the trust policy and were encouraged to do so by their managers. Staff reported serious incidents clearly and in line with trust policy.

Adverse incidents were reviewed by team managers and senior management within localities. Staff received feedback from the investigation of incidents where appropriate. There were governance processes to monitor incident reporting, identify trends and share learning. Managers completed 72-hour post incident reviews and investigated incidents where required.

Mental health crisis services and health-based places of safety

Managers shared learning from incidents in team meetings, handovers and supervision. Team managers and senior management from localities attended trust-wide learning events and fed back learning to staff in team meetings and via emails. Staff we spoke with were aware of incidents and associated learning from within their locality but were not always aware of feedback from trust-wide events. We saw evidence that learning had led to changes including the introduction of a new referral form in some community-based services and the redesign of the handover sheet on the SAFIRE Unit following learning from incidents.

Managers debriefed and supported staff after any serious incident. Services had access to the trust's Post Incident Debrief team if required. Psychologists within the community-based teams had also provided debrief and reflective practice sessions following incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. For most services, care plans reflected the assessed needs, were mostly personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient. Teams within the crisis care pathway used an evidence-based biopsychosocial assessment, which included, mental health and medication, psychosocial and psychological needs, strengths and areas for development and suicide risk.

The liaison psychiatry team's assessment of risk included liaising with staff at the acute hospital to decide the appropriate response time to assess a patient. For example, if a patient was intoxicated, it would be important to ensure they were ready and able to engage in the assessment. We reviewed 72 care records and found that all patients had a completed and updated assessment of need.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Staff worked with patients and other medical professionals to ensure that physical health concerns were considered and captured within care planning and that relevant support was provided. Staff were trained to carry out physical health procedures such as electrocardiograms and blood tests. Community services ran physical health clinics for patients.

Staff worked with patients, families and carers to develop individual care plans and updated them when needed**.** Staff at the crisis helpline completed a biopsychosocial assessment with individuals who called the service, completed a helpline outcome form and added progress notes to the electronic record system for staff in other teams to review.

Mental health crisis services and health-based places of safety

We reviewed 72 care records. Care plans reflected the assessed needs and were mostly up-to-date, personalised, holistic and recovery oriented. In the Wigan Crisis Resolution Home Treatment and Wythenshawe Home-based Treatment teams we identified that care plans were not always personalised or holistic. This had been identified by managers through internal assurance processes and work was ongoing to improve the quality of care plan documentation.

Best practice in treatment and care

Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audit.

Staff delivered care in line with best practice and national guidance. Staff provided a range of care and treatment suitable for the patients in the service. Patients had access to a range of brief interventions within community teams and some services offered a 'crisis toolbox' which was a series of nine sessions that could be delivered as required. The interventions were intended to provide support and help develop coping skills. Areas covered included distress tolerance, problem solving and grounding skills.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Community services offered physical health clinics. Care records demonstrated relevant liaison with physical health services. Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice, for example around smoking cessation or healthy eating.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. The service completed mental health clustering data. Specialists within teams used rating scales to monitor patients. For example, psychologists used rating scales such as the patient health questionnaire for depression and the general anxiety disorder tool for anxiety.

Staff used technology to support patients. For example, video appointments were used during the COVID-19 pandemic and remained available for patients if appropriate. Services used video conferencing to review and adjust daily staffing provision and to facilitate attendance at clinical meetings and care reviews.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers completed audits around care records and documentation. Managers were able to run audit reports from clinical systems. Staff could access support from a clinical audit team. Managers used results from audits to make improvements.

Skilled staff to deliver care

The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients. The staff and skill mix varied between the different services. Crisis resolution and home-based treatment teams in all the localities and the urgent and rapid response teams within Wigan had doctors, registered nurses, psychologists, healthcare support workers and peer support workers. The crisis line was staffed by registered nurses and psychologists. The SAFIRE Unit was staffed by registered nurses and healthcare support workers. All the services had access to additional allied health professionals such as occupational therapy if required.

Mental health crisis services and health-based places of safety

Managers ensured staff, including bank and agency, had the right skills, qualifications and experience to meet the needs of the patients in their care. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff had access to a Trust learning hub that provided a range of training. Staff had completed additional training around personality disorders, autism, learning disabilities, domestic violence, substance misuse and psychological therapies such as cognitive behavioural therapy. In addition, some staff had completed training to be non-medical prescribers and approved mental health professionals.

Managers supported staff through regular, constructive appraisals of their work. Managers supported staff through regular constructive supervision. The percentage of staff that received regular supervision was 79%. Staff told us they felt supported and could access support and advice from clinical leaders when they needed to. Staff could also attend a range of group reflective practice sessions to discuss complex cases and best practice.

Managers gave each new member of staff a full induction to the service before they started work. There were induction programmes in place which ensured new staff were orientated to the service and service user population. New staff were able to shadow existing staff as part of their induction.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings were held regularly within each service although the frequency varied and could be impacted by demand. Meetings were minuted and key messages were circulated via email.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers could access support from human resources.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The service had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. This included community and inpatient services.

Community-based crisis services had daily multi-disciplinary meetings to discuss and review patients awaiting assessment or on the teams' caseload. We attended two of those meetings. Staff from all disciplines attended the meetings either in person or by video or phone. Staff worked as multi-disciplinary team for assessment, care planning and discharge. Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Staff liaised with the central bed-hub when admission to a mental health ward was required. The SAFIRE Unit held multi-disciplinary ward rounds four days a week.

There were clear referral pathways and staff from different teams and services worked collectively to manage patients and facilitate the transfer of care where appropriate.

The service had strong and effective working relationships with relevant services outside the organisation. The trust was delivering a transformation programme for its crisis services and pathways. Plans had been developed collaboratively with local NHS bodies, healthcare providers, third sector organisations and other services including local police forces.

There was evidence of pro-active multi-agency working in the delivery of care. For example, the crisis line service had a daily multi-agency call with the local ambulance, police and acute hospital services. The meeting reviewed calls received by ambulance and police services to identify individuals known to services where rapid engagement could

reduce the need for either ambulance or police attendance or for a hospital admission. We observed one of those multi-agency meetings during the inspection. The meeting was well structured and focused on pro-active interventions to support individuals in the community. The trust had also established community-based crisis 'cafes' in conjunction with third sector providers. The home-based treatment team in Wythenshawe held daily calls with the local provider of community physical health services.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Overall, 90% of staff in this service had completed training in the Mental Health Act. Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew how to access this support and who their Mental Health Act administrators were. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff completed regular audits to make sure they applied the Mental Health Act correctly.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on Mental Capacity Act. Staff also demonstrated an understanding of how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary. Staff knew how to apply the Mental Capacity Act to patients aged 16 and 18 and where to get information and support on this.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We saw evidence of best interest meetings within care records we reviewed. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision where appropriate.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Mental health crisis services and health-based places of safety

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. We spoke with 12 patients during the inspection. Patients we spoke with were generally positive about staff. They told us that staff were caring, treated them well and behaved kindly.

Staff and patient interactions we observed during the inspection were respectful and conducted in a caring manner. Staff gave patients help, emotional support and advice when they needed it. Staff supported patients to understand and manage their own care treatment or condition. For example, patients told us they were aware of their diagnosis and their care plan. Staff directed patients to other services and supported them to access those services if they needed help.

Staff respected patients' privacy and dignity. However, patients on the SAFIRE Unit told us that the use of dormitory facilities impacted upon their privacy and dignity. Patients had access to locked storage facilities but felt that the use of dormitories meant they could not control access to their bed space and were not always able to have privacy if other rooms on the unit where in use.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff followed policy to keep patient information confidential.

Involvement in care

Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Patients we spoke with were aware of their care plan and planned interventions. However, it was not always clear from clinical records that they had been offered a copy of their care plan.

Involvement of patients

Staff involved patients and gave them access to their care plans. We reviewed 72 records and found that not all of them recorded whether the patient had been offered or given a copy of their care plan. However, patients we spoke with were aware of their care plan and treatment programme.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Staff had access to interpreters if patients needed them. Staff visited patients at home where required to increase engagement.

Mental health crisis services and health-based places of safety

Patients could give feedback on the service and their treatment and staff supported them to do this. There was a friends and family survey that patients could access. Patients were given information on how to access this and QR codes linking to the survey were included on leaflets and posters within services and on some care plans.

Staff supported patients to make advanced decisions on their care. Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with four carers and they told us that staff had been supportive, they had been informed about the care of their loved one and had been part of decision making where appropriate. Care records we reviewed demonstrated carer involvement where appropriate.

Staff helped families to give feedback on the service. Families and carers could access the trust friends and family survey. Carers were given information on how do so and QR codes linking to the survey were included on leaflets and posters within services and on some care plans.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated people promptly. Staff followed up people who missed appointments.

The service provided a range of ways to access the services. Patients could self-refer or be referred by other medical professionals. There was a 24-hour crisis line and other ways to self-refer through the community-based crisis support cafes and through multi-agency initiatives such as a mental health police street triage car. Crisis teams had skilled staff available to assess patients promptly 24 hours a day seven days a week and teams responded quickly when patients contacted them.

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists.

Mental health crisis services and health-based places of safety

Staff reviewed referrals into the service and triaged these accordingly as either an emergency assessment, an urgent assessment or a routine assessment. Emergency referrals were reviewed and assessed within 4 hours. Urgent referrals were reviewed and assessed within 24 hours. Routine or non-urgent referrals were reviewed and assessed within 72 hours. In addition, there were groups identified as a priority for review and assessment including veterans, pregnant women and men aged between 40 and 60. Staff saw urgent and non-urgent referrals within the trust target time.

For patients in health-based place of safety during regular office hours we found that mental health assessments were generally carried out within the trust target. However, assessments outside of office hours could take longer to complete. This was due to a range of factors including patient intoxification or the availability of an approved mental health professional or doctors.

Patients attending emergency departments were reviewed and assessed by mental health liaison Teams. The trust had targets to see people within one to two hours and a target to discharge from the emergency department within four hours. Performance against the targets varied between teams but in general were improving. The ability to meet the target for assessment and discharge from the emergency department within four hours was impacted negatively by the availability of specialist mental health beds.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. The team tried to contact people who did not attend appointments and offer support. Patients had some flexibility and choice in the appointment times and locations available. Where patients needed an alternative, the teams were responsive and were able to offer this.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Teams held daily calls to review where they were and what appointments, actions were outstanding. Staff supported patients when they were referred, transferred between services, or needed physical health care.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms mostly supported patients' treatment, privacy and dignity. However, the SAFIRE unit had dormitory accommodation which impacted on patients' privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Patients on the SAFIRE unit had access to outdoor space, communal lounge facilities, quiet rooms and a dining room. However, the unit had dormitory sleeping accommodation. We spoke with four patients on the unit. Patients did not like the dormitory accommodation and stated they would prefer individual bedrooms. They stated that they felt the dormitory provision impacted upon their privacy and dignity. The trust was aware of these concerns. A replacement facility was under construction at the time of our inspection. The new facility was due to be completed in 2024.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Community teams were able to meet patients at locations that best met their needs, including a home address. The SAFIRE unit had accessible facilities suitable for disabled people including an assisted bathroom.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The service provided information in a variety of accessible formats so the patients could understand more easily. This included documents and leaflets in easy read, braille and large print formats. The service had access to translation services and provided information leaflets in languages spoken by the service user and local community. Managers made sure staff and patients could access interpreters and signers for face to face, phone or video engagements.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

Between May 2021 and May 2022, these services received 46 complaints. Two of those complaints were withdrawn. Five complaints were upheld, 19 complaints were partially upheld, 14 complaints were not upheld, and six complaints were either waiting for or currently under investigation. In the same period, these services received 44 compliments.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Patients we spoke with had not had reason to raise a formal complaint but told us they would be confident to do so if they felt it necessary.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed. Service and team managers were visible in the service and approachable for patients and staff.

Mental health crisis services and health-based places of safety

Managers we spoke to demonstrated a good understanding of the challenges their services faced and were able to describe plans to address them. Staff we spoke with told is that local service and team managers were a visible presence within services. However, staff told us that senior managers at trust level were not as visible. Staff suggested that this was related to the size of the trust and the impact of the recent pandemic.

Staff had opportunities for leadership development and access to relevant managerial training.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Staff were aware of the trust's values and displayed these in their work. These values were also displayed on posters and leaflets within services. Managers were able to explain the trust's vision and key strategic objectives as well as how these related to their team, service delivery and improvement.

Staff had the opportunity to contribute to discussions about strategy and development within the service through supervision, team meetings, staff surveys and ad-hoc events such as staff away days.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff we spoke with generally felt respected, supported and valued. Staff were positive about their colleagues and felt they worked collaboratively to manage demand and workload. Staff morale was generally positive. Staff told us that they were well supported by local team managers and by senior management within localities. Staff told us that managers were approachable and visible within the service. However, staff felt there was a disconnect with senior management within the trust.

Staff we spoke with told us they felt able to raise concerns without fear. Staff knew how to escalate concerns and how to use the whistle blowing process. They understood the role of the Freedom to Speak Up Guardian and described they worked in an open and honest culture.

Staff were able to discuss career development within supervision and appraisal sessions and had access to additional training. Managers followed appropriate policies and procedures when managing poor performance There was additional support available from a trust human resources department. There were staff awards and recognition programmes at trust level.

Governance

Our findings from the other key questions demonstrated that governance processes generally operated effectively. There were processes to identify, understand, monitor and address current and future risks.

Leadership at service, locality and trust level demonstrated a good understanding of the issues and challenges faced by the service. Teams had action plans in place to address concerns that had been identified through assurance processes such as audit.

There was a governance structure in place to support service delivery. Staff had access to a suite of policies, procedures and operational guidance to support them in the delivery of care. There was a framework of governance meetings at

team, locality and service level that fed into trust-wide governance meetings. These facilitated the day to day running of services as well as ongoing monitoring of performance and risk. The implementation of recommendations and action plans from the review of deaths, incidents, complaints and safeguarding notifications were monitored within the governance framework.

Staff understood the arrangements for working with teams within and external to the provider to meet the needs of patients.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Managers and staff had access to performance reports which supported them in their awareness of risks and in understanding areas requiring improvement. There was a clear structure and framework of meetings where performance was discussed.

The service operated a risk register that local managers could access. There were mechanisms in place for risks to be discussed at different levels of the trust. Risk registers reflected the risks identified by staff we spoke with and risks that we identified during our inspection.

The service had business continuity plans in place to support managers and staff to plan for emergencies.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service used systems to collect data from services which were not over-burdensome for frontline staff. Team mangers had access to information to support them in their role.

Patient information was stored on two secure electronic record systems. Services within the Wigan and Leigh locality continued to use the electronic record system utilised by their previous trust. There was a plan in place to transfer those services onto the electronic records system used by the rest of the trust in October 2022.

Staff had access to the equipment and information technology needed to do their work. Staff working in the community had access to a laptop or a mobile device where it was needed. Staff were required to undertake information governance training as part of their mandatory training.

The service submitted notifications to external bodies, including the CQC, when needed.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Mental health crisis services and health-based places of safety

There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting.

Staff, patients and carers had access to up to date information about the work of the provider and the services they used. Information was available through the trust website, social media channels and on display within services. Patients and carers had the opportunity to give feedback on the service they received in a manner that reflected their individual needs.

Learning, continuous improvement and innovation

The service was committed to learning, continuous improvement and innovation.

There was evidence of learning identified through governance processes such as audit and incident reviews. Staff we spoke with told us that managers were open to ideas for improvement. The service had a clear plan in place to improve crisis pathways through its transformation programme.

The service was involved in research projects. For example, an academic paper had been published in relation to the effectiveness of the crisis toolbox used within community-based services to support patients.

Forensic inpatient or secure wards

Inadequate ↓↓

Is the service safe?

Inadequate ↓

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Wards were not safe, well maintained, well-furnished or fit for purpose. However, all wards were clean and well equipped.

Safety of the ward layout

Staff completed risk assessments of all ward areas, but these were not always updated. Actions to remove or reduce any risks were not clearly identified and not all ligatures were recorded. Ligature audits were completed annually by a central team and although these were available on the intranet, some staff could not locate them. Ligature audits differed in quality and completeness. Actions to mitigate risk were not detailed and the ligature audit data sheets were cumbersome. Environmental ligature audits were lengthy spreadsheets that listed ligatures across the ward, but this proved difficult to read. Some wards also had a ligature summary and action plan sheet. Controls to manage risk were not always effective or descriptive. For example, on Borrowdale, under 'outside space', the ligature point description was 'numerous ligature points'. Individual points were not specified on the list. The mitigation under 'observation and staffing levels to minimise the risk' relied on good staffing levels and skill mix which was not always possible. Borrowdale's ligature assessment did not specify which kitchen had ligatures; the activities daily living kitchen, or main kitchen. Borrowdale and Rydal wards had part of the ligature audits printed but Borrowdale staff could not locate the full risk assessment online. On Rydal, under the 'existing risk controls and their effectiveness' heading, the action specified, 'operationally managed'. Where risk assessments identified maintenance jobs to improve safety, these had not been updated on the ligature audit so there was no documented assurance that all risks had been removed. On Kingsley ward, the ligature audit stated that items required removal but there was no date for when this was to be completed. We queried how ward staff were updated when maintenance actions were completed within the trust. The trust advised that ligature audits were undertaken with the trust ligature lead, capital estates, facilities manager and ward manager present. Audits were completed and written up by the ligature lead and shared with the clinical services for them to review and manage through the senior leadership team. They also said that when any works identified were completed and the ligature reduced this gets updated by the local team. We did not see any updated ligature audits during the inspection.

Managers had added 'invest in our environments' to the service's risk register in February 2016. The service had identified that bedroom windows on Derwent, Buttermere, Hayeswater, Borrowdale, Silverdale, Ullswater and Keswick wards scored in the enhanced risk range and needed replacing. In July 2017 the windows on Derwent, Buttermere and Hayeswater were completed. In July 2019 Hayeswater, Buttermere and Derwent were completed and Borrowdale was completed as part of the planned ward refurbishment. In December 2021 Silverdale, Keswick and Ullswater were completed. There remained two outstanding bedrooms on Borrowdale since the initial risks were identified.

Forensic inpatient or secure wards

Staff could not observe patients in all parts of the wards. However, staff knew where the ligature risks were, and described increasing patient observations or relocating patients to keep them safe. Where there was poor lines of sight and a risk to patients' staff would increase observations and implement corridor observations. Keswick ward had an upper floor bedroom corridor, but patients were risk assessed for suitability and were moved if risks increased.

There was no mixed sex accommodation. There were dedicated female and male wards.

All staff and visitors carried alarms.

Staff received a security bulletin by email to keep them updated on new or important procedural, physical and relational security issues. For example, bulletins reminded staff of key inductions, secure emailing, ligature alerts, searching incoming items, reducing restrictive practices and training opportunities.

Maintenance, cleanliness and infection control

Ward areas were not all well maintained, or well-furnished and fit for purpose. All wards had maintenance issues that impacted on the delivery of care. For example, rooms that could not be used, including activity rooms and bathrooms or kitchens with broken equipment. Maintenance requests had been logged for all the issues identified. Staff told us that there was a delay in getting maintenance requests completed. They explained that this was due to the number of requests raised and because ward staff worked shifts and could not always respond immediately to queries raised.

However, the trust had a refurbishment plan in progress to improve the older ward environments and all ward areas were clean. There was a housekeeping team for each ward. Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing.

Seclusion room

The seclusion rooms allowed clear observation and two-way communication. Each had a toilet and a clock.

Rydal ward had a chalkboard on the wall that detailed the patients likes and dislikes, and patient specific prompts to engage with the patient in seclusion. Staff said this was useful, particularly when the patient was from another ward and they did not know them as well.

Clinic room and equipment

Clinic rooms were not all fully equipped, and staff did not check, maintain, and clean equipment consistently. However, clinic rooms had accessible resuscitation equipment and emergency drugs that were checked regularly.

Equipment was not always checked, and staff did not always act when issues were identified. The medicines fridge on Buttermere ward had ice that was restricting the air flow and fridge temperatures were not consistently recorded on Ullswater ward; we recorded five dates that were missed in April. Medicines management safe storage audits were completed annually by the pharmacy team; the last one was October 2021. We saw no ward-based audits that reviewed medicines storage.

Forensic inpatient or secure wards

Clinic room temperatures were not always recorded consistently, and action was not taken when the temperature exceeded 25 degrees. Derwent did not record daily temperatures as there was no thermometer; Derwent ward's clinic room was small and poorly ventilated. There was no air conditioning to control the temperature. Keswick identified a faulty thermometer over a ten-day period however staff did not raise this as an incident in line with trust policy. Rydal ward recorded 10 dates above 25 degrees in May and seven dates up to the 14 June when we inspected.

On Derwent ward there were no clinic room cleaning records and Keswick ward had 14 dates missed across January, February, May and June.

Keswick, Silverdale and Derwent wards, had no precautions in place to prevent the medicines fridge being switched off accidentally. This could mean that medicines may be spoiled or unavailable when needed.

Six of nine of the wards visited had expired items in the clinic room including syringes, saline solution, dioctyl, liquiband and water used for injections. Pharmacy confirmed that expiry dates of medicines stocks should be monitored. Two of the wards had expired dioctyl and one ward had expired water for injections.

On Keswick the blue bins to dispose of medicines had no opening date and staff on Rydal did not record waste medicines. The blood glucose monitor on Ullswater had not been calibrated in May and had only been checked once in June.

Keswick and Silverdale wards did not have spare oxygen on the wards in addition to the oxygen stored in the emergency bag. However, staff said they could use other wards if needed.

Safe staffing

The service did not have enough nursing staff, who knew the patients and received basic training, to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nurses and healthcare assistant to keep patients safe.

The trust had not accurately calculated and reviewed the number and grade of nurses, nursing associates and healthcare assistants for each shift.

In August 2019 the provider used the Mental Health Optimal Staffing Tool to review the staffing establishment across the female forensic services. The trust said that there was a plan to undertake a further review of the establishment in the next calendar year.

The 2019 review identified the establishment on Hayeswater enhanced medium secure ward as 11 registered nurses and 19.8 healthcare assistants. The review determined that the levels were enough to accommodate the level of dependency on the ward. However, the establishment sent by the trust for this inspection for the same ward was seven registered nurses, 13.75 healthcare assistants and five nursing associates. Nursing associates hold foundation degrees, enabling them to perform more complex and significant tasks than a healthcare assistant but are not registered nurses.

On Buttermere, the 2019 tool stated an establishment at nine registered nurses and 18 healthcare assistants. The current establishment was eight registered nurses, 18.5 healthcare assistants and one nursing associate. The 2019 tool evaluated that there were nine occasions where more staffing was required due to observation levels.

Forensic inpatient or secure wards

Derwent ward had an establishment of seven registered nurses and 11.5 healthcare assistants in 2019. The tool showed that 2019 staffing numbers were above the required levels. Derwent's 2022 staffing establishment was seven registered nurses, eight healthcare assistants and one nursing associate.

Hayeswater and Derwent ward types had not changed since 2019, however Borrowdale and Buttermere wards were now blended services. This meant there was a mixed acuity within the patient group. In 2019 when the staffing establishment was reviewed, Buttermere was a 12-bed high secure unit and Borrowdale (then Kingsley ward) was a 12-bed low secure ward.

The 2019 audit suggested that the overall staffing establishment for female wards met the needs of the service. The number of registered nurses across the female wards in 2019 was 36.5 whole time equivalents but had reduced to 30 during this inspection. The number of healthcare assistants in 2019 was 66.8 whole time equivalents and had reduced to 54 during this inspection. The role of nursing associate was not recorded in 2019; However, there were eight nursing associates working in the forensic services during this inspection.

The trust completed Mental Health Optimal Staffing Tool review of the male forensic wards in quarter three of 2019/20. The review concluded that staffing levels met patients' needs.

On Rydal, the 2019 tool set an establishment at 10 registered nurses and 14 healthcare assistants. The current establishment was nine registered nurses and 18.5 healthcare assistants.

On Coniston, the 2019 tool recorded an establishment of nine registered nurses and 14 healthcare assistants. The current establishment for the Coniston patients on Ullswater ward was seven registered nurses and 13 healthcare assistants.

On Silverdale, the 2019 tool recorded an establishment of nine registered nurses and 14.8 healthcare assistants. The current establishment was seven registered nurses and 13 healthcare assistants.

On Keswick, the 2019 tool recorded an establishment of five registered nurses and 13 healthcare assistants. The current establishment was five registered nurses and 11 healthcare assistants.

Ullswater ward had 8.4 registered nurses and 7 healthcare assistants in 2019. During this inspection the Kingsley ward, with Ullswater patients, had 8.4 qualified staff and 13 healthcare assistants.

The number of registered nurses across the male wards in 2019 was 41.4 whole time equivalents but had reduced to 36.4 during this inspection. The number of healthcare assistants in 2019 was 62.8 whole time equivalents and had increased to 68.5 during this inspection.

The review stated that staff planning templates were to be reviewed every three months and Mental Health Optimal Staffing Tool audits were to be undertaken every six months as trust standard. We requested copies of the last three reviews referred to in the audits and instead received the Trust Safe Staffing reports which reported staffing data at the Operational network levels. I.e. for Specialist Services, RIBS (Rehabilitation, Improving Access to Psychological Therapies, Bolton and Salford), Manchester and Trafford. The Safe Staffing reports for quarters three and four stated that all networks returned a safe staffing position. We were not provided with a quarterly review of staffing for the adult forensic services.

In addition to the lowered establishment figures, the service held several vacant posts.

Forensic inpatient or secure wards

Buttermere ward had three band five registered nurse posts vacant, one band seven post vacant and five and a half healthcare assistant posts vacant. The Buttermere establishment was set at five band five registered nurses and 18.5 band two or three healthcare assistants. This meant that the ward had 56% of its nursing establishment and 81% of its healthcare assistant's establishment filled. Managers had recruited an additional two band three healthcare assistants, but the service was still under its preferred numbers.

Derwent ward had just under four band five registered nursing posts that were vacant as well as half a band seven post, one band two healthcare assistant post and a band four nursing associate post vacant. The Derwent establishment was seven and a half registered nurses (including the ward manager), eight healthcare assistants and one nursing associate. The ward had filled 42% of its nursing establishment but was over staffed on their healthcare assistant establishment at 113%. Ullswater ward had just over two registered nurse and healthcare assistant vacancies. This meant that they had recruited to 74% and 71% of their establishment respectively.

Across the other wards there averaged one registered nurse vacancy per ward. For example, Kingsley ward had 1.9 registered nurse vacancies, but Silverdale had zero.

Rydal ward had 73% of its healthcare assistant establishment filled, Keswick, 65% and Hayeswater and Silverdale both had 77 % of their healthcare assistant establishment filled.

Staff regularly worked under the minimum staffing establishment levels. Establishment figures provided by the trust for the forensics wards specified either one or no registered nurses as the minimum establishment, but the safe staffing report said it was standard to have two. Derwent and Keswick wards had no qualified nurses on their night shift establishment. The trust said that qualified support was available from the duty manager and night band six staff if needed. They said the Keswick registered nurse was combined with Ullswater ward. Ullswater ward temporarily housed Coniston medium secure treatment patients so Ullswater was no longer a pre discharge ward.

Shift patterns were: early 7:00 to 15:00, late 15:00 to 19:00 and night 19:00 to 07:00. Rydal ward also had a 9:00 to 17:00 mid shift showing on the rotas. This was not included in the Rydal minimum establishment figures provided by the trust or in the figures below. Minimum establishment figures do not reflect where additional staff may be needed, for example for enhanced observations, high risk escorts, emergency leave etc.

- Ullswater Ward (Coniston patients):15 of 84 shifts worked under minimum establishment (18%)
- Silverdale Ward: 79 of 84 shifts worked under minimum establishment (94%)
- Kingsley Ward (Ullswater patients): 13 of 84 shifts worked under minimum establishment (15%)
- Keswick Ward: 21 of 84 shifts under minimum establishment (25%)
- Rydal Ward: 15 of 84 shifts worked under minimum establishment (18%)
- Derwent Ward: 8 of 84 shifts worked under minimum establishment (10%)
- Buttermere Ward: 2 of 84 shifts worked under minimum establishment (2%)
- Hayeswater Ward: Seven of 84 shifts worked under minimum establishment (8%)
- Borrowdale Ward: 45 of 84 shifts worked under minimum establishment (54%)

We reviewed four weeks of rotas from Monday 23 May to 19 June 2022. Out of 336 shifts on the female wards there were 72 shifts, or 21% of shifts where there was no registered nurse on duty over the 28-day period. These figures include Derwent and Keswick wards where the establishment is set as no registered nurse on night shifts.

During the same period, male wards had 34 of 420, or 8% of shifts, with no registered nurse present.

The quarter four 2021/22 safe staffing report specified that the fill rate minimum level for nursing staff was 90%. The median of the fill rates during the day for nursing levels was 84.1%. Safe staffing levels exceeded the 90% desired rate on four months between April 2021 and March 2022; the other eight were below 90% and six of these were below the median for the year. However, staffing at night for the same period had a median of 103% which exceeded the desired rate and the service had an average combined nurse and care fill rate of 110.6%.

The reporting and monitoring safe staffing exception and breaches guidance specifies that when the numbers on the shift were as planned but the skill mix on the shift is different that, this is to be reviewed by managers and monitored by the senior leadership team. We requested this data from the trust. The data showed that wards regularly worked below the planned levels for registered nurses on both day and night shifts and that managers increased the numbers of healthcare assistants.

Patients and staff told us that escorted leave or activities were cancelled, when the service was short staffed. All staff described how staff were moved across wards to meet minimum staffing levels. Staff said that this was disruptive and impacted on patient care; They said that it made continuity of care difficult. Patients, carers and advocates also commented that the service did not have enough staff. Staff said that they regularly worked below their minimum staffing numbers and that nurses from other wards regularly held onto their ward's medicines keys.

Staff explained that they prioritised leave as missed leave could impact on ward acuity. The trust explained that they did not routinely monitor leave during the pandemic and that this had only recently been reintroduced. They acknowledged that there were times when leave may have to be cancelled or postponed; sometimes due to a change in the individuals mental health or risk, but at other times due to staffing pressures such as clinical acuity on another ward or an unplanned high risk escort elsewhere in the service. The trust also acknowledged that some challenges relating to leave were communicated via the Patient Empowerment Group. In response, each ward had implemented a leave planner to ensure that staff could support patients to access escorted leave in a co-ordinated way.

Borrowdale team meeting minutes from March showed that staff had raised concerns that patients were not getting the levels of support that they needed. However, the minutes also indicated that that observations and escorts were the priority. On Buttermere, meeting minutes from June asked all staff, including the nurse in charge to contribute to enhanced observations and Hayswater's meeting minutes also asked nurses to support with observations. Derwent meeting minutes showed staff concerns about covering seclusion as this meant that they were unable to complete ward activities or do a ward shop. Team meeting minutes also indicated that staff worked for the trust and that any staff refusing to cover other wards without a valid reason would have a first warning in their file note for 12 months followed by a statement and further investigation if they continued to refuse.

Recovery workers and occupational therapy assistants delivered planned activities on the wards. Keswick, Rydal, Ullswater, Kingsley and Silverdale wards all had one whole time equivalent recovery worker or occupational therapy assistant to deliver planned activities. Hayeswater, Derwent, Buttermere and Borrowdale wards had 0.6 of a whole-time equivalent recovery worker allocated. Patients across the wards told us that there were not enough ward-based activities, other than television. Managers confirmed that themes from the female community meetings identified the need for more structure around activities.

Forensic inpatient or secure wards

The service used bank staff including registered nurses and healthcare assistants from NHS Professionals who ran the trusts staff bank to cover gaps in shifts. The bank staff included many of its permanent staff who were registered with the service and worked additional shifts. Wards offered their own staff additional shifts before requesting through NHS professionals.

In the previous four weeks 772 forensic shifts had been covered by bank staff on the nine wards we visited.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff described working across wards and picking up shifts across the service. The number of unfilled shifts were decreasing across all wards, but Hayeswater and Buttermere wards continued to have the highest numbers.

The trust provided the average number of unfilled shifts between June 2021 to June 2022.

- Borrowdale Ward: 46
- Buttermere Ward: 135
- Ullswater (Coniston) Ward: 40
- Derwent Ward: 10
- Hayeswater Ward: 62
- Keswick Ward: 23
- Rydal Ward: 37
- Silverdale Ward: 37
- Kingsley (Ullswater) Ward: 20

Managers said that all bank and agency staff had a full induction and understood the service before starting their shift. Staff we spoke with confirmed they received an induction.

Although the service had improving staff turnover rates since April 2022, the average staff turnover from June 2021 to May 2022 indicated high levels of staff turnover throughout the year, this ranged from 7% on Keswick Ward to 27% on Ullswater Ward.

Levels of staff sickness were reducing. There had been an improvement in staff sickness in May 2022 on six of the nine wards. However, Borrowdale, Rydal and Kingsley wards had staff sickness rates of 15%, 13% and 13% respectively in May.

Average staff sickness figures from June 2021 to May 2022 ranged from 8% to 14%.

Managers supported staff who needed time off for ill health. Staff described being supported by managers and colleagues. Staff with physical health issues were moved to wards with lower acuity and lower physical intervention rates to minimise risk.

Ward managers could adjust staffing levels according to the needs of the patients. Managers met twice a week to plan staffing needs for enhanced observations, escorts and planned activities or appointments. Each shift also had a band six or seven duty manager who would respond to staffing requests and reallocate staff across the wards.

Patients had regular one to one sessions with their named nurse. Patients also had named associate nurses and healthcare assistants who they could approach for additional support.

Staff said the service had enough staff on each shift to carry out any physical interventions safely. Staff told us that when they pulled their alarms, staff responded. However, staff also said that some bank staff were not trained in restraint which could impact on how physical interventions were managed. The trust's Use of Force guidance specified that all staff participating in physical interventions must have completed the five-day training course. This meant that staff who had not received the training were not allowed to participate in physical interventions on the wards.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Patients and staff spoke positively about medical cover. Both groups described medical staff as available and supportive when needed. Nursing staff explained that they could easily request additional input and one patient described their doctor visiting them on the ward following a family bereavement. Patients liked their doctors and felt well informed and involved in their care.

Managers could call locums when they needed additional medical cover and made sure all locum staff had a full induction to understand the service before starting their shift.

Mandatory training

Staff had not completed and kept up to date with their mandatory training. 14 courses across the wards were below 75%. This included Basic Life Support; Fire Safety; Health and Safety; Infection Prevention for Clinical Staff; Mental Capacity Act (Including Introduction to Care Act); Mental Health Act Code of Practice; Moving and Handling (Inanimate Objects); Prevention Management of Violence and Aggression (including Breakaway); Prevent (Workshop to Raise Awareness of Prevent); Safeguarding Adults Level 2 and Safeguarding Children Level 2.

None of the wards had achieved the target in Safeguarding Children Level 3 or Moving and Handling (Inpatient) and only Keswick ward had achieved the target completion for Safeguarding Adults Level 3 training.

The mandatory training programme did not meet the needs of all patients and staff. Training data provided by the trust showed that training in the Mental Health Act Code of Practice and Mental Capacity Act was not viewed as mandatory training for support and recovery workers. Immediate life support training and autism awareness were not mandatory courses.

All ward managers acknowledged that immediate life support training was below the expected standard. Training could not be provided during the pandemic because the course required face to face learning. Managers said there was always an identified immediate life responder on each shift.

We asked the trust for immediate life support training statistics as these were not included in the mandatory training information received. The trust confirmed that immediate life support training was not mandatory but was 'essential to role'. They said local systems ensured that every shift had an identified trained staff member available to respond across the cluster for that shift. If no one was available this was to be escalated via on call, reported as an incident and cover would be deployed. The service had identified the number of staff who needed to be trained in each support cluster. They had not met their own required numbers of 100% on the forensics wards.

- Prestwich Topsite included Kingsley ward. 12 of 16 (75%) of staff were compliant; one member of staff had been booked on training between now and the end March 2023 and three members of staff needed a date booking.
- Edenfield (Borrowdale, Buttermere, Derwent, Hayeswater). 10 of 22 (45%) of staff were compliant; nine members of staff had been booked onto training by the end of March 2023 and three were awaiting a training date.
- Edenfield (Coniston, Ferndale, Keswick, Silverdale, Ullswater). 20 of 28 (71%) of staff were compliant; Four members of staff were booked on training between now and the end of March 2023 and four members of staff were awaiting a date.
- Edenfield (Dovedale, Eskdale, Rydal). 14 of 24 (58%) of staff were compliant. Seven members of staff were booked on training between now and the end of March 2023 and three staff were awaiting a date.

The service's risk register twice recorded that immediate life support training was not compliant. The first, specified that staff were not compliant with mandatory training including immediate and basic life support. The original training entry was added in 2015. The identified consequence of the poor training levels was determined to be 'minor – first aid treatment and medium financial loss'; it was assigned a moderate risk level of six. With the cluster response in place, the trust reduced the risk level to four. The second, added on March 2022, acknowledged that there were 62 nurses not trained in immediate life support and that it was impacting on the cluster model. They added that there were basic life support trained nurses available and senior staff who worked 9 to 5 who could offer immediate life support. This also was assessed as moderate risk level six with minor consequences. There were no controls identified on the second entry.

Managers monitored mandatory training and alerted staff when they needed to update their training. Team meeting minutes showed that training was discussed, and protected time offered. Some managers explained that the trust's online training statistics were not always accurate because staff that had left were included in the returned data. On Ullswater the ward manager kept their own spreadsheet so that they were confident in staff training levels.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. We were told they achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff said they had the skills to anticipate, de-escalate and manage challenging behaviour. As a result, staff said they only used restraint and seclusion after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

We reviewed 15 care records and risk assessments. Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after incidents. Risk profiles included a comprehensive description of historic risks as well as a review of violence to others, self-harm, absconsion etc. Staff on Rydal described using the Dynamic Appraisal of Situational Aggression tool to assess patient risks as part of a new quality improvement initiative.

However, on Ullswater ward we identified one patient whose historic risks included a risk of ligature, but this had not been reviewed in their current risk assessment. Another Ullswater patient had been involved in an incident of violence but we did not see their risk assessment updated. All other risks had been identified and discussed.

Management of patient risk

Forensic inpatient or secure wards

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff we spoke to knew patients well and we saw positive interactions between these staff and patients. Care plans detailed actions to offer support and suggested phrases to use with patients.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff we spoke with described using the intensive care suites as quiet areas to give patients space and using soft words to minimise potential incidents.

Staff followed procedures to minimise risks where they could not easily observe patients. We observed corridor observations in use and enhanced observation levels in use. These were also recorded in patient records we looked at and staff we spoke with knew which patients needed additional support and why.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Random searches and room searches were completed where there was an identified risk, for example, when returning from leave. On Ullswater ward, staff described an incident where patients were behaving erratically through suspected drug misuse. Staff facilitated the completion of urine tests, used drug identification wipes to detect residue and searched suspected patients, their belongings and rooms. Following the incident staff identified how the drugs had been smuggled onto the ward and they improved security arrangements surrounding dropping off items and visiting procedures. This information was also shared with the trust security team and circulated in the all wards security bulletin. Staff explained that pat down searches were completed by the same gender as the patient.

Use of restrictive interventions

The trust told us that the forensic service did not have a blanket restriction register however we saw that staff used least restrictive practice on most wards. Ullswater ward was trialling unrestricted mobile phone access and the ward kitchen was left unlocked. The security role counted cutlery and items to make sure that nothing had been removed. Patients had responded well and enjoyed the additional access. However, on Hayeswater, patients were restricted in accessing the day room. Patients had to go to their rooms between 10:00 to 14:00 and 16:00 to 18:00. Staff explained that they had identified peak times for incidents and this restriction was to try to reduce incidents on the ward. The sign in the day room said ‘subject to staffing levels’ however staff could not explain what this meant. Five of six patients were on enhanced observations. The trust had provided a list of restrictions on the forensics wards however accessing the day area was not included. The list also identified that patients in the low secure wards had to be accompanied in the kitchen due to risks, however patients in the medium secure treatment wards had free access to the activities of daily living kitchen. The trust said that all restrictions were monitored locally by Pathway Leadership Teams and have Senior Leadership Team oversight. Restrictions varied in accordance with the clinical model of the ward.

All staff we spoke with were aware of restrictive interventions and could explain reducing restrictive practice. Buttermere had recently completed a reducing restrictive practice quality improvement programme and had reduced restraint by 7.5%.

The service was smoke free and supported patients with nicotine replacement products. Patients and staff told us that patients were limited to nine vapes per week, (equivalent to 30 cigarettes a day). Staff described a change in presentation and an increased risk when patients ran out of vapes. Following the inspection, we queried this with the trust who advised that patients shared their concerns at the Patient Empowerment group in May 2022. They confirmed that the trust had agreed to provide patients with a choice of either one 18 milligram or two 12 milligram vapes per day. The service also provides smoking cessation advice and support for patients who wished to give up smoking entirely.

Forensic inpatient or secure wards

Staff told us they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We reviewed incident data from 30 May to 27 June 2022. Of 139 reported incidents, 12 related to the use of restraint. There were two restraint incidents recorded on Borrowdale and Buttermere wards, five on Hayeswater and one on Kingsley, Rydal and Ullswater. The service followed the SafeWards programme, a research-based initiative, to reduce conflict, aggression and the need for restrictive interventions. Patients we spoke to described how staff took them aside to discuss concerns and we saw good relationships between patients and staff. Most patients we spoke with said that they had not been recently restrained and one family member from Hayeswater said that when their relative had been restrained, it had been managed well.

Staff we spoke with understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. Physical health checks were completed, and rapid tranquilisation use was reviewed by the clinical team.

When a patient was placed in seclusion, staff kept clear records that followed best practice guidelines. Records were seen to be updated in line with guidance and staff we spoke with were clear of their role and expectations.

We reviewed one patient in long term segregation. Staff struggled to confirm if the patient was secluded (temporarily placed in the seclusion room until risks had reduced) or segregated (placed separately from other patients due to risk so self or others). Although long term segregation cases were discussed at multidisciplinary team meetings and documented on the patient record system, the trust did not audit data for long term segregation.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was placed in long-term segregation. This included regular reviews. Staff attempted to reintegrate patients to the main ward which was evidenced in the patient documentation we reviewed.

Safeguarding

Staff training levels on how to recognise and report abuse were poor. However, staff we spoke with understood how to protect patients from abuse and the service worked well with other agencies to do so.

Not all staff received training on how to recognise and report abuse, appropriate for their role. Staff were not all up to date with their safeguarding training. None of the wards had achieved the target in Safeguarding Children Level three and only Keswick ward had achieved the completion target for Safeguarding Adults Level three. Hayeswater ward had not met the target in Safeguarding Adults and Children's level two and Buttermere was also below target in Safeguarding Children level two. Five wards recorded Safeguarding Children Level Three training compliance as 50% or lower and four wards recorded figures between 51% and 72%. Five wards recorded Safeguarding Adults Level Three training compliance as 51% or lower. Four wards recorded training figures between 56% and 80%.

Hayeswater recorded Safeguarding Adults Level Two training compliance as 70% and Buttermere and Hayeswater wards recorded training compliance as 71% and 70% respectively for Safeguarding Children Level Two.

However, all staff we spoke with could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Forensic inpatient or secure wards

Staff told us they knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff raised safeguarding incidents covering a wide range of issues in the documentation we reviewed. Staff we spoke to could describe how to escalate concerns.

Staff followed clear procedures to keep children visiting the ward safe. The service had a family visiting room at the entrance away from the main wards. Visits were risk assessed before being arranged and staff updated the patient records with their named visitors.

Staff we spoke to knew how to make a safeguarding referral and who to inform if they had concerns. They described attending safeguarding panel reviews, contacting the safeguarding leads and discussing safeguarding in supervision.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff sometimes struggled to access clinical information on the IT system, but when they did, it was easy for them to maintain high quality clinical records.

Patient notes were comprehensive, but staff could not always access them easily on the trust IT system. We observed some delays in logging into the system. Staff explained that if they did not log out correctly this could cause a delay. They also said that logging in was more difficult following an operational system update. Some staff described delays in getting IT issues resolved quickly because of differing shift patterns and ward acuity but felt that patient information was accessible. We observed staff logging into the electronic record system to familiarise themselves with patient data when they arrived on the wards.

Records were stored securely and when patients transferred to a new team, there were no delays in staff accessing their records. Staff could access the patient's clinical information from other wards and admissions on the electronic record system.

Each ward also had an emergency 999 paper record for each patient. This contained at a glance information that might need to be shared with emergency services.

Medicines management

Physical health observations to review the effects of medicines were not always completed and documentation was not always available or completed.

However, the service had systems and processes to safely prescribe, administer and store medicines.

Staff did not always review the effects of each patient's medicines on their physical health according to NICE guidance. Staff did not always personalise monitoring to the patient's health needs or complete monitoring consistently. For example, Rydal ward completed weekly checks for patients; including for two patients with tachycardia who would require more frequent monitoring. One patient had only one National Early Warning Score (NEWS) check completed in April. On Ullswater ward, National Early Warning Score results were not monitored when out of range and patients weren't monitored consistently on Keswick and Ullswater wards. Ullswater ward had 10 missing dates across March, April and June with no record to say why these had not been completed.

On Borrowdale ward one patient had a significant weight increase recorded over a three-week period. This was identified as an error when raised with staff, but staff had not queried their weight when reviewing the patient.

Forensic inpatient or secure wards

Staff completed medicines records accurately and kept them up-to-date. Staff stored and managed medicines and prescribing documents safely. However, paperwork for consenting to, or not consenting to medicines, was not always accurate or available in the clinic room. For example, on Silverdale, some consent paperwork was available on the electronic record system but not in the medicines folder. On Derwent ward, one consent form did not cover clozapine, but the electronic form did. Additionally, Rydal and Silverdale wards stored their old copies of consent paperwork with the newer copies which could be confusing for staff not familiar with the wards. On Keswick ward where most patients were self-medicating, there were no formal documented assessments for self-medication. Capacity assessments for treatment were not always completed or recorded consistently. On Silverdale, three of six patients were missing assessments, on Keswick one patient was missing a capacity assessment and although capacity was recorded for Rydal patients, they were not consistently completed.

Staff described how they followed systems and processes to prescribe and administer medicines safely. Staff gave examples of being supported with additional training following medicines errors. Multiple staff described the process for ordering medicines as poor and time consuming. They described occasions where they had to borrow medicines from other wards.

Staff reviewed patients' medicines regularly and provided advice to patients and carers about their medicines. Patients told us that they felt well informed about their medicines and could speak with a doctor or associate practitioner nurse when needed.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. They ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff learned from safety alerts and incidents to improve practice.

Track record on safety

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. Staff recognised incidents but did not always report them appropriately. Managers investigated incidents but did not share lessons learned with the whole team and the wider service.

However, when things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. However, not all incidents were raised on the incident management system. For example, some staff said that the trust did not want poor staffing levels recorded as incidents. The staffing policy specified that staff were to raise incidents when staffing levels when there was no qualified cover or immediate life or basic life support staff available. Data detailing when the shift skill mix was different than planned was also provided to managers via a different system. We reviewed four weeks of incident data and skill mix data for the period of the rotas and saw no staffing incidents recorded for any of the wards we visited. We reviewed team meeting minutes and saw that one ward had asked staff to raise patient incidents on the reporting system as they had not been doing so.

There were 139 incidents reported across the nine wards we visited between May 30 and June 28 2022; 42 of these were categorised by the service as Violence/Aggression/abuse /harassment to staff.

In addition, staff raised 19 safeguarding incidents on the incident reporting system.

Forensic inpatient or secure wards

Staff told us that they reported serious incidents clearly and in line with trust policy.

There had been three patient deaths while on leave in the previous 12 months. These were investigated by the trust in line with the trust policy. We reviewed current risk leave assessments and security processes prior to leave and saw that they were in order. The service had no never events on any wards.

Staff we spoke to were able to explain duty of candour requirements. They told us they were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after serious incidents. Psychologists supported reflective practice sessions for staff and advocacy were encouraged to attend debriefs to support patients. Staff said it was not always possible to attend reflective practice sessions due to staffing levels and they described occasions where there had been no debrief following incidents.

Managers investigated reported incidents thoroughly. Patients and their families were involved in these investigations. Staff completed a three-day review and looked for lessons learned.

Staff within the service did not receive feedback from investigation of incidents, both internal and external to the service. Managers described discussing incidents at team meetings and sending emails to staff not in attendance. We reviewed 26 team meeting minutes; only two wards discussed incidents and there was no evidence of any learning from across the trust being shared.

Managers did not always share learning about serious incidents with their staff and across the trust. Some staff said that information was shared with them at team meetings or via emails, but others said they did not receive information. We reviewed team meeting minutes and saw no learning shared from other parts of the trust.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. Care plans reflected patients' assessed needs, were holistic and recovery oriented. Staff developed care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans included specific safety and security arrangements, but patients did not have positive behavioural support plans in place and goals were not always personalised.

We reviewed 15 care plans and saw that staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. For example, staff completed Venous Thromboembolism (VTE) screening. Patients could access GPs, chiropodists, opticians and dentists onsite.

Forensic inpatient or secure wards

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were holistic, and recovery orientated. The service used a recovery-based approach that involved patients.

Staff regularly reviewed and updated care plans when patients' needs changed.

Some aspects of care plans were not personalised. Most of the care plans we reviewed were written in a clinical manner from the perspective of the clinician. For example, on Ullswater, one patient goal was 'to maintain compliance with medicines' and 'to continue with settled period on ward'. However, there was visible input from patients in most of the records viewed.

Patients did not have positive behavioural support plans however staff knew patients well and could describe patients' cues, triggers and preferences. On Rydal ward staff said that positive behaviour support plans had been completed but they could not find them. Hayeswater patients were meant to have one-page profiles however these could not be located.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance (from relevant bodies e.g. NICE).

Staff identified patients' physical health needs and recorded them in their care plans. Keswick ward had recently ordered fitness equipment and were running a competition for patients and staff to see who could burn the most calories.

Staff made sure patients had access to physical health care, including specialists as required. In addition to the on-site healthcare provision patients also attended local hospitals for specialist or emergency appointments.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The service ran an eight-week programme called Motiv8 to encourage patients to become more active and learn about how their diet could be improved. There were also healthy eating programmes delivered by the recovery academy and patients were encouraged to use the on-site gym and gym equipment in the outdoor recreation areas. The recovery academy had several courses that supported patients with their health including courses on the shared pathway care plans, specific mental health issues and taking back control courses covering communication and providing emotional, wellness and behaviour skills.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. We saw that staff used Health of the Nation Outcome Scales and the Glasgow Antipsychotic Side-effect Scale regularly.

Staff used technology to support patients. Patients could access computers and were encouraged to use the on-site technology suite at the Patterdale Centre. Many patients had access to their own mobile phones and staff facilitated video calls with families when appropriate.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Motiv8 was a clinical trial that was being run in collaboration with the National Institute for Health and Care Research.

Managers used results from audits to make improvements. Managers audited care plans and risk assessments.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards, but staffing levels did not meet the needs of the patient group. Managers had not ensured that staff had the skills needed to provide care. Training levels fell below the expected standard and some specialist training was not provided to staff.

However, managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers told us they provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients on the ward. Staff from different disciplines contributed to the multi-disciplinary care but there was only 0.6 whole time equivalent speech and language therapist in post for the adult forensic service.

Managers had not ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. For example, although some managers had allocated funds from their budgets to train regularly used bank or agency staff in restraint so that they could actively participate in patient care, some did not. When staff were redeployed to other wards due to staff shortages, duty managers would review the most appropriate staff member to move.

Managers told us they gave each new member of staff a full induction to the service before they started work and supported staff through regular, constructive supervision and appraisals of their work. Staff we spoke with confirmed they had received a full induction.

Although most managers held regular team meetings and gave information to those that could not attend, we found team meeting minutes to be minimal. Meeting minutes did not contain full records of discussions and were very basic and task orientated. Meetings did not follow a set agenda and there was limited staff input and discussion recorded.

Managers identified some training needs and gave staff the time and opportunity to develop their specialist skills and knowledge. Staff gave examples of being supported to complete additional training such as psychosocial interventions training and British Sign Language training. Many staff were promoted and progressed through different roles in the service.

However, managers had not ensured that staff received all specialist training to support them in their role. For example, Buttermere ward staff had not received any training in caring for patients with autism.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers described having difficult conversations with staff about performance and behaviour and moving staff to alternative wards when appropriate. One ward manager described the support given to staff following a medicines error.

Forensic inpatient or secure wards

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. In addition to scheduled reviews, nursing staff said that they could request additional meetings when there was a change in presentation or incident.

Staff made sure they shared information about patients and any changes in their care, including during handover meetings. Multidisciplinary team meeting information was clearly documented, and staff knew how to access records on the system. However, recording of handover meetings varied. Keswick and Ullswater wards held verbal handovers because their standardised handover books were full or missing. The other wards recorded basic handover information.

Ward teams had effective working relationships with other teams in the organisation. We observed allied health professionals and staff from the forensic assessment and support team visiting patients on the ward. They received a handover and shared key points from ward staff. Nursing staff described how they worked as a team and supported each other.

Ward teams had effective working relationships with external teams and organisations. Advocacy services spoke highly of the staff and described a collaborative approach to care.

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

Registered staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them. However, training in the Mental Health Act 1983 and the Mental Health Act Code of Practice was not mandatory for all staff.

Not all staff received training on the Mental Health Act and the Mental Health Act Code of Practice however registered nurses could describe the Code of Practice guiding principles. Four of the nine wards we visited were below the trust target for Mental Health Act and the Mental Health Act Code of Practice training. Buttermere 71%; Derwent 67%; Hayeswater 73%; and Silverdale 67%. Training data provided by the trust also showed that training in the Mental Health Act Code of Practice was not viewed as mandatory training for support and recovery workers. This meant that the staff who spent most time caring for patients were not familiar with the legislation that covered the assessment, treatment and rights of people with a mental health disorder. One healthcare assistant said that it took them a long time to understand the different types of sections used on the ward.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Advocacy attended the service regularly and their contact information was visible on all wards in patient areas.

Forensic inpatient or secure wards

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated them as necessary and recorded it clearly in the patient's notes each time.

Staff did not ensure that patients could take all section 17 leave that they were legally entitled to. Section 17 leave is permission to leave the hospital and is agreed to by the Responsible Clinician and/or with the Ministry of Justice. It is a therapeutic activity that supports patient recovery; it is risk assessed and regularly reviewed. Patients explained that they were not always able to take all the leave that they were legally allowed to. For example, on Ullswater, patients described having shortened leave sessions or only being able to go out for two of three sessions of leave due to staffing pressures. However, leave information was available in leave folders and on the record keeping system. Patients were only signed out after speaking with staff who completed safety checks. However, we did see a record keeping error in one record on Ullswater. The multidisciplinary team had agreed for leave to be reinstated, but this had not been updated in the leave care plan.

Staff had not always requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Three patients had overdue section 61 reviews; One patient on Buttermere, one since February on Rydal and another since March on Silverdale. Section 61 of the Mental Health Act requires that, where a patient has received treatment certified by a panel under Section 57 or a Second Opinion Appointed Doctor under Sections 58 or 62A, a report on the treatment and the patient's condition must be given by the approved clinician in charge of the patient's treatment to the Care Quality Commission.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. Information on after care services was also available in patient and carer welcome packs.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff told us they supported patients to make decisions on their care for themselves. Registered nurses understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. However, training in the Mental Capacity Act was not mandatory for all staff.

Not all staff received training in the Mental Capacity Act and three of the wards were significantly below the trust target; Buttermere 57%; Derwent 67%; and Silverdale 44%. Training data provided by the trust showed that training in the Mental Capacity Act was not viewed as mandatory training for support and recovery workers. The primary purpose of the Mental Capacity Act is to promote and safeguard decision-making within a legal framework. This training is normally considered mandatory for workers involved in the care, treatment and support of adults who may lack capacity in making life decisions. However registered nursing staff had a good understanding of at least the five principles.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff held best interest meetings and invited all relevant parties such as families and healthcare professionals to be involved in the discussion.

Forensic inpatient or secure wards

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff mostly treated patients with compassion and kindness. Staff told us they respected patients' privacy and dignity. Staff described how they understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were mostly discreet, respectful, and responsive when caring for patients. We observed staff interacting with patients in a friendly way. We spoke with 20 patients during the inspection. Most patients said that staff were polite and caring. A patient on Keswick described how the consultant psychiatrist had supported them immediately on the ward following a family bereavement. On Ullswater one patient described how staff respected their privacy by taking them to a side room to talk. They described staff as helpful and easy to talk to. Patients we spoke with said they felt safe on the wards and that staff supported them. Two patients from Hayeswater ward said that most staff were respectful and polite but that some could be short or snappy with them.

Staff mostly gave patients help, emotional support and advice when they needed it. Patients we spoke with said that staff were supportive and interested in their wellbeing and recovery. Rydal patients we spoke with said they felt listened to. On Ullswater one patient described staff as a good bunch of people. One patient on Buttermere and another on Kingsley said that night bank staff did not engage with patients; they said staff sat on their phones and sometimes slept. We raised these concerns with managers at the time of inspection and were informed they would take action following us raising the concerns.

Staff said they supported patients to understand and manage their own care treatment or condition. Staff we spoke with were visibly proud of how patients progressed. We observed staff reminding patients of their progress in a kind and reassuring manner. One patient on Rydal felt they were not involved in writing their care plan, but another described how they were listened to and their points were always included. Patients said they were offered their care plans and could access doctors and approach ward staff for support.

Staff directed patients to other services and supported them to access those services if they needed help. Staff encouraged patients to attend the onsite recovery college and attend art classes and activities at the Patterdale Centre.

Most patients said staff treated them well and behaved kindly. Patients we spoke with said they appreciated staff and spoke positively of them. One patient said that staff were friendly and looked after the patients well. Another said that that staff always tried their best to help. On Rydal ward, one patient said some staff could be disrespectful.

Most patients we spoke with felt safe on the wards but felt that more staff were needed. Some patients said when there were staff shortages leave had been cancelled or rearranged.

Staff we spoke with understood and respected the individual needs of each patient. Staff were knowledgeable about patients and built good relationships with them based on mutual respect. One patient on Derwent said this was one of the best hospitals that they had been in.

Staff we spoke with felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. When patients were admitted from prison, staff visited them during their assessment and provided information on the service or met with them via teams. All wards had welcome packs that were given to new patients. When patients were being treated on another ward within the unit staff also facilitated visits to the wards. Additionally, when new patients were admitted to the ward, they were first taken to a quiet room and introduced to staff and provided with additional information. Once staff were assured that patients were ready, they introduced them to the other patients and showed them round the wards.

Staff involved patients and gave them access to their care planning and risk assessments if they wished.

Staff said they made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Staff involved patients in decisions about the service, when appropriate. Patients, staff and advocates described patient involvement in the service. The service focussed on co-production. Patient representatives attended management meetings and took part in interview panels. Patients and senior management attended patient led patient empowerment groups. These meetings helped to gauge patient opinion and promote discussion into policies that may impact on the patient group. Advocacy said that the service took a patient-centred approach.

Patients could give feedback on the service and their treatment and staff supported them to do this. All wards held community meetings where patients could feedback about their care. Staff also helped patients to contact the trust's customer care team and advocates so that they could raise concerns that were not able to be managed locally by ward staff.

Forensic inpatient or secure wards

Staff made sure patients could access advocacy services. We saw advocacy contact details on all wards and advocates made regular visits to the ward. Advocates said that staff were responsive to information requests and we saw that advocacy services were invited to clinical meetings. Advocacy said that the service took a patient-centred approach and that patients were given opportunities to participate in their own care, treatment and recovery.

Staff supported patients to make advanced decisions on their care.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We spoke with six carers or families during the inspection.

Staff supported, informed and involved families or carers. Five of six families and carers described ward staff as helpful and responsive. On Ullswater one family described staff as being very interested in their relative's wellbeing and two families whose relatives were on Hayeswater described regular staff as fantastic. However, two carers from Rydal and Hayeswater felt that there were also some less than empathetic staff.

The trust also provided handbooks and information packs for carers, family and friends that provided information on emotional support, confidentiality, advanced decisions and The Mental Health Act.

Families and carers said they could attend carers events and received information through the post. They felt well informed and involved when their relatives wished them to be. Families and carers described visiting their relatives and being invited to Care Programme Approach meetings. Carers said that staff knew their relatives well and that they responded to any queries raised.

One carer commented that they struggled to get through on the phones which made arranging visits more challenging. Staff also said that there were issues with the service's ward telephones so ward managers carried mobile phones to try and improve telephone contact; However, some wards did not have consistent mobile phone coverage.

Staff helped families to give feedback on the service. Families we spoke with felt able to complain and feedback about the service.

Staff gave carers information on how to find the carer's assessment. Information was shared via the trust's dedicated carers team, carers champions and in the ward welcome packs.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Forensic inpatient or secure wards

Bed management

Bed occupancy went above 85% between April 2021 and March 2022. Bed occupancy averaged 90% across the whole adults' forensics services and 98% on the low secure wards; 93% on the medium secure wards but was under target at 81% in the women's blended service. When patients required increased psychiatric intensive care, beds were available.

Managers regularly reviewed the length of stay for patients to ensure they did not stay longer than they needed to. However, staff described some challenges in moving patients on due to a lack of suitable placements and accommodation in the community. This impacted on the availability of beds for the patients to step down to on the forensics wards. Where patients had been placed on wards which were unable to meet their individual needs, managers were working with NHS England to find alternatives.

Greater Manchester Mental Health Trust is the Lead Provider for the Greater Manchester Adult Secure Provider Collaborative. The Lead Provider, acting in its capacity as a commissioner, has responsibility for placing all in-scope admissions for the Greater Manchester population. NHS England Commissioning Specialised Services guidance uses Natural Clinical Flows to describe what was known as out of area placements. There were three new placements for the Greater Manchester population by the commissioning team outside of Natural Clinical Flows in the last 12 months. One of these was placed by NHS England. The remaining two patients were reviewed by the Lead Provider and deemed clinically appropriate to be placed outside of Natural Clinical Flow.

Managers and staff worked to make sure they did not discharge patients before they were ready or move or discharge patients at night or very early in the morning. Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

When patients went on leave there was always a bed available when they returned.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The service monitored their admissions and discharge data. For example, there were 11 patients waiting for admission to the low and medium secure services in March 2022. There were three delayed discharges in the medium secure wards, four in the low secure services and two in the women's blended service. Between April 2021 and March, across the forensics services, there were more discharges than admissions.

Patients did not have to stay in hospital when they were well enough to leave. However, some staff explained that delays could occur due to the lack of community provision or Ministry of Justice restrictions.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Forensic inpatient or secure wards

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not support patients' treatment, privacy and dignity. The environment was not well maintained, and the environment did not meet patient's needs. However, each patient had their own bedroom and somewhere they could use to keep their personal belongings safe. There were quiet areas for privacy. The food quality was improving, and patients could access hot drinks and snacks at any time.

Keswick ward was dated and tired looking. Bathrooms had cracked walls, one of the washing machines was out of use as was one of the activity rooms following a leak from the ward above; the kitchen had peeling panels and seals and the oven was broken. Areas of the wards smelled of smoke.

Ullswater ward had two toilets out of use due to drainage issues, so the staff had opened the staff toilet until they were fixed. We also saw one bedroom that was so narrow that it only allowed approximately 25-30 centimetres between the bed and built in furniture along the wall.

Kingsley ward was tired, dated and smelled heavily of smoke. The sink was coming away from the wall in one of the bathrooms. There was limited furniture, but this was because patients were moving back to Ullswater ward and the ward was getting ready for the move.

Borrowdale ward had a toilet out of order and a damaged doorframe by the entrance; Another bathroom had not yet been fixed as the staff that came to attend did not have the correct keys. The tap sensors in one room had been turned off as they were faulty and a notice saying materials ordered 31 May 2022. This had not been fixed when we inspected on 16 June 2022. One patient said they had not had water in their room for three weeks but could access alternative bathrooms.

Hayeswater ward's lounge and dining room were cramped and uncomfortable. Patients described the lounge as pokey when staff and patients were in the space. One of the activity rooms was being used to store wheelchairs and walking frames.

On Derwent ward there was a radiator cover damaged, one of the bathrooms was missing a toilet roll dispenser and the sensory room was due to be refurbished. Silverdale had some ripped furniture, but the ward was pleasant and bright.

Borrowdale and Hayeswater wards shared an internal courtyard that needed weeding. Some wards had outside space that patients could access easily but Derwent's garden access was restricted due to a rodent problem. Although pest control had set traps, these were two weeks overdue for collection and patients could not use this area.

Maintenance requests had been logged for all the issues identified. Staff told us that there was a delay in getting maintenance requests completed. They explained that this was due to the number of requests raised and because ward staff worked shifts and could not always respond immediately to queries raised.

The trust explained that on average, the Edenfield Unit received approximately 4,000 reactive maintenance requests each year (equivalent to 77 requests per week or 15 requests a day). Due to the combination of the operational service type, age and condition of the building, the number of maintenance requests received is abnormal in comparison to other Trust premises. The trust explained that the Estates team are currently being reviewed with a view to improving effectiveness going forward.

The trust had a refurbishment plan in progress to improve the older ward environments. For example, patients from Ullswater pre discharge ward had been moved to Kingsley ward. Patients from Coniston medium secure treatment ward

moved to Ullswater ward within the secure gated environment while Coniston was being redecorated and refurbished to include en-suite bathrooms. Coniston patients were moving back to their ward at the end of June. Borrowdale ward had also recently been refurbished and Keswick ward was due to be refurbished in 2022/2023. Ullswater staff explained that they were due for refurbishment after Keswick. They could not provide a date.

Each patient had their own bedroom, which they could personalise. They had a secure place to store personal possessions and access to a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private. Patients could make phone calls in private.

Although some wards had outside space that patients could access easily, patients on upper floors described delays in accessing the recreation areas when a staff escort was required. Staff explained that even patients with unescorted leave needed escorting to reception. They said that this was not always possible when staffing levels were low.

The food quality was improving. Some patients said that portions were small and or that the food was unpleasant. The trust identified meals as an area for improvement and had recruited a new head chef with 'cook from fresh' experience so that meals could be prepared on site from July 2022. Patients from Rydal ward participated in a cook off where they sampled menu items and influenced the final menu as part of a local quality improvement initiative. The kitchen team planned to integrate more special diets, such as Halal and Caribbean options into the main body of the menu, so that patients felt more involved in the overall meal service.

Some patients also cooked their own meals as part of their recovery journey. Patients would discuss their meal choices in community meetings and budget, shop and prepare fresh meals. For example, on Derwent and Keswick patients could cook their own meals if they wished and Silverdale was trialling cooking one meal per day with patients.

Patients could access hot drinks and snacks and were not dependent on staff. However, one patient on Ullswater said that hot drinks and snacks were only available until 10pm.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work. Some patients worked in the onsite car wash, shop or café and others attended college external to the site. Patients could also attend the onsite recovery academy and complete a variety of courses or attend the Patterdale Centre to work on art projects and other activities.

Staff helped patients to stay in contact with families and carers. Families visited their relatives in the service and video called or phoned each other.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Patients volunteered in local charity shops and the service increased leave to support patients to interact in the local community.

Meeting the needs of all people who use the service

The service met the needs of patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. However, staff did not have all the specific training required to meet patient's individual needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Ward boards displayed an array of relevant information including how to complain, managing finances, LGBT+, healthy living, Black Lives Matter, SafeWards and CQC ratings information.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed. We observed some staff speaking to patients in languages other than English.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. Wards had prayer rooms and patients were visited by religious clergy such as imams and priests. Patients with approved leave were supported to attend services off site.

Listening to and learning from concerns and complaints

Managers told us they treated concerns and complaints that were raised with them, seriously. They investigated them and learned lessons from the results, but learning was not shared with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff we spoke with understood the policy on complaints and knew how to handle them. They described how they would respond to local concerns and support patients to contact the trust customer care team.

Between April 2021 and March 2022 there had been 56 complaints raised; 35 in medium secure services; six in low secure services and 14 in the women's blended service. 19 of these complaints were to do with the clinical treatment provided.

Managers investigated complaints and identified themes. Managers investigated and responded to other wards complaints so there was an impartial view.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff we spoke to knew how to acknowledge complaints and patients said they received feedback from managers after the investigation into their complaint.

Managers did not share feedback from complaints with staff, so learning was not used to improve the service. We reviewed 26 meeting minutes and saw no discussion of any complaints for any of the wards, the service or across the trust.

The service used compliments to learn, celebrate success and improve the quality of care. Between April 2021 and March 2022 there had been 11 compliments raised; eight of these were on the medium secure wards. Compliments were visible in some of the team meeting minutes viewed.

Forensic inpatient or secure wards

Is the service well-led?

Inadequate ↓↓

Our rating of well-led went down. We rated it as inadequate.

Leadership

Ward managers had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible and approachable for patients and staff. However, more senior managers were not visible or accessible, and staff did not feel valued and respected by them.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff knew the provider's vision and values and displayed these values in their work. Staff we observed were visibly compassionate and empathetic. We saw staff having focused conversations with patients about their progress and future. Staff worked well together and valued each other's contributions.

Culture

Staff felt respected, valued and supported by their immediate line managers. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All staff we spoke with were positive about the importance of patient recovery and the care provided.

Most staff felt they were able to develop into new roles and had clear career progression opportunities.

Staff gave positive feedback about their immediate line managers. On Silverdale and Ullswater wards staff told us they were involved in decision making on the ward. On Rydal ward staff gave examples of how their ward manager had supported them.

However, staff said that other leaders, including the operational managers and service managers only attended the wards when something went wrong. One member of staff described this as demoralising. Staff felt that senior managers did not act on staff concerns such as staff retention and another said that operations managers did not always respond to queries. There was evidence that incidents related to staffing levels were escalated but not responded to by managers. Staff said that inappropriate staffing levels increased the stress of their roles.

Staff felt they worked well together but some staff said that they did not get the time to reflect as a group and felt this impacted on relational security.

Forty five percent of forensic staff responded to the trust 2021 staff survey in October/November. The staff survey identified the following improvement areas:

- We are compassionate and inclusive
- We are recognised and rewarded

- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team
- Staff engagement
- Morale

The service had an action plan in place following the 2021 staff survey. The action plan focused on staff wellbeing, quality improvement, compassionate leadership, senior management presence, staff involvement and safety at work (from other colleagues). The action plan did not address issues that we found on inspection including staff retention, relational security and staffing levels.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risks were not managed well.

Managers had not ensured that there was a safe and consistent approach to identifying and minimising environmental risks and much needed improvements on the wards. All the ligature risks on the wards had not been identified and controls to manage risks were not reliable as they depended on suitable staffing levels. We saw that the wards were regularly understaffed. The service had not responded quickly to environmental risks. For example, in two bedrooms risks were originally identified in the service's risk register in 2016, a period of some six years.

The maintenance and estates arrangements to maintain the ward environments did not meet the patients' needs. The environment was poor and lacked investment. Patients were living in an environment that needed immediate improvement, however despite staff requests for improvements managers were not seen to be responding in a timely way.

Although the service had an active refurbishment programme, the volume of maintenance requests logged meant that maintenance staff could not respond to them all in a timely way. This added to the challenges of the poorly maintained and unsuitable patient setting.

Managers did not have oversight of medicines management, clinic rooms and equipment. Clinic rooms were not all fully equipped, and staff did not check, maintain, and clean equipment consistently. Clinic room temperatures were not always recorded, and action was not taken when the temperature exceeded 25 degrees. Medicines fridge temperatures were not always checked, and staff did not always act when issues were identified.

Physical health observations to review the effects of medicines were not continuously completed and documentation was not always available or completed. Paperwork for consenting to, or not consenting to medicines, was not always accurate or available in the clinic room.

Managerial oversight and governance around medicines management was poor.

Despite ward managers and duty managers managing the reallocation of staff to cover shortfalls, service managers and operations directors did not have oversight of the challenges faced by staff. The service did not have enough nursing and

healthcare assistant to provide all the care and treatment expected to patients. Staffing establishment levels had reduced since 2019 and managers had not continued to review staffing requirements. All wards held vacant posts and bank staff were used regularly. Staff frequently worked under the minimum staffing establishment levels, there was not always a registered nurse present and the wards had unfilled shifts. Staff and patients had repeatedly raised concerns with the management team.

The service did not always report poor staffing levels. Staff recognised incidents but trust policy did not support staff to raise issues when skill mix did not meet the planned levels. This meant that staff shortages were not escalated outside of the care group. Managers investigated incidents but did not share lessons learned with the whole team and the wider service.

Although there were mechanisms to gather staff feedback, managers had not listened to staff concerns and these were not adequately reflected in the service's risk register. The action plan in response to the staff survey had not addressed concerns that had been shared.

However, levels of staff sickness were reducing and processes to support staff back to work were effective. Managers ensured that staff had development and career progression opportunities.

Managers had not identified that the mandatory training programme did not meet the needs of all patients and staff. Training figures were poor, and the trust had not ensured that enough staff were adequately trained in fundamentals when providing patient care, including safeguarding, immediate life support, the Mental Health Act and Mental Capacity Act.

Although wards implemented approaches to reduce restrictive interventions, there was no management oversight or monitoring of the specific restrictions on each ward.

The service had clear systems and processes to review bed management, admissions and discharge and moved patients to alternative suitable placements.

Management of risk, issues and performance

Teams mostly had access to the information they needed to provide safe and effective care and used that information to good effect.

Patient documentation was regularly updated and reflective of the care given. Staff could not always access care records easily on the provider's IT system and staff described issues with telephony in the service. Issues related to logging in more so than the effectiveness of the IT system.

The forensics service recorded and reviewed key performance indicator data for the Medium Secure wards, Low secure wards and the Women's Blended Service. Managers monitored performance in a number of areas including, average length of stay, admissions, unplanned admissions, bed occupancy, reportable incidents, complaints, compliments, discharge planning, physical health, outcome measures, restraint, Care Education and Treatment Reviews and access to Social, Education, Vocational and Occupational activities.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Forensic inpatient or secure wards

The service collected ward data and reviewed it regularly. Staff reviewed information and outcomes relating to admissions and discharge, incidents, complaints, physical health, restraint and infection control. However, the service did not use all staffing data available to improve staffing levels within the forensic service. Staffing challenges were raised and reviewed but not acted on by the trust.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Greater Manchester Mental Health Trust's Adult Secure Services were the lead provider in the Adult Low and Medium Secure NHS-Led Provider Collaborative. NHS-Led Provider Collaboratives seek to enable specialist care in a community setting to prevent people being in hospital when they don't need to be. They also ensured patients could leave hospital when they were ready. The trust had the responsibility for the budget and pathway for their local population.

Learning, continuous improvement and innovation

Ward managers all described quality improvement initiatives that they were working on or had completed. For example, on Hayeswater staff were focusing on trauma informed care. This initiative included core clinical risk training for staff, trigger warnings on dictations for admin staff, incidents follow up emails to staff, rate my shift and ward temperature checks.

Buttermere had completed phase one of their Reducing Restrictive Practice initiative. They aimed to decrease their use of restrictive practice by 5% by 30th November 2021. The result of phase one was a reduction of 7.5%.

Rydal ward aimed to decrease violence and aggression by 50% by the end of August 2022. They had re-launched Safewards, created a self soothe room, introduced a seven day a week activity programme, budgeted to train bank staff and had introduced the Dynamic Appraisal of Situational Aggression tool. Recent team meeting minutes showed a decrease in ward incidents.

All wards were also involved in the building an improvement culture programme:

- Buttermere: Promote civility, going home checklist, sports day, staff recognition.
- Ullswater (Coniston): Daily huddle, pamper hamper, Bronze QI training for patients, co-produced patient pathway. Coniston staff and patients presented at The Big Conversation event held by NHSI/E, NHS Horizons team.
- Silverdale: Daily Huddle, Mood Jar, gym sessions, activity planner, healthy eating.
- Keswick: Promoting health & wellbeing, exercise equipment, exercise mats, self-catering
- Kingsley (Ullswater): Improving the discharge process, co-production.
- Rydal: Reducing restrictive practices.
- Derwent: Discharge passport.
- Hayeswater: Staff counter system, staff wellbeing, identifying incident peaks, identifying skill mix.

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

Inadequate ↓↓

Is the service safe?

Inadequate ↓

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Safety of the ward layout

We had significant concerns during this inspection that people were at risk of avoidable harm across these wards, particularly in relation to fire safety and ligature risk audits and actions.

The fire safety operating procedures and processes were routinely not being followed by staff within the service. This meant that patients were at risk of avoidable harm. Concerns about fire safety included; access and signage relating to the storage of fire extinguishers, gaps to the tops of fire doors, broken fire panels, broken fire alarm bells.

Application of the No Smoking Policy varied across all sites, and there was substantial evidence of smoking on wards and we saw patients smoking at the Meadowbrook site, Rivington Unit, Atherleigh Park, Laureate House and Park House. Only one ward clearly enforced the no smoking policy. We were concerned that lack of adherence to the policy significantly increased the risk of fire.

At Meadowbrook, Rivington Unit, Moorside Unit and Park House we saw evidence of patients smoking in communal areas both inside and outside the wards. There was evidence of ash, burn marks, cigarette butts and we witnessed patients smoking and staff lighting cigarettes for patients.

Staff across the trust told us there was no guidance or practical support in how to effectively manage the fire risk of patient's smoking, and to comply with the trust policy. The trust had a smoke free policy, outlining the health implications of smoking for patients and staff and the legal framework around smoke free legislation. There was no practical guidance within the policy for staff to follow; the policy advised staff to respond to breaches sympathetically and not place themselves in a position of risk in order to manage non-compliance.

The risk was significantly increased because the trust had not ensured that staff had undertaken fire safety training. Whilst the overall average across all wards was that 74% of staff had been trained, some wards had much lower compliance levels at Atherleigh Park, Park House, Moorside unit and Laureate House.

There had been a significant number of fire and smoking related incidents on these wards.

In the 12 months leading to this inspection, the trust supplied data about number of fires recorded in this core service.

National safety data for the last 12 months showed 94 fire related incidents.

There had been at least one fire incident on every ward except Maple House. There were 13 incidents on Bronte ward at Laureate House, nine each on Chaucer ward at Meadowbrook and Medlock ward at the Moorside unit and eight on the Westleigh unit at Atherleigh Park.

These were all fires which the trust reported had been started by patients, including starting fires with bedding, towels, paper, paper towels, books and clothes. Nearly all incidents involved the use of lighters and several were the result of cigarettes either not extinguished properly or hidden and not extinguished. Two incidents occurred in seclusion rooms where patients had been secluded, this meant that patients had been secluded with access to lighters. Several incidents included patients barricading doors to prevent staff access to the fire.

A further 19 incidents were reported as self-harm rather than a fire related incident but included the use of fire.

These incidents were all recorded as low or no harm incidents. The trust had not taken any action to use this data to improve their management or mitigation fire risk across the service.

Ward managers completed local fire risk assessments for their wards. These varied in quality and thoroughness.

The fire safety officer completed risk assessments at each site as a minimum every three years. These assessments identified issues relating to smoking, lack of extinguisher notices, storage issues and action plans were devised to correct issues. These were often with longer timescales than the recommended timeframes and did not capture all risks. It was not clear how actions were followed up and which staff were responsible.

The fire safety risk assessment for the Meadowbrook site in June 2022 noted actions in relation to fire door deficits were initially identified in 2019 and not addressed at the time of this inspection. Three other actions were carried over from a previous fire risk assessment. This assessment also noted that there were no fire extinguisher location notices present on the doors to the rooms, which had not been rectified at the time of this inspection a week later. There was no reference to this in the action plan.

The fire safety risk assessment for Laureate House showed the fire panel on Bronte ward was damaged at the last inspection in 2021, this had not been rectified at the time of this inspection. The action plan has a timescale that this would be repaired within one month.

We did not see that these assessments had been increased, revisited or enhanced as a result of the high number of fire related incidents.

We had significant concerns about the assessment and management of ligature risks. In the last 12 months, there had been serious incidents of harm relating to ligature use, including three in-patient deaths.

There were potential ligature anchor points in the services, including bathroom and bedroom fittings and furniture. Staff did not know about all potential ligature anchor points and did not mitigate the risks to keep patients safe. This meant that the facilities were unsafe.

Wards had ligature risk assessments and audits in place which identified some but not all ligature risks. The risk assessments did not list all ligature risks to support their identification to ward staff which meant they were unable to adequately monitor them. Where ligature risks were identified, there were no specific actions to guide staff or mitigate. Ward staff had access to these assessments but on some wards, these were out of date printed copies with up to date versions held on the electronic system that not all staff had access to.

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

Assessments and audits did not include clear timescales for removal or mitigation of risk, they did not state who was responsible for actions which meant there was little oversight. Where concerns had been escalated to a risk register, some concerns had remained on the registers for prolonged periods with no actions taken.

Staff in most services could observe patients in all parts of the wards; we had concerns about the ability for staff to observe patients on two of the wards. The trust had not taken action to mitigate risks in these wards

Wards used parabolic mirrors where there were blind spots. Some wards had close circuit television cameras in communal areas.

At Maple House, whilst mirrors were sited along a bedroom corridor, a blind spot remained at the end of the corridor with recessed doorways into bedrooms. At Prospect ward, we noted that the entrance to bedrooms were recessed and there were significant blind spots. Additionally, there were blind spots affecting observation of the seated area and assisted bathrooms near bedrooms 12 and 15. Staff were not aware of these issues when we checked. Mitigations on both wards was that more regular observations were done for those patients who were noted as a higher risk, including continuous observations if needed.

We took enforcement action immediately following our inspection on site requiring the trust to make significant improvement to both fire safety and ligature assessment and management.

The wards had some mixed sex accommodation we were concerned that this was not safely managed and that risks of avoidable harm to patients were not mitigated.

The trust had three mixed sex acute admission wards and three mixed sex psychiatric intensive care units.

The layout of some of these wards was in breach of national guidance on mixed sex accommodation. At Maple House PICU, all bedrooms were off one corridor. Female bedrooms were at the top of ward, there was no separation and female patients had to walk past male bedrooms to reach the main ward. Whilst all bedrooms were ensuite, women had to pass male bedrooms if they wanted a bath.

Irwell ward was an “L” shaped ward. The four male bedrooms were at one end and two female bedrooms at the other, there were no doors or physical separation.

There had been a number of incidents within the service relating to sexual safety. Incident data for the last 6 months showed that there had been 26 incidents relating to patient sexual safety noted on these mixed wards. This included sexual advances and threats to female patients, coercive sexual contact, disinhibited behaviour, indecent exposure and sexual harassment. There was also a sexual assault on one mixed ward which was reported to police in January 2022.

On Chaucer ward, we reviewed case notes showing a male patient had been repeatedly able to enter other patients’ rooms, both male and female, without staff being aware.

On Prospect ward, one female patient told us that a male patient had repeatedly exposed himself to her in the garden and that nursing staff had not acted on these concerns. We passed this information to the trust to address the concerns.

Actions following incidents did not always include safeguarding actions or consideration of police involvement. Actions were sometimes around increased staff observation of communal areas however, we were concerned that the evident staffing issues in the service prevented enhanced staffing being put into place to protect vulnerable patients. We noted for example an incident that occurred whilst staff were dealing with another incident on the same ward.

Whilst the trust told us they reviewed all incidents, we were concerned there had been a lack of action taken to mitigate and reduce risk. All of these incidents were reported at a level where they would be actioned and closed by ward managers and categorised as low or no harm.

There was no reference or guidance for staff within the same sex accommodation policy on sexual safety considerations. The trust had developed sexual safety guidance, which guided staff in what actions to take when an incident occurred, but not about preventing incidents occurring, for example, considerations about risk assessment and appropriateness for admission to mixed sex services. The sexual safety guidance had a section relating to staff training, which did not make clear specific training that staff should receive and no clearly defined Trust approach.

Staff had easy access to alarms and some patients had easy access to nurse call systems.

In all services, staff used portable alarms to summon assistance.

There were no alarms available to patients on the Meadowbrook or Bolton wards. This meant that patients in need of assistance were unable to summon help. There was not a contingency in place to manage or mitigate this risk. Staff told us that patients in need of assistance could use their mobile telephone to contact the office.

Maintenance, cleanliness and infection control

Ward areas were not all clean, well maintained, well furnished and fit for purpose.

The environment at the Meadowbrook Unit was unclean, poorly maintained and unsafe. This included ripped furniture, ripped window blinds and privacy curtains, graffitied furniture and walls, rust on radiators, stains and marks to walls and ceilings, and scratched observation windows. Flooring was in poor repair, with gaps at the wall joins which were visibly dirty. Ceiling tiles were stained and damaged.

At Laureate House, on Bronte ward, the ceiling tiles had been damaged and removed on the main corridors but there was no timescale for when these would be fixed. On the first corridor into the ward, this exposed the water and electrical pipes and roof void.

On Blake ward, a fire in a bathroom recently had caused two burned and scorched patches to the floor. The area was still in use and had been reported, but there was no timescale for repair.

On Bronte and Blake ward, the bedroom doors were a standard “leaf and a half” acute hospital design which meant there were no observation panels.

At Park House, staircases to the garden were dirty and marked. All external staircases to garden areas at Park House were dirty, with evidence of smoking and ingrained ash and cigarette debris.

On Laurel ward, there were arm rests and cushions torn on furniture in day area. Some bedroom floors were dirty on Poplar ward. One toilet was blocked, and one bathroom was unclean.

At Maple House in Bolton, some of the furniture was damaged in the dining room; we were told new furniture had been ordered.

There were also issues with storage at the Meadowbrook Unit, with unneeded items including mobility aids stored in cupboards and offices.

Staff made sure cleaning records were up-to-date and the premises were cleaned.

Cleaners were present and working at all areas we visited. Some of the wards and services had been redecorated, with a refurbishment completed recently at the Moorside Unit. However environmental issues in some of the services, particularly at the Meadowbrook and Park House sites, required substantial work. At Meadowbrook, the chief executive and senior managers had visited in the months prior to the inspection. When we escalated concerns the trust told us they had plans for refurbishment of the site, however no documentation or timescale has been received in relation to this. Whilst renovation was required, there were immediate issues about cleanliness and suitability in the environment that had not been attended to at the time of inspection.

Staff followed infection control policy in relation to covid19, including handwashing.

At the time of this inspection, local guidance in relation to Covid19 was for healthcare staff to continue to wear face coverings, and on the wards we visited staff were adhering to this. On some wards, there were patients who had tested positive for Covid19 infection, and barrier nursing was in place with personal protective equipment available outside bedrooms. Where patients did not have an ensuite bathroom, the nearest bathroom was allocated as solely for that patients use.

Seclusion rooms

We looked at all nine seclusion rooms across this core service, they were of differing quality and not all were in line with guidance. There was a seclusion room/suite in each of the psychiatric intensive care units, and on Sovereign, Westleigh and Griffin ward. Each room was of a different layout and design but all had adjoining toilets and showers and controllable lighting and heating, as per the Mental Health Act Code of Practice criteria.

At Chaucer ward, the seclusion room clock was on its side in a cupboard, rather than on the wall. The room had hot drink stains to the wall and the observation panel was stained with fluid spills and clouded in places. There were cracks around the edges of the window. These issues had not been reported or rectified and the room was occupied at the time of this inspection.

At Blake ward, the seclusion room was in use with the door open into the adjoining de-escalation suite due to damage to the ceiling and room. This had been reported for repair but had occurred several days before.

At Priestners ward, the seclusion mattress was damaged and torn and at Sovereign ward, the intercom was not working. Neither of these issues had been reported but neither room was in use at the time. At Juniper ward, the seclusion room door lock had been damaged and replaced by two large bolts.

At Maple House, the seclusion room ceiling was stained. The integrated shower flooded into the main bed area when switched on. This had been reported but not fixed.

At Irwell ward, a new seclusion room and de-escalation suite had been built as part of the recent refurbishment. This included integrated screens to allow for music and games, the display defaulted to a clock when not in use and TV and sound could also be played. The intercom worked and lighting included sensory lighting. Similarly, the room on Griffin ward had a touch screen wall that patients could use to play music, television and games. There were no issues with the seclusion room at Westleigh ward.

At all sites we visited, there had been use of s136 suites as seclusion rooms, when these were not designed for this purpose. However, the Trust told us these were only used in an emergency with the prior approval of senior clinicians and managers.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

All wards had clinic rooms, with some having equipment and space to undertake physical observations, venepuncture and electrocardiogram monitoring.

Clinic rooms all contained resuscitation equipment and emergency drugs, nurses checked these regularly to ensure equipment was in working order for when needed.

Staff checked, maintained, and cleaned equipment.

Some equipment had cleaning stickers on to show when last cleaned.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe.

The service did not always have enough nursing and support staff to keep patients safe. Staff and managers on the ward reported concerns about the level of staffing across the wards and pressures on the wards as a result of lower staff numbers.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Each location held daily safety huddles to assess staffing on each unit and consider any shortfalls. This enabled management at the locations to move staff where necessary or request additional staff to attend.

Establishment levels had been set by the trust. Staff reported that the establishment number of staffing for the number of patients on the wards was lower than required. On some wards we visited, there were not sufficient staff allocated to the ward to enable routine work to be undertaken, including attending ward reviews, provision of activities and facilitation of escorted leave.

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

Wards often had more patients than the number of allocated beds, with no corresponding increase in staff. On reviewing the minutes of safety huddles, surge beds were in routine use across the trust. It was also evident that on occasions patients were managed in seclusion with no bed on the ward to return to, leave beds were admitted to and 136 suites were also being used as seclusion. For example, during May 2022, Juniper ward, a 10 bed ward, had 11 patients under the care of staff, including a patient in seclusion and a patient being nursed in the s136 suite. Bronte ward had two surge beds which were in regular use, meaning the ward had 33 patients rather than the 31 originally allocated. The staffing establishment only took into account increased observations rather than increased patient numbers.

Staff reported that they did not always feel safe on the wards, particularly when there were fewer permanent staff on shift. Staff noted that bank and agency staff were predominantly not trained in the prevention and management of violence and aggression (PMVA) which reduced the number of staff available to support during an incident. Each location visited had a process in place to support and respond to incidents, however, this required support from other wards which impacted on staffing levels for those wards. At times, there were not sufficient staff across sites to provide this response.

We were told and meeting minutes confirmed that at times staff who were identified to respond to incidents on other wards were not trained in prevention and management of violence and aggression.

Staff regularly worked under the minimum staffing establishment levels. We reviewed safety huddle minutes and establishment staffing levels for the four weeks leading to inspection. Across most services, shifts were short staffed. There were occasions where there was no qualified nurse for wards in Trafford, South Manchester and Salford and cover was provided by other wards or the bleepholder. The impact of this for patients is that there may be delays when medication is needed and that cover is provided by nurses unfamiliar to patients.

Nursing staff described how staff were moved across wards to meet minimum staffing levels. Staff said that this was disruptive and impacted on patient care. Patients, carers and advocates also commented that the services did not have enough staff. Patients told us the impact of this was staff not being able to facilitate escorted leave, or that this was postponed, or the time shortened due to difficulties. Staff told us they struggled to complete one to one named nurse sessions, update care plans and risk assessments or facilitate activities or leave, when wards were short staffed.

In all services we saw that support time and recovery workers and ward managers were included in the numbers for whole or part shifts. This impacted on ward management and activity provision.

The service had high vacancy rates. The overall vacancy rate across all these wards was 24%.

There were high vacancy levels for registered nurses, with band 5 and 6 nursing vacancies highest in Wigan (39% of band 5 and 6 posts vacant), Meadowbrook (34% of band 5 and 6 posts vacant), Bolton (33% of band 5 and 6 posts vacant) and Park House (32% of band 5 and 6 posts vacant).

Vacancy rates were also high for band 2 and 3 health care workers, with vacancies highest at Laureate House (28% of band 2 and 3 posts vacant), Moorside Unit (26% of band 2 and 3 posts vacant) and Park House (20% of band 2 and 3 posts vacant).

Staffing at Meadowbrook, particularly for registered nurses, was on the directorate risk register. At Bolton, Oak ward was on the directorate risk register, with five registered nurse vacancies noted as at December 2021.

The service had high rates of bank and agency nurses and nursing assistants.

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

The trust provided figures for bank and agency usage over the last 12 months. The highest usage was Elm ward, with 3934 shifts filled by bank or agency staff, Blake ward, with 3288 shifts filled by bank or agency staff, Bronte ward with 3169 shifts filled by bank or agency staff and Westleigh ward with 2943 shifts filled by bank or agency staff.

Managers limited their use of bank or agency staff and requested staff familiar with the service.

The trust supplied figures indicating that in the last four weeks around 58% of NHS professionals staff working on wards were familiar with the service and this included substantive staff working additional shifts, who had received a full induction, mandatory training and had some clinical experience.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

In some wards, there were induction forms filled in by staff when new bank or agency staff worked on the ward, however these were not in place at all wards and sites.

The service had high turnover rates.

The average turnover rate across all wards was 17%. Higher than average turnover was noted on Sovereign Unit (36%) and wards at Moorside Unit, Laureate House and Park House.

The lowest rates were Priestners Unit (6%) and wards at the Rivington Unit.

Managers supported staff who needed time off for ill health.

Sickness was high with an average sickness rate across all wards of 10%. This should be viewed cautiously in light of Covid 19 outbreaks and isolation changes over time.

Wards with highest sickness rates overall were Mulberry and Elm at Park House (18% and 17%), Priestners 15%, Redwood 14%, Blake 14%, Brook ward 14%, Westleigh 14% and Medlock ward 13%.

Not all patients had regular one to one sessions with their named nurse.

Ward managers had access to dashboards with data collected from the electronic records which showed these were not happening regularly. Staff told us they struggled to complete these due to ward acuity and staffing levels, and some patients we spoke to said they did not have regular sessions with their named nurse.

Patients told us they had their escorted leave or activities cancelled, particularly when the service was short staffed.

The trust did not routinely collect data on activities or leave cancelled due to staff shortages on the wards. Managers and ward staff told us they would try and ensure leave was re-arranged if it could not go ahead at the planned time. Safety huddles showed that significant leave, for example, urgent hospital appointments, was prioritised.

The provision of support time and recovery workers and activity workers at different sites had helped ensure that activity provision was available on all wards, but we saw occasions where they were included in ward staffing numbers when shifts were short staffed.

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

The service did not always have enough staff on each shift to carry out any physical interventions safely.

At times, the wards did not always have sufficient staff trained in prevention of violence and aggression techniques, to undertake physical interventions safely.

This was evident from safety huddles and staffing data particularly relating to wards at Atherleigh Park, Moorside Unit and Laureate House.

Across all the wards, some wards did not have all staff trained in trust approved techniques as staff had not attended trust training. Temporary staff working for NHS professionals did not receive training in appropriate techniques, although the trust had recently started to offer places on training for regular NHS Professionals staff.

Staff shared key information to keep patients safe when handing over their care to others.

Handovers took place between shifts.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

All services except Bolton had consultant vacancies, which were being covered by short or long term locum cover. Just under 40% of consultant posts were locum cover. The trust told us that most locum cover was long term contracted rather than short term cover. Speciality and higher grade trainee posts were filled, along with core trainee and foundation level posts.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had not all completed and kept up-to-date with their mandatory training.

We found that there were a number of mandatory training courses which not all staff had completed. This included basic and intermediate life support, prevention and management of violence and aggression, safeguarding, fire safety and infection prevention and control.

There were not sufficient levels of staff trained in basic life support. Seventeen wards had less than 80% of staff trained in basic life support. The lowest was Medlock and Westleigh with 50% of staff trained.

Training figures for infection prevention and control training showed nine wards with total staff compliance below 80%. The lowest was were Laurel Ward with 59% of staff trained.

Eight wards had less than 75% of staff trained in the mandatory Mental Health Act code of practice.

Mandatory training levels for Mental Capacity Act training were below 75% in seven ward areas.

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

For level 3 safeguarding adults training 14 wards had lower than 75% of staff completing training. The lowest were Priestners Unit 20% and Westleigh Unit 22%.

For level 3 safeguarding children training, there were 14 wards were training compliance was below 75%, the lowest being Brook ward 25% and Sovereign unit 33%.

Training figures for prevention and management of violence and aggression training varied. There were six wards with total staff training compliance below 80%. The lowest was Poplar Ward with 57% of staff trained.

The mandatory training programme was not comprehensive and did not meet the needs of patients and staff. Not all qualified nurses were trained in immediate life support. The trust told us that immediate life support training was not mandatory. The trust told us that they worked with all clinical services to identify ILS cover needs per 'cluster' in each area meaning that not all qualified nurses received this training across the trust. The average of identified staff trained across the trust was 70%. We had concerns about the low levels of staff trained given regular use of rapid tranquilisation, seclusion and restraint across these wards.

The figures supplied showed 56% of eligible staff at Atherleigh, 66% at Trafford and 75% at Bolton were trained. At Meadowbrook, the completion rate for eligible staff was 70%. At Park House and Laureate House, only band 6 and 7 nurses were trained in ILS. For Park House, the trust figures show that 85% of band 6/7 staff were trained. At our last inspection in 2021, the trust informed us that the decision to restrict ILS training to band 6 and 7 staff had been reconsidered and that all qualified nurses would be ILS trained in the future at Park House but this had not happened.

For Laureate House, 71% of eligible staff (band 6/7) were trained.

The trust had local standard operating procedures for each service relating to ensuring an identified ILS trained staff member was available to respond across the wards for that shift. All these protocols were overdue for review and the procedure for the wards at Wigan was a resuscitation policy from the previous NHS provider, which included links to other documents which no longer worked and did not provide practical guidance to staff.

At two sites, we saw that ILS trained staff consideration was part of the safety huddle, although only one site seemed to consider this at each meeting. We did not see evidence of a process for monitoring at Meadowbrook, Park House, Laureate House or the Rivington Unit at Bolton.

The importance of nursing and medical staff being appropriately trained in life support techniques was outlined in the National Institute for Health & Care Excellence NG10 guidance. This includes the need for staff trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend an emergency if restrictive interventions might be used. All of these wards used restrictive interventions, including restraint and rapid tranquillisation, frequently. This was more concerning given the low levels of basic life support completion on wards where high levels of restrictive interventions were reported.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw in staff meetings and during supervision sessions that staff were reminded to complete training, particularly online modules, and staff were being booked for future training sessions. However, staff struggled to have time to complete this during their shifts. Staff at some sites were allocated administration days to complete overdue training, but we saw from safety huddle meetings that these would be cancelled, and staff would work on the wards as there was not sufficient staff on duty. Staff told us that their attendance at face to face training was also cancelled at short notice due to short staffing.

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

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 94 patient records. Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and mostly reviewed this regularly, including after any incident.

We saw four risk assessments which did not include all significant incidents, in one case missing the serious incident leading to admission and in another not including significant safeguarding risks.

Staff used a recognised risk assessment tool. Some wards had started to introduce positive behaviour support plans for patients who required these.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients.

We saw evidence of levels of observation that changed to reflect the current needs of each patient. Staff communicated each patient's level of risk well, via handovers and observation prescriptions.

Staff were aware of least restrictive practice and applied blanket restrictions on patients' freedom only when this was justified. Each ward had some items that were not allowed on the ward, but many items were individually risk assessed.

The front doors of all the wards were locked. Informal patients were not always given information about their rights as informal patients, and information was not on display or available on all wards.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were high across the service.

This service had 3099 incidences of restraint between 17 June 2021 – 16 June 2022, with 320 instances of prone restraint. The trust noted that limitations in the incident reporting system meant that when medication was administered with the patient lying on one side, this was reported as prone restraint, meaning there may be lower numbers that the data suggested. However, the use of prone restraint is high risk and no longer regularly used in mental health settings because there is significant risk of positional asphyxiation which can lead to death.

The highest numbers of restraints including prone restraint were recorded for Blake ward, with 432 incidents, and there were specific clinical explanations given for this figure. The next highest figures were for Bronte ward, with 357 incidents of restraint. The trust noted that Bronte Ward had experienced a sustained high level of acuity over the last 12 months.

This service had 835 incidences of rapid tranquilisation recorded between 17 June 2021 – 16 June 2022. The highest instances were in Blake ward (96) and Chaucer ward (91).

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

There had been 650 incidents of seclusion between 17 June 2021 – 16 June 2022. The highest figures were on Blake ward with 134 instances or 20% of total episodes. The next highest was Chaucer ward with 81 instances.

Between 2018-2019 Blake ward reported a similar much higher number of restraints and seclusion than any other acute admission ward in the trust. Staff told us they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Ward managers told us that they submitted restrictive interventions data to the trust on a monthly basis but did not receive reports or analysis of this data which they could then use within their wards.

Some of the wards were taking part in QI projects aimed at reducing restrictive interventions and this had included incident analysis and staff training.

Staff did not always follow NICE guidance when using rapid tranquilisation because its use was not accurately and consistently monitored and recorded.

We found a lack of consistent physical health monitoring records after administration of 'when required' medicines across the whole trust. There was also variation in documents used to monitor the person following administration of this medication, and when and how the documentation was uploaded to the persons electronic records.

The National Institute for Health & Care Excellence NG10 guidance recommends that while using "when required" medicine, it should be part of a strategy and its rationale and circumstances should be included in the care plan of the patient. No documented plans around "when required" medicines were seen during the inspection and no specific instructions included on the prescription charts.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.

The seclusion records we reviewed showed most nursing and medical reviews took place as per the Code of Practice. Seclusion records were kept as paper records and most medical reviews were recorded on the electronic system rather than in the records, with similar practice noted for nursing reviews. This meant checking both systems to check for reviews.

The trust outlined that there was no current method of recording long term segregation within either the electronic record or incident reporting system. This would be recorded as seclusion and the seclusion policy followed.

Safeguarding

Not all staff had received training on how to recognise and report abuse, appropriate for their role. However, staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

For level 3 safeguarding adults training 14 wards had lower than 75% of staff completing training. The lowest were Priestners Unit 20% and Westleigh Unit 22%. For level 3 safeguarding children training, there were 14 wards were training compliance was below 75%, the lowest being Brook ward 25% and Sovereign unit 33%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. We saw in records we reviewed that safeguarding alerts were made when concerns were raised and care plans for vulnerability were in place for some patients who needed them.

At this inspection, we were concerned that staff were not aware of sexual safety, particularly in mixed sex wards, and we had concerns that incidents which should have raised safeguarding concerns were not reported.

Staff followed clear procedures to keep children visiting the ward safe. At most sites, a specific visiting room was available to book for visits with children which were separate from the wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw good practice at the Meadowbrook site with laminated information and key contacts for staff concerned about safeguarding, including female genital mutilation and modern slavery. This included emergency contacts and the safeguarding flowchart laminated and displayed in offices.

Staff access to essential information

Patient notes were comprehensive, but staff could not always access them easily.

The majority of the wards used one electronic records system. In the Wigan services, a different electronic records system was used. When patients transferred into and from the Wigan services, there was no access to previous records or history if these were on a different system. Services relied on the previous ward printing and sending the most recent documentation.

Staff told us they waited a considerable time before they could access training to use either of the recording systems. We met staff who had worked within services for up to five months with no access to electronic records.

Agency and bank staff couldn't access the records systems and were unable to access information on the trust intranet or the incident recording system.

Medicines management

Staff followed some systems and processes to prescribe and administer medicines safely.

We reviewed medicines management across all wards and practice was inconsistent.

There was also a specific issue at Atherleigh Park, where the trust was using an electronic prescription system. Access to the system was not always available to agency and bank staff. This meant staff were using printed paper charts to check and record the administer of patients' medicines. This meant the completion of the electronic records was sometimes delayed until staff with access to the system, could add the administration of the medicine. This could have resulted in patients being administered medicines unsafely without the correct time interval.

All wards areas had a visiting pharmacist and regular medicine stock checks were undertaken. There were no regular ward-based audits completed by pharmacy staff.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw that medicines were reviewed at multidisciplinary reviews. Some patients told us they had received information about their medicines. Staff completed most medicines records accurately and kept them up-to-date.

We saw most medicine records were completed, and where unable to administer medicines staff recorded this on the prescription charts. However, on one ward at Park House one person was prescribed a mood stabiliser, semi-sodium valproate. Doses were not signed for on 19 occasions in April, May and June 2022. Additionally, on another ward (Elm) a person was being administered oral lorazepam medicine but staff were signing the intramuscular (IM) prescription. We couldn't be assured of the accuracy of the records of administration on these wards.

On one ward at Park House there was evidence of administration of a pain relief medicine without a valid prescription. The continued administration was completed in a blank space on the prescription chart.

We saw good practice in relation to valproate prescribing and pregnancy prevention planning at one site, including consideration of capacity and contraceptive planning.

However, paperwork for medicines prescribed under the mental health act was not accurate across the trust for 16 patients on eight of the wards in which the prescription charts were checked. There were also instances where they were not available in the clinic areas for checking pre-administration of a person's medicine. This resulted in patients being prescribed and administered medicines without authority under the Mental Health Act. This was despite the ward staff completing audit checks on the documents across the trust.

Additionally, there was two patients on one ward who did not receive their critical blood thinning medicines as prescribed. This could have resulted in side effects developing. This had not been incident reported at the time of the inspection. On another ward there was multiple prescribing of paracetamol and paracetamol containing products. Both were being administered within three hours of each other.

Staff stored and managed some medicines and prescribing documents safely.

Fridge temperatures did not always include minimum/maximum readings and there was a lack of escalation on six wards when the temperatures fell outside range. On one ward (MacColl) this had been out of range for three months. Medicines stored in the fridges included insulin, glucagon, pabrinex, lorazepam, liquid antibiotics and antifungal creams. These do not work as well if stored at higher or lower than recommended storage temperatures.

Additionally, a new fridge monitoring system was being introduced at the trust. This appeared to have caused some confusion for staff. Staff at one ward (Laurel) inspected were no longer completing a daily minimum/maximum record of the fridge temperatures as they thought the new monitoring was now in place. It had not gone live at the time of the inspection of the acute/PICU wards and was restricted to wards at the Woodlands hospital.

Some liquids for example, promethazine, morphine, methadone, aripiprazole, require opening dates to be added to label. The manufacturer advises they have new expiry dates once opened. We saw this had not been completed on five wards. Once, past the new date the medicine may no longer work as well.

On one ward (Medlock) insulin pens had been removed from the fridge and stored in the trolley for administration. They had not any additional labelling to say when this had been done. Insulin pens have a reduced expiry date when removed from recommended storage temperature. They do not work as well if stored outside recommended temperature for usually 8 weeks. It was unclear from the records if this was the case.

Clinic room temperature monitoring on one ward (Bronte) exceeded 25 degrees regularly each month and were monitored as one reading overnight. During May 2022 the temperatures exceeded 25 degrees on 8 consecutive readings. This should have resulted in a review of the medicines held in the clinic room.

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

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Pharmacists and pharmacy technicians told us that they provided the medicine reconciliation service, with a target of completing this within 24 hours of admission during the week and 72 hours including the weekend. They had access to summary care records (SCR) in GP services. They also used community pharmacy records, depot clinic records, clozapine clinic records and acute hospital discharge summaries.

The service did not always ensure that people's behaviour was not controlled by excessive and inappropriate use of medicines.

On one ward (Blake), we saw higher than British National Formulary (BNF) maximum doses of a medicine used in behavioural management prescribed for two patients. This was mirrored with prescribing of long acting behavioural control medicines for four patients on the same ward. One of the patients having been administered this on three occasions, with a further prescribed dose available for administration. Patients on the ward were prescribed multiple medicines for controlling behaviour. There was no evidence of rationale and direction as to in which circumstances, they should be used. They were not included as part of a behavioural care plan or given any direction on prescription charts.

Prescribing behavioural medicines using injections was not excessive on most wards inspected at the trust. We saw good practice and evidence of reduction in prescribing when required medicines on one ward at Park House. However, where it was prescribed, there was lack of care planning and direction for staff on which medicines should be used to manage violence and aggression. No documented plans around behavioural medicines were seen during the inspection and no specific instructions included on the prescription charts. National Institute for Health & Care Excellence NG10 guidance recommends that while using "when required" medicine, it should be part of a strategy and its rationale and circumstances should be included in the care plan of the patient.

Staff did not always review the effects of each patient's medicines on their physical health according to NICE guidance.

We found there was no documented physical health care plans for a person with breathing difficulties, diabetes and prescribed a blood thinner on one ward (Atherleigh Park). On another ward (Poplar) staff were unaware that a patient was asthmatic and although was prescribed an inhaler to be used when needed, had no physical health management plan in place.

On one ward (Blake), an elderly person was prescribed high doses of antipsychotics including, those with known cardiac side effects without physical health checks as had refused monitoring. The trust had agreed to review the prescribing.

We found a lack of consistent physical health monitoring records after administration of medicines to control behaviour across the whole trust. There was also variation in documents used to monitor the person and when and how uploaded to the persons electronic records. One particular medicine was used on several wards, which required prolonged physical health monitoring checks. The documents being used to record these checks stopped after four hours. This meant there was a lack of monitoring records available for review and escalation if needed.

Venous Thromboembolism (VTE) is a condition where a blood clot breaks off from a formed clot and moves around the body. This can be formed from a deep vein thrombosis (DVT) and can lead to pulmonary embolism (blood clots causing

arterial blockage in the lungs). The trust policy was for all patients admitted to be fully assessed for VTE risk and appropriate treatment provided. The policy discussed hospital acquired VTE being a common cause of mortality within adults in inpatient services. However, the process in practice included a screening tool which meant that not all patients had a full screening completed as per National Institute for Health & Care Excellence guidance CG92.

However, there were blood test monitoring and therapeutic level monitoring being carried out across the trust, including those for regular clozapine administration. Others included baseline test for prescribing antipsychotics and lithium. On one ward a person having clozapine titration was being monitored for cardiac side effects before administration. On another ward, there was regular routine monitoring completed for a patient on high dose clozapine therapy, including regular serum plasma monitoring. Pharmacy highlighted high dose antipsychotic prescribing monitoring form to nursing and medics. The form included baseline tests and continued regular physical health checks.

Track record on safety

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) between 1 June 2021 and 31 May 2022. There were 27 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'Apparent/actual/suspected self-inflicted harm meeting SI criteria' with eleven. Four of the unexpected deaths were instances of 'Sub-optimal care of the deteriorating patient meeting SI criteria'.

There have been five in-patient deaths in the last 12 months within the trusts acute admission wards which have involved the use of ligatures.

The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a Preventing Future Deaths report because the power comes from regulation 28 of the Coroners (Inquests) Regulations 2013. The report is sent to the people or organisations who are in a position to take action to reduce the risk. There had been two preventing future deaths reports issued to the trust in the last 12 months specific to inpatient admission wards. One report issued in April 2022 related to different computer systems in use between inpatient and psychological services and a lack of safeguarding actions taken. The other issued in September 2021 related to physical health care and monitoring, including care planning, primary and secondary care information sharing, lack of specialist referral and no robust audit system for checking compliance with trust policies. There were also concerns about lack of formal capacity assessments and that the trust investigation report contained errors and misinterpretations.

The trust had responded to the regulation 28 reports and taken action in response to these concerns. The trust told us that review of regulation 28 reports was taken at executive level and actions monitored via the trust quality improvement committee.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

Staff reported serious incidents clearly and in line with trust policy.

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

Staff understood the duty of candour. They were open, transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

We spoke to managers in services where serious incidents had occurred. They outlined support including check ins with staff involved in incidents, either by phone or in person, local debriefs with everyone involved. Matrons and unit managers ensured staff were supported at work.

The services had also accessed psychology led reviews held with staff. Staff had access to short term external counselling and support through an employee assistance programme.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff did not always receive feedback from investigation of incidents, both internal and external to the service. In some of the wards, staff meetings were used to provide feedback to staff about incidents and learning from incidents.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

We reviewed 94 patient records. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients mostly had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

At Meadowbrook, annual physical health assessments had not been completed for patients whose admission had been longer than one year. At Trafford, physical health assessments were not completed and closed.

Staff mostly developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff did not always regularly review and update care plans when patients' needs changed.

Some care plans were personalised, holistic and recovery-orientated.

In all settings, there were some comprehensive care plans. Across the trust, there was use of some standardised wordings and content which was generic and not personalised for individuals. At Wigan, there was some use of core care plans which were generic. Care plans at Griffin ward were noted to be generic and missing key details.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

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

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance. At Park House, there was one clinical psychologist and two assistants who worked across all the wards. They ran reflective practice and formulation sessions, and assistants ran groups on all the wards, including psychosocial interventions groups, for example, to assist with hearing voices.

Redwood ward were looking to develop a trauma informed approach, with nursing and psychology staff working to develop trauma informed care plans.

At Atherleigh Park, staff had received training in the self-harm pathway. The pathway was developed from good practice guidance and was in the process of being evaluated. A clinical psychologist was able to undertake individual work with patients, and groups were run throughout the week by assistant psychologists. Psychology staff also ran weekly reflective practice sessions.

At Meadowbrook, on Keats ward, staff ran groups as part of a managing difficult emotions pathway with some staff having undertaken additional compassionate focused therapy training.

At Bronte ward, there were groups run by assistant psychologists twice a week.

Staff identified most patients' physical health needs and recorded them in their care plans. There was good practice noted at Atherleigh park in relation to physical health and repeated attempts to complete monitoring if patients refused. Across the trust there was use of a format to record visual signs, for example, respiration rate if patients were refusing physical health monitoring, but this was not used consistently. Staff made sure patients had access to physical health care, including specialists as required.

There were physical health staff/teams at Atherleigh Park, Bolton and Park House, who completed monitoring including electrocardiogram readings and blood monitoring. Some staff in other parts of the trust had completed venepuncture and ECG training.

The trust employed specialists, including physiotherapists and speech and language therapists. Some staff had moved across as the trust expanded, and there was no clear strategy or management of these posts. For example, there were eight physiotherapists across the trust, including a community post in Bolton. Posts were not graded similarly, and all were managed by ward-based management in localities. There was no overarching budget for physiotherapy and no single lead to address or escalate concerns, which meant there could be delays in funding equipment.

Patients had access to physiotherapy, dietetics, speech and language therapy, and tissue viability advice and support. These services were provided by the trust in some areas and were accessed from the community in others. Patients were referred to specialist healthcare teams when necessary and supported to attend appointments for assessment and treatment.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Admission checklists included prompts and signposting for resources which promoted healthier lives. At Atherleigh Park, a new health and wellbeing worker post had been developed with a remit looking at smoking cessation, weight management, physical health and developing community plans, for example, supporting community gym induction and sessions.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Occupational therapists used the Model of Human Occupation Screening Tool (MOHOST) to assess patient needs. There were specific symptom checklists and scales used in services. Side effect rating scales were available in all settings.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Across the services, wards were undertaking quality improvement projects. These included local plans for implementing trauma informed care, reducing restrictive practices and reducing violence and aggression. At a trust level, there was QI work planned around physical health, delayed transfers of care and promethazine and promazine prescribing practices.

Ward managers and modern matrons undertook regular audits of ward based practice, for example, named nurse audits and consent to treatment audits. Some managers used results from audits to make improvements, some actions identified from ward based audits had not been actioned when checked.

The trust had undertaken a number of audits in the last 12 months relating to these wards including venous thromboembolic risk assessment, early warning scores and physical health audits, admission of young people to adult wards, hand hygiene, mattress audits, risk assessment and medicines management in MDT working.

The trust had also completed a high number of local thematic audits of clinical practice over the last 12 months with key actions identified for improvements.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service mostly had a full range of specialists to meet the needs of the patients on the ward.

At each service there were multidisciplinary teams. Occupational therapists were based at each acute location. Technical instructors, occupational therapy assistants, activity co-ordinators and support, time and recovery (STR) workers also worked with patients.

At Park House, Bolton, Meadowbrook, Atherleigh Park and Laureate House, there was psychology provision, including individual and group sessions. There was no psychology provision at Trafford or Griffin ward. A personality disorder lead post was being recruited to at Trafford.

Managers did not always ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Not all staff had received mandatory training when they commenced in post and some staff had worked for months without completion of essential training.

Managers gave each new member of staff a full induction to the service before they started work.

Permanent staff spoke positively about their induction to the trust and their area of work. Some staff told us that they did not complete mandatory training when starting work, and there had been difficulties accessing training, to the extent that some staff had been working for months without completing prevention of violence and aggression training, for example.

Managers sometimes supported staff through regular, constructive appraisals of their work. Most ward areas had completed the majority of staff appraisals due. The main outliers were Priestners ward with 11% completed, Westleigh ward with 50% completed and Chaucer ward at Meadowbrook with 63% completed. The trust ensured that medical appraisal and revalidation were completed.

Managers sometimes supported staff through regular, constructive clinical supervision of their work. Most ward areas had completed supervision rates above 75%. Poplar ward, Priestners ward, Westleigh ward and Irwell ward were below this. Many wards had reflective practice sessions and formulation groups which delivered aspects of clinical supervision.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings were held at each ward, with most meetings held monthly. These varied across the trust in content and information covered, with some using a set format including lessons learned and updates from incidents but others less well attended or organised.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff described additional training they had been able to access for their role, and opportunities to develop skills and knowledge. The trust had supported health care workers to develop with training to become registered nurse associates and both trainees and registered nurse associates spoke positively of their training.

Managers recruited, trained and supported volunteers to work with patients in the service. Volunteers worked in the service at the Meadowbrook Unit and peer support workers had been recruited to work at Atherleigh Park, with recruitment for similar roles taking place across the trust. These roles were well received by patients and staff, and volunteers and peer support workers we spoke to felt valued and supported in their roles.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We attended patient reviews at Wigan, Park House, Meadowbrook and Bolton. These were well structured and patient centred.

We also attended safety huddles and daily patient review meetings at several sites. Patient review meetings and board rounds were centred on identifying any obstacles or difficulties in patient's progress. At Park House, the board rounds included housing and social care representation. These meetings were focused and clear actions identified.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

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

Some staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Training compliance varied with eight wards having less than 75% of staff trained in the mandatory Mental Health Act code of practice. Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff did not always explain to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Regular ward-based audits were completed to check patients' rights had been explained, but records showed this did not always happen as soon as practicable.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff did not always request an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Paperwork for medicines prescribed under the mental health act was not accurate across the trust for 16 patients on eight of the wards in which the prescription charts were checked. There were also instances where they were not available in the clinic areas for checking pre-administration of a person's medicine. This resulted in patients being prescribed and administered medicines without authority under the mental health act. This was despite the ward staff completing audit checks on the documents across the trust.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Copies of detention papers were stored on the electronic system and staff knew where to access these.

Seclusion records were completed on paper and within the electronic records system. We reviewed four seclusion records during this inspection and found all four paper records in the seclusion suite did not have a complete record of reviews as a result. Some of the paper records were missing printed names and signatures. Seclusion care plans were in place, although one had been completed three days after seclusion commenced. One patient's medical reviews were not within the trust policy timescales.

Informal patients did not always know that they could leave the ward freely and the services did not always display information to tell them this.

There was no signage for informal patients in most services. We saw an instance at Park House where an informal patient was asking to leave and was told they needed to wait for the nurse in charge to see them, the same patient had still not been able to leave the ward two hours later. One informal patient in Wigan was not aware that they did not have to stay on the ward and they had been on the ward for four days.

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

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Some staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

Mandatory training levels for Mental Capacity Act training were below 75% on seven ward areas.

There were no deprivations of liberty safeguards applications made in the last 12 months.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff across these services outlined scenarios and examples of capacity assessments and support with decisions in practice. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

We spoke to 62 patients during this inspection and collected 48 comment cards.

Patients said staff mostly treated them well and behaved kindly. Most patients spoke positively about staff who they worked with, including substantive nursing and medical staff, ward managers, occupational therapy and psychology staff. Patients were positive about input from activity and support time recovery workers. Staff were described as supportive, kind, respectful and caring. Patients were also positive about support they received from volunteers and peer support workers across the services.

However, patients at every site said there were not enough staff, particularly nursing staff. One patient said short staffing meant staff were pressured and sometimes short with patients at times. Some patients said they felt uncomfortable with high numbers of temporary staff on the ward they were admitted to, finding it more difficult to approach unfamiliar staff. Patients highlighted a lack of consistency when there were changes of staff and frequent use of agency staff. Patients complained that temporary staff didn't offer support or interact with them or other patients, and there were

several complaints from patients of feeling ignored and of staff talking to each other or spending time on mobile phones. Patients at Bolton, Trafford and Park House spoke specifically about night staffing issues, noting night staff as being unapproachable, rude and dismissive at times. We raised these concerns with mangers on the wards who informed us they would take appropriate action to follow up the concerns raised by patients.

Feedback about activities was mixed. At Bolton and Park House some patients mentioned there was limited choice and no activities at weekend. Most patients noted some activities taking place during the week and there was positive feedback for psychology led groups were these were running.

Wards at Bolton, Laureate House, Park House and Griffin ward were described as noisy and chaotic at times. Patients spoke of limited spaces they could use when they were feeling distressed or wanting quiet time. The regular use of surge beds where bedrooms were created in quiet rooms, visitors' rooms, lounges and activity rooms further impacted on patients' access to space on the wards.

The surge bed procedure also included provisions for use of seclusion rooms, 136 suites and a process entitled safe waiting, for when a bed was not available anywhere and a patient was admitted to the ward/lounge. The policy advised that if no physical bed was identified a lounge area will be allocated exclusively to the service user to provide comfort whilst waiting for a bed. The policy did not detail what happened at night and where the patient would sleep if there was still no bed. The impact of this on patient's privacy and dignity was not considered in the guidance, nor the impact on already limited space.

Patients at Park House raised concerns about dormitories. The most common themes were about a lack of privacy, theft of personal belongings and interpersonal issues with other patients including threats and aggression within dormitories. Of the 33 patients we spoke to at Park House, nine felt unsafe on the wards they were on, with patients having been physically assaulted or feeling at risk of violence and threatened by other patients. One patient spoke of having slept in the lounge on the ward when possible due to the threats and aggression experienced from other patients in their dormitory. Another patient disclosed current threats being made toward them which we escalated immediately.

Three patients on wards in Bolton also described feeling unsafe on the wards, with concerns about risk of violence and other patient's behaviour and illness severity.

We raised the concerns patients had discussed with us about not feeling safe on the wards with managers on the wards. They told us they would take action to follow up the concerns we raised.

We saw caring and positive interactions at all sites during this inspection, including difficult situations and safeguarding concerns which were dealt with sensitively and patiently.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Most patients had been given some information when admitted. Some wards had admission packs or information that they gave to patients.

Some wards had developed staff information boards, with information and pictures from staff about themselves, and patients reported that they found these helpful in getting to know staff on the wards. On Keats wards, patients had organised to develop a similar board for patients to share a little information about themselves.

Staff involved patients and gave them access to their care planning and risk assessments.

Most patients that we spoke to had copies of their care plans. Some patients described detailed involvement in drawing these up. When we reviewed records, there was evidence of patients being given care plan copies at Meadowbrook, Park House, Laureate House, Griffin ward and Atherleigh Park.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Patients told us they had received information about their care and treatment from staff, including written information about conditions and medication choices. Patients who did not speak English as their first language told us they had received translated information, including relating to their rights under the Mental Health Act. We saw individual plans drawn up using pictures and easy-read formats for patients who preferred this.

Staff involved patients in decisions about the service, when appropriate. Some wards had developed "you said, we did" boards, with a colourful board at Beech ward including photographs and simple explanations felt to be striking and effective.

Patients could give feedback on the service and their treatment and staff supported them to do this. Community meetings were held at each ward although the frequency and format of these varied between services. Some wards did not record who attended which made it difficult to know if they were capturing feedback from most patients or if meetings were effective.

Bronte ward meetings included actions to follow up and included summaries of discussions and actions from patients contributing. Some wards used a mutual help agenda and format. Elm ward meetings showed who had attended and used a mutual help agenda with rounds of thanks, news, suggestions and requests. Medlock and Irwell ward meetings were well attended with lots of suggestions and discussions.

Staff made sure patients could access advocacy services.

Patients told us they were aware of advocacy services. At some sites, there were specific advocacy sessions including for patients who identified as from a black, Asian or minority ethnic background. At some sites, there were also regular clinics run by organisations to assist with welfare rights or housing.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We spoke to 10 carers. Staff supported, informed and involved families or carers.

Patients told us their loved ones were able to visit, including children where appropriate. Carers were able to attend ward rounds and meetings when patients wanted them to attend, including some carers whose attendance was worked around other commitments.

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

Carers were all broadly positive about the support for their loved ones, including engaging with therapy and psychology support, nursing staff and their knowledge of patients and being able to attend multidisciplinary reviews, either in person or via virtual meetings. Some carers had regular calls set up to keep them up to date with plans and progress. There were some individual situations where carers felt that staff went beyond their expectations, with examples around liaison and attendance with medical and acute hospital care and one carer who reflected that previous support for them when their loved one was nursed in seclusion, including daily calls.

Some themes raised by carers were around staffing levels and impact on support available, limited involvement in discharge planning and limited activities on wards. There was mixed feedback about being able to ring in to wards and calls not being answered for some carers, whereas other carers reported they had no problems contacting wards. Some carers noted limited space available in some settings for visits, with use of quiet rooms and activity rooms that did not always feel welcoming.

At Atherleigh Park, there was space at the entrance to the wards for visitors seating and carers information. Staff helped families to give feedback on the service. Carers mostly knew how to complain and who to speak to if they had concerns. Some carers had positive feedback and praise and weren't aware of how to pass this on.

At Park House, there were staff who had put themselves forward as carer champions for each ward and they had recently run events for Carers Week. There was a monthly carers meeting and carer information packs on the wards to send out to carers. At Atherleigh Park, there was a carers support group which ran on a monthly basis, and staff were aware of local carers services for people to access.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

A bed was not always available when a patient needed one. Patients were moved between wards when this was not for their benefit. Patients did stay in hospital when they were well enough to leave.

Bed management

Bed occupancy regularly exceeded 100%, this meant that patients did not always have access to a bed when they needed it.

The demand for acute admission beds exceeded capacity. The trust had contracted beds with other providers to help with demand. However, there were still excessive waits for acute admission beds with over 100 incidents logged in the last 12 months related to bed management and non-availability.

Six incidents related to patients who were subject to recall under community treatment orders waiting in the community whilst a bed was sourced, including a patient where a bed was not found and 10 days after a bed was requested the community order expired.

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

The trust noted that bed occupancy figures within Adult Acute Functional and PICU wards were consistently over 100%. The trust reported bed occupancy to commissioners and shared with NHS Gold Command on a weekly basis, so all partners were aware of the pressures. Work was underway to help reduce the pressure on beds, including the use of capacity in the North West Bed Bureau and a programme of work around Healthier Patient Pathways.

The lack of bed availability had a direct impact on patients, who often waited for a bed to become available or were admitted to unsuitable accommodation.

Patients on overnight leave or absent without leave did not have a bed to return to on at least five occasions.

There were 22 incidents where patients no longer required seclusion, but there was no bedroom on their ward available for them to return to.

In order to cope with demand, across this core service, the trust had introduced the use of "surge beds" as additional acute capacity. These additional bedrooms were created in quiet rooms, visitors' rooms, lounges and activity rooms. There were 11 in total. There were 654 instances in the last 12 months where use of a "surge bed" was documented. The "surge bed" on Griffin ward was used twice for patients under 18 years old. Whilst the policy for use of additional beds had been adopted during the pandemic, and the procedure for use of these reviewed in February 2022 and an escalation process included, these were still in use regularly across all wards with 36 instances during April and May 2022. Additional beds had been in use across the trust consistently for the past 12 months. Although these arrangements were for periods of exceptional demand and there was an escalation process in place these "surge beds" were being used on a regular basis. The risks of having regular increased bed numbers had not been recognised in terms of additional staffing establishment. Some surge bedrooms were identified as high risk areas on ligature risk assessments.

The revised policy also included guidance for staff on the use of seclusion rooms, 136 suites and a process entitled safe waiting, for when a bed was not available anywhere and a patient was admitted to the ward/lounge. The policy advised that if no physical bed was identified a lounge area will be allocated exclusively to the service user to provide comfort whilst waiting for a bed. The policy did not detail what happened at night and where the patient will sleep if there was still no bed.

On one occasion, a patient was "admitted to the quiet room on Keats ward", a patient who returned from failed overnight leave slept in the lounge on MacColl ward and on another occasion a patient was admitted to the family room at Laureate House. One incident notes a patient sat in the waiting area in a recliner chair awaiting informal admission at Wigan and another a patient sat on the corridor quite distressed saying they wanted to go to bed, but no bed was available at Park House. One incident was reported in May 2022 where a patient was admitted into Bronte ward therapy room. The use of rooms and lounges as waiting areas and bedrooms presents risks in terms of ligature points and fittings, safe observations and also stops patients on the ward from using these areas. There was no additional staffing in place for this so staff had additional responsibility for patients newly admitted to their ward area above the maximum bed number.

Incident reporting over the last 12 months showed s136 suites used as additional beds on 33 occasions, including the rooms at Bolton, Meadowbrook, Park House. This included three instances where 136 suites were used as additional seclusion rooms. This meant that the s136 suites were in use and unavailable for their intended purpose as a place of safety for patients detained by the police and awaiting assessment. These suites were also not designed as seclusion facilities.

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

There were six psychiatric intensive care units across the trust. Assessments of patients on acute wards were carried out by staff from the unit. This included determining if a psychiatric intensive care bed was required, and if one was not immediately available advice on supporting the patient safely. The bed flow team determined if a trust bed was available, or a private bed elsewhere. Staff told us that they were usually able to access a psychiatric intensive care bed when necessary, but sometimes this may take several days.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

There were two patient flow calls per day to manage admissions, transfers and discharges. Additionally, huddles and meetings at each site reviewed patient progress and any obstacles to discharge or unmet needs. The meetings that we attended were well structured, focused and attendees were in a position to agree actions needed and who would undertake them.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

The trust collected information about delayed discharges and transfers and the reasons for these. Between 01/06/2021 and 31/05/2022 there were 148 instances across the trust. The highest number of delays related to care packages being developed, identification of residential placements and waits for specialist placements and supported accommodation placements.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Patients told us their plans for discharge could be delayed by a lack of available care co-ordinators in local community teams. This could impact on referrals and funding for discharge placements.

Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards did not always support patients' treatment, privacy and dignity. Each patient did not have their own bedroom with an ensuite bathroom and could not always keep their personal belongings safe.

Where patients had their own bedroom, most said they could personalise.

In the surge bedrooms we viewed, there was not always storage for patients' belongings, some rooms had no window and access to natural light and beds were seclusion mattresses.

The use of these spaces as bedrooms meant that patients lost access to rooms for quiet space, therapies or visits.

Five of the wards at Park House had four-bed dormitories. Each bed area had a solid wall with the neighbouring bay, and a curtain at the front. The trust had plans and had started work on building a new mental health unit on the hospital site to replace Park House, however this was not due for completion until 2024. Patients told us they did not always feel safe, that dormitories could be noisy and there was little privacy.

Patients did not always have a secure place to store personal possessions. At Park House, Meadowbrook and Moorside wards, patients had safes in their room, but these did not all work. The situation at Park House was particularly pressing

for patients, as they were staying in dormitories with no way to control access into their bed space when they were not there. Patients told us they were able to lock some possessions in the office safe on the ward but otherwise they would carry possessions around or sleep with them under pillows. Patients told us that possessions frequently went missing, including toiletries, clothes and phone chargers.

Staff used a full range of rooms and equipment to support treatment and care. Wards varied in terms of the layouts, size and rooms available. On some wards, there were plans to repurpose some rooms, including quiet rooms, with sensory equipment which wards had recently received funding for. Patients were positive about increasing space available to have spaces they could use when feeling distressed or needing somewhere to relax.

The facilities available on each of the wards varied, but patients had access to activity and clinic rooms. Some wards had separate rooms for physical examinations to the main clinic room.

All wards had an activity programme, but the availability varied between wards, as did the role and availability of staff to provide it. All wards had occupational therapy, and all wards had a support time and recovery worker or activity worker whose role was to provide and support activities for patients. Activity rooms were often used for multiple purposes, including sessions, visits and quiet areas.

Some wards within the trust had been able to commission external groups to facilitate sessions, including weekly music groups at Moorside and pet therapy sessions across many of the wards and these were well received by patients. At Atherleigh Park, there were time for change groups which focused on substance misuse and motivation. There were also recovery groups, including a recovery through art group.

At most sites, there was activity provision off the wards, with the Meadowbrook recreation room staffed by volunteers and providing a social space and planned activity sessions. Similarly, the activity room at the Moorside Unit was staffed by occupational therapy staff and used for social and therapeutic activity. Access was limited to wards at Moorside with only one ward at a time able to use the facilities, and no use at weekends.

Some wards had developed activity boxes to use for sessions at weekends. The services had quiet areas and a room where patients could meet with visitors in private. Some wards had visitor rooms on site, including Laureate House and Park House. At other wards, visits took place in rooms on the ward.

Patients could make phone calls in private.

Most patients preferred to use their own mobile phones, but there were phones available on all wards for patients to make or receive calls. Some wards had tablets that patients could use to pick up email or for music, movies and games.

The service had an outside space that patients could access easily. All the wards had outdoor space that were open for patients to use. This varied from ward to ward, and was freely accessible in some areas, but only accessible by stairs in others. Some of the outdoor space was attractive with plants and seating, but others were sparse and bare and appeared to be predominantly used for smoking. Most wards had been able to purchase outdoor seating and often outdoor exercise equipment. Some of the wards had developed sport areas for patients to use, including basketball and outdoor table tennis equipment. The garden areas at Moorside and Meadowbrook had been developed with a view to creating sensory spaces, with tactile planting and aromatic plants. Patients were involved in planning and maintaining these.

At Atherleigh Park, there was a public nature trail path which ran alongside the wards. Bedrooms were located on this side of the building. These bedrooms were overlooked from the pathway and were not one way glass. Outside there was a low hedge and no other screening offered patients privacy. The path was regularly used by the public.

Patients could make their own hot drinks and snacks and were not dependent on staff. On the psychiatric intensive care wards, access to kitchen areas was risk assessed and hot drinks were often made by staff on request.

The services offered a variety of good quality food. The food was of adequate quality and patients could make hot drinks and snacks at any time. All the wards had facilities for patients to make hot and cold drinks. The provision of meals was different at each site but they were provided from a central source on a rolling menu. Most of the patients were positive about the food quality on the wards.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Because of the short stay nature of the services, staff were able to signpost and link to support available around work and education for patients once discharged. The trust had developed voluntary and paid roles for patients looking to work within services, including peer support worker roles. At some sites, there were pre-discharge groups running, with support from external agencies to support discharge and future planning.

Staff helped patients to stay in contact with families and carers. Staff encouraged patients to develop and maintain relationships both in the service and the wider community. There was information available across services for patients to get involved in and access in the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Accessible bedrooms and bathrooms were available for patients in a wheelchair, or limited mobility. Staff told us that easy read information about medication and some other topics were available on the trust/other websites and were printed off for patients when required.

Across these services, there were a number of patients with autism and/or learning disabilities. Some patients had information including care plans in formats that worked for them. Learning disability teams remained involved and visited patients and supported staff when patients were admitted. Staff told us they were able to access learning disability and autism training.

Some wards were using the green light toolkit for patients with a learning disability.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The service had information leaflets available in languages spoken by the patients and local community. Patients had access to information on all the wards. There were notice boards and leaflet racks, which included a range of information. This included information about the ward, treatments, medication, advocacy and complaints.

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff and patients told us that interpreters and information in different languages were available when required.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. Patients were asked about spiritual support on admission, and there was access to chaplaincy and multifaith rooms throughout the trust.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. In the last 12 months, there had been 145 complaints raised about these services. There were 87 adult acute inpatient complaints upheld or partially upheld of all complaints closed. Actions taken from patient and carer complaints and feedback included developing procedures for carer contact, plans to improve activity provision and work underway to develop training and resources around trauma informed care.

The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

The trust told us about improvements made following feedback, we saw for example the focus on carer involvement and communication at Park House and work being undertaken in relation to trauma informed care in services.

At Laureate House, changes to the phone system and an answering service had been changed following carer and patient complaints. Similar complaints at Park House re unanswered phones had led to the purchase of cordless phones to ensure calls were answered.

The wards at Bolton had regular ward newsletters which included compliments and learning from incidents and complaints, in a well designed format.

The service used compliments to learn, celebrate success and improve the quality of care. A total of 149 compliments were recorded from June 2021 – May 2022. Many wards also had their own mechanisms for capturing feedback, including during community and staff meetings and displaying thank you cards.

Is the service well-led?

Inadequate 

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

Our rating of well-led went down. We rated it as inadequate.

Leadership

Local 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.

Leaders provide clinical leadership. The organisation had a clear definition of recovery and this is shared and understood by all staff.

Local leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide the appropriate care they within the constraints of staffing challenges and poor environment.

Local leaders were visible in the service and approachable for patients and staff. Managers and matrons completed regular walk arounds of their services. Senior executives had visited some sites in the months before inspection. However, although senior leaders spent time on the wards we did not see that their visits resulted in immediate changes or improvements.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff know and understand the vision and values of the team and organisation and what their role was in achieving that. The trust values were displayed throughout services and were printed on staff lanyards.

Some staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff at Park House told us they had been involved in service planning and meetings about the new service being built. However, staff at Wigan who had transferred over into the trust from another provider did not feel that good practice they had in place was valued or supported and they did not feel involved in changes that had taken place in the service.

Some staff in various parts of the trust felt their views were sought but that there was then no corresponding action taken or feedback about any action taken.

Culture

Most staff felt respected, supported and valued within their immediate services by their teams and managers.

The staff group as a whole had mixed morale and identified high levels of stress. Staff felt this was due to staffing levels and turnover of staff, particularly senior staff and managers on the wards.

Staff did not always feel valued and part of the organisation's future direction. Staff felt valued by their immediate ward managers however, at a more senior level they felt their concerns were not taken seriously or addressed, particularly in relation to staffing or patient safety. At a trust level, staff and managers felt decisions were made, for example in relation to staffing changes, patient moves and additional patients, which impacted on their ability to run services effectively.

Staff told us that whilst their views and opinions were sometimes sought, the issues and concerns they raised were not addressed and they did not receive feedback. Some staff said they had stopped raising issues, speaking of "becoming immune", "lip service", "just put up with it", "what's the point?"

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

At Atherleigh Park, we saw staff raising concerns about the trust culture, staffing levels and change being introduced, with the processes not being as thorough as the previous provider. At the time of this inspection, a meeting was being convened to review processes at Wigan, to identify duplication and align processes with other areas in the trust, however this was over 12 months after the transfer of services.

Staff appraisals included conversations about career development and how it could be supported.

The service responded proactively to bullying and harassment cases. At Park House, the managers had identified levels of staff abuse, including racial harassment, and had put measures in place to address this and to support staff.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

Staff had access to occupational health and an external counselling service. Psychologists held reflective practice and case formulation groups to support staff to work with clients more effectively and manage their own response to challenging situations. The trust had a staff wellbeing strategy, and there were local initiatives to support and recognise staff. For example, some wards had introduced ward based staff recognition and star of the week and on Laurel ward staff had worked on a working better together board with information about different countries and cultures that reflected staff backgrounds and celebrated these.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

Despite senior leaders visiting the wards, we identified a number of concerns during the inspection of this service where governance systems had not ensured the safe running of this service.

Wards were not safe and clean, environmental risks such as fire safety relating to smoking and management of ligatures had not been acted upon. Leaders had not acknowledged or proactively taken action to address these issues.

Issues in relation to mixed sex accommodation and sexual safety were not always identified or addressed. The trust stated they were committed to providing same sex accommodation within their services, but they had opened a further 16 bed mixed gender ward this year. They could not give a timescale or plan for achieving eliminating mixed sex accommodation, despite the NHS guidance originally published in 2012. The trust policy was devised in 2017, reviewed in 2019 and not reviewed since, despite the trust having three further mixed wards since then.

Managers had not prioritised mandatory training, supervision and appraisal to ensure staff were able to complete their roles to the best of their ability.

Managers did not have oversight of medicines management, clinic rooms and equipment. Clinic rooms were not all fully equipped, and staff did not check, maintain, and clean equipment consistently. Clinic room temperatures were not always recorded, and action was not taken when the temperature exceeded 25 degrees. Medicines fridge temperatures were not always checked, and staff did not always act when issues were identified.

The service did not have enough nursing and healthcare assistants to provide all the care and treatment expected to patients. Staff frequently worked under the minimum staffing establishment levels, there was not always a registered nurse present and the wards had unfilled shifts.

Ward based audits were undertaken by managers and matrons, but the results were not always acted on, for example, when we checked Mental Health Act audits some deficits had not been addressed. Named nurse audits highlighted areas for improvement, but there was little action and continued shortfalls, exacerbated by ward acuity and staffing. Managers noted a lack of information coming back to ward and service level, for example, managers relayed information about restrictive interventions to the trust, but no results were fed back down.

There wasn't a clear framework of what must be discussed at a team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Some staff meetings were held regularly and included a broad range of information and discussion, whilst others were not held regularly and had a narrow focus which did not include wider learning.

The trust was aware of the risks of having different systems in operation between sites, including the two electronic records systems at Wigan and across the trust and delays in being trained to access the systems, but this had not been addressed effectively.

Staff had implemented some recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Some issues, for example, in relation to ligature risks or risks highlighted on directorate risk registers, were unchanged despite having been identified in some cases years before.

Whilst staff undertook or participated in a wide range of local clinical audits there was no evidence of longer-term changes made or plans to re-audit.

Management of risk, issues and performance

There is little understanding or management of risks and issues, and there are significant failures in performance management and audit systems. A number of areas of risk identified during this inspection had not been managed and mitigated.

Staff maintained and had access to the risk register at facility or directorate level. Staff at service level could escalate concerns when required. Staff had the ability to submit items to the provider risk register. Staff concerns matched those on the risk register.

The directorate risk register was split into the separate services and local risks were highlighted. Some of the risks had been added to the register in previous years, for example, environmental issues at the Laureate House site, including barricade risks, observation panels and windows were added to the risk register in March 2017. Mattresses and fire safety in relation to Park House was added to the risk register in December 2017 with new mattresses ordered in 2022 but not yet delivered. Anti-barricade door issues had been added to the Salford register in 2019 but there had been no action taken to address this risk.

The service had plans for emergencies – for example, adverse weather or a flu outbreak. There were continuity plans in place for all service areas.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service used systems to collect data from facilities and directorates that were not over-burdensome for frontline staff. Data was collected from the electronic records system and incident reporting systems.

Staff did not always have access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, did not always work well.

Staff noted there were not always sufficient computer terminals available on wards, and in some areas the computers ran slowly, we witnessed staff logging in to systems with a prolonged wait in some settings. At some sites, staff reported issues with the phone system in use, with incoming calls not working or problems with equipment including headsets and speakers.

The majority of the wards used one electronic records system. In the Wigan services, a different electronic records system was used. When patients transferred into and from the Wigan services, there was no access to previous records or history if these were on a different system. Services relied on the previous ward printing and sending the most recent documentation.

Staff told us they waited a considerable time before they could access training to use either of the recording systems. We met staff who had worked within services for up to five months with no access to electronic records.

Agency and external bank staff couldn't access the records systems and they were unable to access information on the trust intranet or the incident recording system. This meant they were dependant on permanent staff being available to print information they needed which was not an effective system to mitigate the risks.

Information technology worked well with the use of virtual meetings for patient reviews, enabling carers and care co-ordinators to dial in to meetings and allowing flexibility for attendance.

Information governance systems included confidentiality of patient records.

Staff made notifications to external bodies as needed.

All information needed to deliver care was stored securely.

Engagement

Information about the ward and local services was on display in the wards. Patients were given an information pack about the ward when they were admitted. Patients and carers were able to give feedback about the service, either directly to the ward staff or through its patient advice and liaison service or complaints team. There was information on the trust website for patients and carers.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

The services collected data using the friends and family test, with 271 responses in the last 12 months. For the majority of the 12 months, there had been higher positive than negative or neutral responses received overall.

The highest positive responses were around confidence and trust in staff, with lowest responses around activity provision and interventions.

Learning, continuous improvement and innovation

The organisation had a number of quality improvement initiatives taking place across their wards and services.

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

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

Priestners ward had been accredited under the previous NHS provider as part of the Royal College of Psychiatrists Quality network for psychiatric intensive care services. The end date for this was August 2022. Chaucer ward had been previously accredited under the same scheme but shows as accreditation suspended at the time of this report.