

Greater Manchester Mental Health NHS Foundation Trust

Inspection report

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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.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Outstanding 

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.

Summary of findings

Background to the trust

Greater Manchester Mental Health NHS Foundation Trust was formed on 1 January 2017, following Greater Manchester West NHS Foundation Trust's acquisition of Manchester Mental Health Social Care Trust. One of the reasons that the trust took over Manchester services was to enable further improvements to be made. Greater Manchester Mental Health NHS Foundation Trust provides community-based and inpatient mental health care and treatment to a population of 1.2 million people living in Salford, Bolton and Trafford and Manchester. The trust employs around 4750 staff. The trust provides a wide range of more specialised mental health and substance misuse services across Greater Manchester and the North West of England. The trust also provides in reach services to prisons across the north of England. The trust has one of three national sites providing care for people who are deaf and an inpatient mother and baby unit which provides care to mothers and their babies in the North West.

Greater Manchester Mental Health NHS Foundation Trust has a total of 13 registered locations serving mental health needs. There are 851 beds across the trust in 58 wards. The trust provides 347 outpatient clinics a week and 369 community clinics per week. Over a year the trust expects to provide care to 53000 people.

The trust is commissioned to provide services by a number of organisations: NHS England for specialist commissioning of forensic and children and young people's services. The local clinical commissioning groups which the trust works with are in Bolton, Salford, Trafford and Manchester. The trust is also part of the Salford Together partnership, one of the first integrated care organisations in the country. These commissioners sit within the Greater Manchester Combined Authority and are part of the Greater Manchester Health and Strategic Partnership. The trust sits within the Greater Manchester Sustainability and Transformation Plan.

We last inspected the trust in June 2016 when it provided core services in Bolton, Salford and Trafford. At that inspection, we rated the trust as good overall with the safe domain rated as requires improvement. We found that the trust did not comply with regulation 10- dignity and respect, regulation 12 – safe care and treatment, regulation 17 – good governance and regulation 18 -staffing.

Since June 2016, the trust had 25 Mental Health Act reviewer visits. The most common themes were failing to record how leave went and when rights were explained to patients, and care plans failing to capture patient views.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good ● → ←

What this trust does

The trust provides mental health services to people living in Bolton, Salford, Trafford and Manchester. It also provides more specialised services to people living in the North West and beyond.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Summary of findings

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

Our ratings are based on our judgement of the services that the trust managed before the acquisition. We take this approach so we do not discourage trusts from taking over failing services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected two of the trust's mental health core services, child and adolescent mental health wards and wards for older people because at our last inspection in June 2016 we rated them as requires improvement.

The three other core services we inspected as part of our continual checks on the safety and quality of healthcare services were:

- acute wards for adults of working age and psychiatric intensive care units
- long stay/rehabilitation mental health wards for working age adults
- substance misuse services.

The trust provides a further four core services which we did not inspect:

- community-based mental health services for adults of working age
- mental health crisis services and health-based places of safety
- community-based mental health services for older people
- forensic inpatients/secure wards.

All these services had been rated good at the last inspection. Where services were not complying with regulations, and we have not inspected, we have monitored the trust's actions and are assured of progress.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed *Is this organisation well-led?*

What we found

Overall trust

Our decisions on overall ratings take into account factors including the relative size of services and we use our professional judgement to reach a fair and balanced rating.

Our rating of the trust stayed the same. We rated it as good because:

- We rated eight of the nine core services as good, with one service rated as requires improvement. This takes account of the ratings of the four core services that we did not inspect this time
- We rated safe as requires improvement, effective, caring, responsive as good.
- We rated well-led at trust level as outstanding. The leadership team had effective oversight of the risks and challenges for the trust. They had overseen a very quick acquisition of a failing trust and were managing to maintain a strong clinical and financial performance. The trust was working in partnership with other organisations, including the

Summary of findings

housing and voluntary sector to promote well-being and good mental health. The trust carried out thorough investigations into serious incidents and had well established systems for learning lessons. The trust apologised when things went wrong. There were established systems for involving carers and service users with the transformation plans in Manchester demonstrated true co-production.

- Staff generally managed risks well, with risk assessments well completed and reviewed. Staff recognised and reported safeguarding concerns and incidents. Staff understood the duty of candour. Although there were vacancies and sickness, systems ensured there were sufficient staff. Although some training courses were below trust target, the trust had taken steps to ensure there were enough skilled staff to provide care. Medicines were managed safely. Risks related to the two electronic management systems were being managed.
- In four of the five core services we visited, care plans were holistic and patient centred. This was not always the case in acute wards for working age adults and psychiatric intensive care units where care plans were not always personalised. There was a comprehensive audit programme and effective systems to monitor action plans. Although people's rights who were detained under the MHA act were protected, we found that in wards for older people, there were issues with forms of authorisation and requests for second opinion doctors.
- Feedback from people using the service was positive, with patients and carers telling us that staff were supportive and kind. Patients and carers gave us examples where staff had gone the extra mile to support them. People were generally involved in planning their care although this was not always the case in acute wards for adults of working age and psychiatric intensive care units. Feedback from substance misuse services was universally positive during the inspection and received the highest proportion of compliments by the trust.
- Services were responsive to the needs of the population they served. Following the acquisition of Manchester out of area placements were high; the trust had plans in place to address and effective systems to monitor this. The transformation plans in Manchester were reviewing care pathways to improve access to services. Staff, patients and carers were involved in developing services. Complaints were well handled locally and at trust level.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- We rated three of the nine core services as requires improvement and six as good. We took into account the ratings of services not inspected this time.
- In acute wards for working age adults and psychiatric intensive care units, staff had not always identified environmental risks and staff were not aware of them. There were blind spots and staff had not mitigated these in Eagleton, MacColl and Chaucer wards. There were environmental concerns in acute wards for working age adults and psychiatric intensive care units, Eagleton and Keats wards had challenges with their plumbing and drainage systems. There were stains on the ceiling of Eagleton and Blake wards. The outdoor space at Maple House and Elm ward contained cigarette ends and rubbish at Maple House. Anti-barricade doors did not open both ways for three of the rooms on Brook and Medlock wards.
- In acute wards for working age adults and psychiatric intensive care units, staff were not following the trust's policy in relation to rapid tranquilisation. The monitoring forms for physical observations were not always available within records.
- In child and adolescent mental health wards, checks to ensure that equipment was safe to use had not always been carried out.

However:

- Staff assessed and managed risks. Staff completed risk assessments with patients which were reviewed as necessary. There were no blanket restrictions.

Summary of findings

- Staff recognised abuse and reported safeguarding and incidents effectively. Staff and patients received a debrief following incidents.
- Staff understood the duty of candour and followed trust processes. There were supportive systems in place to help share learning after things went wrong.
- Medicines were managed well, with a good level of support from the pharmacy team. Although, staff were not always using the trust monitoring form after using rapid tranquilisation, staff were usually recording observations to monitor people's health.
- All wards complied with the guidance on same sex accommodation.
- Although there were high vacancy rates, agency, bank and locum staff were used to keep people safe.
- There were challenges with two electronic management systems in place which were being managed.
- There were established systems for sharing learning. Staff described learning events as positive and supportive.

Are services effective?

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

- We rated seven of the nine core services as good and two as requires improvement. We took into account the ratings of services not inspected this time.
- The trust provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs. The service made adjustments for patients' religious, cultural and other preferences.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Although the trust was using two electronic management systems since acquiring Manchester services, the trust had taken steps to reduce the risks associated with this. There were plans in place to align the systems once remedial work had been completed
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- In wards for older people, authorisation was not always in place for giving medicines to people who were detained under the Mental Health Act.
- In acute wards for working age adults and psychiatric intensive care units staff were not always receiving regular supervision.
- Care plans were not always person centred in acute wards for working age adults and psychiatric intensive care units.

Summary of findings

- Not all patients with a learning disability who were being cared for on acute wards had care plans in an accessible format.

Are services caring?

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

- We rated eight of the nine core services as good and one as outstanding. We took into account the ratings of services not inspected this time.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.

However:

- In acute wards for working age adults and psychiatric intensive care units, staff did not always give patients a copy of their care plans.

Are services responsive?

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

- We rated eight of the nine core services as good and one as outstanding. We took into account the ratings of services not inspected this time.
- The trust planned and provided services in a way that met the needs of local people. The trust was transforming the delivery of care in Manchester and working to reduce the number of out of area placements. Patients, carers and staff were involved in the plans and listened to.
- The service took account of patients' individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- There was a strong focus on recovery with the use of the recovery model and a vibrant recovery college which was highly valued by staff, patients and carers.

Are services well-led?

Our rating of well-led improved. We rated it as outstanding because:

- The entire inspection team were struck by how well the leadership team had brought the Manchester services into the trust and improved them. The relationships with stakeholders for Manchester services, including staff, unions and commissioners had improved. There was a strong commitment to provide the best care for all patients across the service.
- Leadership, governance and culture promoted the delivery of high quality care. Leaders were visible and approachable. Leaders understood the challenges to the service and took actions to address them. Staff across services spoke highly of the leadership shown during the acquisition of Manchester services.
- Leaders understood the challenges for the trust and worked together to ensure delivery of services.

Summary of findings

- Strategies and plans in place were challenging and innovative and fully aligned with the wider health economy. There was a systematic and integrated approach in place to monitor the progress against plans. Plans were consistently implemented and had a positive impact on the quality of services. This was seen in the transformation plans for Manchester.
- There was an open and transparent approach when things went wrong. Staff were proud to work for the organisation and spoke highly of the culture. Although staff were encouraged to speak up and there were systems in place to support this, the freedom to speak up network needed further embedding throughout the trust.
- The trust had reviewed their governance arrangements to reflect best practice. Structures and processes were clearly set out and staff understood their responsibilities.
- The trust identified, monitored and responded to current and future risks. There were effective audit processes in place and actions were taken when issues were identified. Service developments and cost improvement plans were developed with clinicians so that their impact on quality of care was understood.
- The trust engaged constructively with staff and people who use services and developed services with their full participation. The trust showed that there was a commitment to act on feedback and co-production was evident in service development and training.
- The trust gathered information to monitor and improve performance where necessary. Plans were in place to align the electronic information system across the trust following acquisition and plans in place to manage the risks whilst this was happening.
- The trust worked proactively to gather people's views about services. The trust had mature, open relationships with stakeholders about performance.
- There were systems in place to support improvement and innovation. The trust were committed to implementing more sustainable models of care and worked collaboratively with others to share learning and make improvements.

However:

- Although the trust has made great progress, there was still work to do to bring all services to a consistent level.
- Although, there were networks and actions to promote opportunities for all staff, there was poor representation of staff from all backgrounds at management level.
- The trust held figures for training did not reflect locally held figures in the services which were higher.
- The freedom to speak up guardian role needed further embedding.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found four examples of outstanding practice in two services.

For more information, see the Outstanding practice section of this report.

Summary of findings

Areas for improvement

We found areas for improvement including breaches of four regulations that the trust must put right. We found 23 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued five requirement notices to the trust. Our action related to breaches of four legal requirements in three core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

In substance misuse services:

The rapid access to alcohol pathway provided by the Chapman Barker Unit was an innovative and effective service. The service was introduced in 2013 in part due to the high number of alcohol related admissions to general hospitals. The service accepted referrals from all accident and emergency departments; ten in total, across Greater Manchester and provided rapid access to specialist detoxification as an alternative to hospital admission. The service has received recognition from a variety of areas including winning the non-age specific psychiatric team of the year in 2014 from the Royal College of Psychiatrists. Independent reviews of the service estimated that it saved the local health economy over £1 million by reducing alcohol related admission to acute hospitals. The service was highly praised by clients and commissioners during our inspection process.

The trust had established a building recovery in communities asset fund. This was used to support a range of recovery orientated groups and projects including allotments, training cafes, theatre groups and gym access.

In child and adolescent mental health wards:

The service had a close relationship with Independent Mental Health Act Advocacy providers, and recognised the importance of the role of advocates. This had led to the formation of an advocates working group from each of the different advocacy providers. The working group worked with the senior leadership team, meeting quarterly to assess and evaluate the impact of individual policies on young people and their thoughts about these.

The service worked with other agencies to identify opportunities for volunteering and part time work for patients, including within the hospital.

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Summary of findings

Action the trust **MUST** take to improve

We told the trust that it must take action to bring services into line with four legal requirements. This action related to three services.

In acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that staff receive regular supervision.
- The trust must ensure that staff receive the appropriate training for their role including learning disability training.
- The trust must ensure that the ligature audits are an accurate reflection of the ward and are shared with staff and environmental challenges shared at staff's induction to the ward.
- The trust must ensure that they mitigate blind spots in Eagleton, MacColl and Chaucer wards.
- The trust must ensure that care plans are person centred and written in an accessible way for patients.

In wards for older people with mental health problems:

- The trust must ensure that Mental Health Act documentation is completed correctly on all wards. This includes ensuring that medication is authorised correctly under section 62 and that second opinion doctors are requested in a timely manner to ensure that treatment is given under the correct authority.
- The trust must ensure that on Cavendish ward, staff explain Section 132 rights to patients on admission and at relevant points during their detention.

In child and adolescent mental health wards:

- The trust must ensure that all safety checks are completed so that equipment is in date and safe to use.

Action the trust **SHOULD** take to improve

Trust wide:

- The trust should continue to embed the work of the freedom to speak up champion so that all staff are able to raise concerns.
- The trust should continue work to ensure people are treated the same as others and have the same opportunities.
- The trust should improve the system for monitoring training rates so that local and centrally held figures align.

In acute wards for adults of working age and psychiatric intensive care units:

- The trust should review the arrangements for measuring fridge temperatures, ensuring there is the range of temperatures recorded and prompt action taken when a reading is outside of the recommended range.
- The trust should ensure staff follow the trust's policy in relation to the administration of rapid tranquillisation, that the monitoring of physical observations takes place, is recorded, and the records are accessible.
- The trust should ensure anti-barricade doors open both ways on Brook and Medlock wards.
- The trust should review the environment of Eagleton and Keats wards to ensure that the ward is free of odours, the drainage is working and the showers are clean and hygienic to use.
- The trust should review the process in supporting patients to complete advanced statements and decisions regarding their care and treatment.
- The trust should review access to psychology provision across the wards.

Summary of findings

- The trust should review the contribution of other disciplines within the team in the care planning process.
- The trust should ensure staff have enough time to share the important information regarding patients, especially on Bronte ward where there are 31 patients and 15 minutes allocated.
- The trust should ensure all relevant policies reflect the Mental Health Act code of practice 2015.
- The trust should ensure patients have their section 132 rights explained to them and that it is recorded.
- The trust should ensure that staff offer patients a copy of their care plan and that staff document this.
- The trust should consider how agency staff work in line with the values of the service and deliver the level of care expected.
- The trust should review the numbers of staff trained to support patients to access the gym to increase the opportunity for patients to access the gym at Meadowbrook hospital.
- The trust should ensure there is information on display on all wards to advise patients how they can contact the Care Quality Commission.
- The trust should continue progressing with their plans to eliminate dormitories.

In wards for older people with mental health problems:

- The trust should ensure that observations following rapid tranquilisation are recorded on the correct paperwork to ensure this is easily located on one document during an emergency and for audit purposes.
- The trust should ensure staff at Woodlands hospital are aware of the procedures to use rapid tranquilisation at Woodlands Hospital.
- The trust should ensure that patients' privacy and dignity is protected by ensuring that privacy screens on bedroom windows are not routinely left open when patients are in their bedrooms.
- The trust should consider the use of privacy curtains in the bathrooms on the main corridor on Bollin ward.
- The trust should consider that there is a quiet space where patients can relax on Bollin and Greenway wards and an alternative space to the main lounge for activities.

In child and adolescent mental health wards:

- The trust should ensure that patients understand their medication so that they can be effectively involved in decisions about their medication.

In substance misuse services:

- The trust should ensure consistent use of alarm systems within community-based services.
- The trust should ensure services hold a register of substances deemed hazardous to health.
- The trust should ensure that consideration of mental capacity is recorded.
- The trust should ensure that staff are compliant with mandatory training.

In long-stay or rehabilitation mental health wards for working age adults:

- The trust should ensure that the refurbishment of Acacia ward is considered with some urgency.
- The trust should ensure that electronic systems designed to collate information regarding mandatory training collate all data to give a true recording of the efforts of staff to stay up to date with training.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as outstanding because:

- The entire inspection team were struck by how well the leadership team had brought the Manchester services into the trust and improved them. The relationships with stakeholders for Manchester services, including staff, unions, commissioners had improved. There was a strong commitment to provide the best care for all patients across the service.
- Leadership, governance and culture promoted the delivery of high quality care. Leaders were visible and approachable. Leaders understood the challenges to the service and took actions to address them. Staff across services spoke highly of the leadership shown during the acquisition of Manchester services.
- Leaders understood the challenges for the trust and worked together to ensure delivery of services.
- Strategies and plans in place were challenging and innovative and fully aligned with the wider health economy. There was a systematic and integrated approach in place to monitor the progress against plans. Plans were consistently implemented and had a positive impact on the quality of services. This was seen in the transformation plans for Manchester.
- There was an open and transparent approach when things went wrong. Staff were proud to work for the organisation and spoke highly of the culture. Although staff were encouraged to speak up and there were systems in place to support this, the freedom to speak up network needed further embedding throughout the trust.
- The trust had reviewed their governance arrangements to reflect best practice. Structures and processes were clearly set out and staff understood their responsibilities.
- The trust identified, monitored and responded to current and future risks. There were effective audit processes in place and actions were taken when issues were identified. Service developments and cost improvement plans were developed with clinicians so that their impact on quality of care was understood.
- The trust engaged constructively with staff and people who use services and developed services with their full participation. The trust showed that there was a commitment to act on feedback and co-production was evident in service development and training.
- The trust gathered information to monitor and improve performance where necessary. Plans were in place to align the electronic information system across the trust following acquisition and plans in place to manage the risks whilst this was happening.
- The trust worked proactively to gather people's views about services. The trust had mature, open relationships with stakeholders about performance.
- There were systems in place to support improvement and innovation. The trust were committed to implementing more sustainable models of care and worked collaboratively with others to share learning and make improvements.

However:

- Although the trust has made great progress, there was still work to do to bring all services to a consistent level.

Summary of findings

- Although, there were networks and actions to promote opportunities for all staff, there was poor representation of staff from all backgrounds at management level.
- The trust held figures for training did not reflect locally held figures in the services which were higher.
- The freedom to speak up guardian role needed further embedding.

Ratings tables

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
Requires improvement ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Outstanding ↑ Feb 2018	Good ↔ Feb 2018

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.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↔ Feb 2018	Requires improvement ↓ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Requires improvement ↓ Feb 2018
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
Forensic inpatient or secure wards	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Child and adolescent mental health wards	Requires improvement ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
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
Community-based mental health services for adults of working age	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Mental health crisis services and health-based places of safety	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
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
Overall	Requires improvement ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Good ↔ Feb 2018	Outstanding ↑ Feb 2018	Good ↔ Feb 2018

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.

Substance misuse services

Outstanding 

Key facts and figures

Greater Manchester Mental Health NHS Foundation Trust provides community and inpatient substance misuse services. The trust's service provision covers a wide geographical area. The trust provides services in:

- **Cumbria.** The trust provides community-based drug and alcohol services from five locations across Cumbria under the branding 'Unity'. The five locations are Barrow-in-Furness, Carlisle and Eden, Whitehaven, Kendal and Workington. The service offers support and advice around substance misuse and provides clinical and psychological interventions for clients with drug and alcohol issues. The service works with partner agencies within the local treatment network.
- **Salford.** The trust is the lead provider within the Salford substance misuse treatment network. The trust provides community-based drug and alcohol services from four locations under the branding 'Achieve'. The four locations are The Orchard Community Hub, Acton Square, King Street and a young people's service. The service offers support and advice around substance misuse and provides clinical and psychological interventions for clients with drug and alcohol issues. The service works with partner agencies within the local treatment network
- **Trafford.** The trust provides community-based drug and alcohol services to the population of Trafford under the branding 'AIM'. The service is delivered from a central location in Trafford and from satellite clinics. The service offers support and advice around substance misuse and provides clinical and psychological interventions for clients with drug and alcohol issues. The service works with partner agencies within the local treatment network
- **Central Lancashire.** The trust provides community-based drug and alcohol services from three locations in central Lancashire under the branding 'Discover'. The three locations are Preston, Chorley and Skelmersdale. The service offers support and advice around substance misuse and provides clinical and psychological interventions for clients with drug and alcohol issues. The service works with partner agencies within the local treatment network
- **Wigan and Leigh.** The trust provides community-based drug and alcohol services from one location in Wigan and one location in Leigh as well as from satellite clinics. The services are delivered under the branding Wigan and Leigh Recovery Services. The service offers support and advice around substance misuse and provides clinical and psychological interventions for clients with drug and alcohol issues. The service works with partner agencies within the local treatment network.

In addition the trust provides inpatient substance misuse services from two inpatient wards at the Chapman Barker Unit in Prestwich, Greater Manchester. The two wards are:

- **Apollo ward,** a 24 bed male ward for individuals requiring detoxification from alcohol or drugs
- **Athena ward,** a 12 bed female ward for individuals requiring detoxification from alcohol or drugs

Within their 36 bed provision the Chapman Barker Unit offered a rapid access to alcohol detoxification pathway. The pathway was open to male and females who attended accident and emergency departments across Greater Manchester. The unit offered up to eight rapid access to alcohol detoxification placements at a time. Clients on the pathway were admitted to the relevant ward dependent upon their gender. There was not a separate ward for rapid access to alcohol detoxification clients.

The service has not previously been inspected by the Care Quality Commission. On this inspection, we looked at all five key questions. The inspection was unannounced.

Substance misuse services

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information. During the inspection we:

- reviewed the environment and facilities of six community services and the inpatient wards
- spoke with 35 clients and reviewed 27 comment cards
- spoke with team managers in each community service and the ward manager at the Chapman-Barker Unit
- spoke with 59 staff including service managers, doctors, nurses, recovery workers, recovery coaches, support and therapy workers, volunteers and an occupational therapist
- reviewed 41 care records
- reviewed seven prescription charts and associated documentation
- observed one medication round, one shift handover, one ward round, one team meeting, one safeguarding meeting, one daily risk assessment meeting and four client assessments.
- observed five therapy groups.
- reviewed 19 staff files
- reviewed policies and procedures used in the running of the service.

Summary of this service

We have not previously inspected substance misuse services. We rated it as outstanding because:

- There was a very strong recovery emphasis throughout the service. Staff worked with clients to help identify their goals and to develop their recovery capital. Staff were knowledgeable about local recovery and support services and they were promoted within teams.
- Services were tailored to meet the needs of individuals and were delivered in a way that offered flexibility and choice. There were different pathways within community teams to address individual need and an innovative rapid access to alcohol detoxification pathway within inpatient services.
- Client and carer feedback on the service was overwhelmingly positive. Clients spoke highly of staff and their supportive nature. Clients and carers were active participants in care and in decisions about treatment. Carers were able to access carer assessments and relevant support.
- There was excellent multi-agency working. Services worked collaboratively with partner agencies within the local treatment network as well as with physical health services. There were clear referral processes into support services and mutual aid groups. Staff were active in facilitating client engagement.
- The service employed volunteers and peer navigators with lived experience of substance misuse and recovery. Clients we spoke with talked positively about staff members and the visual representation of recovery that they provided.
- There was excellent engagement with the community. Clients were encouraged and supported to attend community groups and services. There were community leads within teams to develop effective links and ensure that recovery was embedded within the team. There was a building recovery in the community asset fund that clients and staff could access to support new projects such as community allotments or trainee kitchens.
- Clients and carers were able to give feedback on the service they received in a variety of manners. The service responded to feedback and developed action plans to address concerns.

Substance misuse services

- Buildings were clean and well maintained. There were regular checks of equipment and maintenance records were in place. There were appropriate health and safety checks.
- Staff actively managed client risk. Staff worked collaboratively with clients to complete risk assessments and develop risk management plans. The service prescribed in line with risk assessments and utilised methods such as supervised consumption to manage the risk of overdose or diversion. There were strong processes and procedures to manage safeguarding concerns and effective links with local authorities.
- Staff had been trained to deliver psychosocial interventions. Services offered a range of one to one and group sessions to meet client need. Clients we spoke with were positive about the psychosocial interventions they received
- There was a good governance structure. Quality of service provision and performance was monitored. Service and team managers were well regarded by staff. The service engaged effectively with stakeholders when introducing change.

However:

- Staff in community services did not use personal alarms in a consistent manner.
- Staff in community services did not always record consideration of mental capacity.
- We found three care records where there was no consent to treatment or confidentiality agreement in place.
- Although information sent by the trust showed six mandatory training courses below 75% compliance, local figures and staff confirmed training rates were higher. We observed skilled staff, competent in their role.

Is the service safe?

Good 

We have not previously inspected substance misuse services. We rated it as good because:

- Buildings and premises were clean and well maintained. Equipment was checked regularly and was fit for purpose. Staff completed annual health and safety and fire safety assessments. Weekly and monthly checks were in place for fire detection and fire-fighting equipment.
- Staff assessed and managed client risks. Risk management plans reflected the findings of risk assessments. Staff completed activity specific risk assessments, for example around clients' safe storage of medication at home.
- Staff managed safeguarding effectively. Staff demonstrated a good understanding of safeguarding principles and how to identify concerns. There were good links with local safeguarding services in each area and established procedures to raise safeguarding alerts.
- Staff were skilled and competent. Although staff received mandatory training to support them in their role, centrally held training figures did not reflect local training rates.
- There were processes to ensure shared learning as a result of adverse incidents and complaints. Shared learning events were held across the service quarterly.

However:

- Sites did not hold an itinerary of materials that met control of substances hazardous to health standards. The requirement to have an on-site list of substances was detailed in the trust health and safety policy. However staff did have access to product safety sheets in the event of an incident.

Substance misuse services

- There was inconsistent use of alarms within community teams. Staff had access to personal alarms but did not always use them.

Is the service effective?

Good 

We have not previously inspected substance misuse services. We rated it as good because:

- The service and staff was recovery focused. There was a strong emphasis on community engagement, mutual aid the development of recovery capital. Services employed volunteers and peer navigators who provided a visible example of recovery to clients.
- Staff planned care and treatment in line with current evidence based guidance, standards, best practice and legislation. Community teams offered different pathways to clients to ensure they received treatment best suited to their need.
- Assessments were completed in a timely manner. Staff worked collaboratively with clients through the assessment process. Recovery stars were used to help identify client need and areas for development. Care plans reflected clients' goals and objectives.
- Medication was prescribed in line with Department of Health guidance. Staff completed relevant assessments and physical health checks before commencing prescribing and whilst the client was receiving medication.
- Information about clients care and treatment and their outcomes was routinely collected and monitored.

However:

- Consideration of mental capacity was not always documented within community teams. We found three care records without a completed consent to treatment form.

Is the service caring?

Outstanding 

We have not previously inspected substance misuse services. We rated it as outstanding because:

- Clients and carers were continually positive in their feedback about the service. They held staff in high regard and told us that care exceeded their expectations.
- Staff interactions we observed were highly supportive and very caring. Staff actively encouraged and facilitated the involvement of clients and carers in decisions about their care. Staff showed creativity to overcome obstacles to delivering care.
- Staff took a holistic approach to client needs and were committed to working in partnership with clients and carers. Assessment and care planning were collaborative processes that helped identify client needs and find ways to meet them. Staff empowered clients to have a voice and realise their potential.
- Staff and client relationships were very positive. Clients fed back that staff were highly supportive, motivated and personalised in their approach. There was a strong, visible person centred culture and a recovery focus. Staff were passionate about helping clients through their recovery.

Substance misuse services

- The service was engaged with the Triangle of Care programme to support carers. Carers had access to carer assessments and a range of support from staff and partner agencies. Carers we spoke with were positive about the support they received.
- Client and carers had the opportunity to give feedback on the service they received. Clients and carers were actively involved in decisions about the service. Clients had sat on interview panels for new staff. There was a recovery action group which meant quarterly to review services and suggest improvements.

Is the service responsive?

Outstanding ☆

We have not previously inspected substance misuse services. We rated it as outstanding because:

- The Chapman Barker Unit offered an innovative rapid access pathway for clients attending accident and emergency departments due to alcohol use. This meant that clients in crisis were able to access urgent help and pressures on bed admissions in acute hospitals were reduced.
- There was excellent engagement with the wider community. Services were fully embedded in local recovery communities and actively promoted client engagement with community services. There were community engagement leads and a building recovery in the communities asset fund which was used to develop new groups and activities.
- The Orchard community hub in Achieve Salford provided a community resource for clients and carers. As well as hosting the delivery of care the hub offered a range of community groups and a training café where volunteers could gain work experience and food hygiene qualifications
- There was a focus on discharge from the point of admission. Aftercare, community support and the development of recovery capital were central to the delivery of care.
- Services had clear admission procedures. Staff worked with clients and other professionals to ensure clients were placed on an appropriate care pathway to meet their need.
- Services were flexible and promoted access. Clients could self refer into community teams. Community teams offered flexible access including evening clinics. Services were proactive in engaging with hard to reach populations such as the homeless and the lesbian, gay, bisexual and transgender communities.
- There was a process in place to record complaints and compliments. The service accounted for 59% of compliments received by the trust between 1 June 2016 and 31 May 2017.

Is the service well-led?

Outstanding ☆

We have not previously inspected substance misuse services. We rated it as outstanding because:

- Leaders were inspiring and supported staff to succeed. The service worked closely with stakeholders to ensure strategies and plans were fully aligned with the local health economy.
- Team and service managers had the skills, knowledge and experience to perform their roles. Staff we spoke with told us that managers were accessible and supportive.

Substance misuse services

- Staff were positive about their roles and morale was good. There was a strong culture of team working and mutual support within the workforce. Staff awards were in place to recognise hard work and positive contributions.
- There was a governance structure and associated processes to assure the quality of service provision. Policies and procedures used by staff had been regularly reviewed and were in date.
- The service engaged with clients and staff over service changes and developments.
- There was a commitment to learning, continuous improvement and innovation.

However:

- There was work to do to ensure consistent standards in community services.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Child and adolescent mental health wards

Good  

Key facts and figures

The trust provided inpatient services for young people at its Prestwich site through two separate units.

Junction 17 unit had two wards with 20 beds in total which provided care and treatment for children and young people aged 13-17 who required assessment and treatment for a range of complex mental health difficulties.

The Gardener Unit was a 10 bedded medium secure child and adolescent mental health unit, for boys and young men aged between 13-18.

When the Care Quality Commission last inspected the service in June 2016, we found that the service had breached regulations. We rated the service as requires improvement overall with safe and well-led rated as requires improvement and effective, caring and responsive rated as good. We issued the provider with four requirement notices. These related to the following regulations:

- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 18 HSCA (RA) Regulation 2014 Staffing.

We inspected this core service to check that improvements had been carried out. We found that improvements had been made in all areas, however

As part of our next phase inspection programme we now ask providers to provide us with service specific information on a regular basis. Prior to this inspection visit, we reviewed the information that we had received about these services. We also asked other organisations to provide information and feedback on services.

We carried out an unannounced inspection of the child and adolescent mental health wards on 25 and 26 October 2017. During the inspection visit, the inspection team carried out a range of activities. These included:

- we visited both wards on Junction 17 and we visited the Gardener unit at the main hospital site, looking at the quality of the ward environment and how everyone interacted with one another to see how staff were caring for patients
- interviewed two ward managers for both units
- spoke with 14 patients who were using the service and two carers of patients
- interviewed the service manager
- spoke with an operations manager for the service
- interviewed a consultant
- spoke with four members of the nursing team
- spoke with a nurse practitioner and an advanced nurse practitioner
- spoke with an occupational therapist
- spoke with the lead consultant clinical psychologist for the service

Child and adolescent mental health wards

- spoke with a consultant psychologist, psychiatrist and a psychologist
- spoke with a pharmacist
- spoke with two social workers
- observed a care, education and treatment review meeting
- collected feedback from seven patients using a comment cards
- carried out medication management on both wards as part of which we reviewed six prescription charts
- looked at eight treatment and care records of patients
- observed lunchtime arrangements on both units
- observed a community meeting
- carried out a specific check of the clinics and emergency equipment on both units
- looked at a range of documents relating to the running of the service.
- spoke with one of the Independent Mental Health Act advocates who works within the service.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service had made improvements in many of the areas which previously were highlighted as concerns.
- There was a shared culture of embracing the organisational values.
- There was a culture of reporting concerns and learning from incidents.
- Use of restrictive practices was carefully monitored and used as a last resort.
- Risk awareness was taken seriously and there was evidence of regular risk assessments being conducted.
- The senior management team met routinely with staff and had a presence within clinical areas.
- There were real attempts to engage patients with every aspect of the service and develop their skills through work and education opportunities.

However:

- Although most equipment was checked so it was safe to be used, not all safety checks had been completed when due.
- The service did not always ensure patients understood interventions including medication.
- Although physical observations were usually carried out, in one case we could not find records to show they had been completed.

Is the service safe?

Requires improvement   

Child and adolescent mental health wards

Our rating of safe stayed the same. We rated it as requires improvement because:

- Checks of equipment were not always carried out when due. Electrical safety checks had not been completed in time on defibrillators, out of date equipment for diabetes testing which was no longer in use had not been returned to pharmacy and one oxygen cylinder and two oxygen masks were out of date.
- Patients told us that medication changes and their potential side effects were not always discussed with them prior to changes in medication or dosage being made.

However:

- The wards were clean and tidy.
- All areas were routinely checked to ensure they were safe and secure with action taken when this was not the case including an outdoor area to which access was restricted due to effects of the recent weather.
- Patients received regular physical health checks.
- There were regular risk assessments carried out and staff knew their patients well enough to understand how to respond to them
- The service had initiated positive steps to ensure staff used least restrictive interventions including implementing safe wards.
- Staff and patients knew when and how to report concerns or incidents
- Staff recognised abuse and reported appropriately.

Is the service effective?

Good ● → ←

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

- Patients could access psychological therapies.
- Staff received managerial and clinical supervision and were regularly appraised.
- Staff regularly communicated with local services and external agencies when planning and delivering care.
- Staff worked with patients to identify best communication strategies and actions to take when they needed help.
- The service worked closely with the independent Mental Health Act advocates to review effectiveness of its policies and procedures including the impact these had on patients.

However:

- Staff did not always ensure leave paperwork and copies of individual care plans were signed and dated and that these were given to patients.

Is the service caring?

Good ● → ←

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

Child and adolescent mental health wards

- We witnessed positive and respectful interactions between staff which were substantiated by patient and carers stating the caring relationships were built on trust and a genuine sense of concern.
- Staff showed a genuine interest in the wellbeing and needs of patients, which the patients and their carers spoke highly of and valued.
- There were opportunities for patients to engage in care planning and individual care plans included views of patients.
- Patients were encouraged to partake in giving their feedback through regular community meetings where by patients would meet with a number of staff and share their concerns and experiences regarding the ward.
- Patients were aware of the advocacy provision available to them.
- Advocates were informed of new admissions and seclusions when they occurred so that they could support patients.

Is the service responsive?

Good   

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

- The service responded positively to patients concerns about the food provision by ensuring there were a range of choices available.
- Discharge planning started on admission.
- Staff communicated with a range of other services and agencies when planning the patient's discharge.
- A range of activities were available for patients including at weekends.
- Staff managed complaints made by patients appropriately.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- The service had taken positive steps to improve and develop the service effectively. Audits were used to drive improvement along with senior staff observation visits. Senior colleagues accessed performance reports to ensure sufficient oversight into the running of the service
- There was a strategic plan in place to ensure the needs of young people were met whilst the service met changing constraints in the coming years.
- The senior team within the service had an awareness of patients and their individualised care.
- Staff we spoke with told us their managers supported them and found senior managers were approachable. Staff commented how cohesion and team working had improved and the positive impact the management team had on this.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Child and adolescent mental health wards

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Wards for older people with mental health problems

Good  

Key facts and figures

Greater Manchester Mental Health NHS Foundation Trust provides inpatient services for people aged 65 and above with mental health conditions. The services treat patients who are admitted informally as well as patients who are detained under the Mental Health Act 1983.

The trust had seven inpatient wards for older adults;

At Trafford General Hospital there were two wards;

- Bollin ward, a 10 bed mixed sex assessment ward for patients with a diagnosis of a functional mental health problem.
- Greenway ward, an 11 bed mixed sex assessment ward for patients with a diagnosis of an organic illness. Greenway ward also provides care for people at the end of their life.

At Woodlands Hospital;

- Delamere ward, a 15 bed female ward for people with a diagnosis of a functional or an organic mental health problem.
- Hazelwood ward, a 15 bed mixed sex assessment ward for patients with either a functional or an organic illness.
- Holly ward, a 20 bed male ward for patients with a diagnosis of a functional or an organic mental health problem and also cares for people at the end of their life.

At North Manchester General Hospital;

- Maple ward is a female ward for patients with a diagnosis of a functional or an organic mental health problem.

At Wythenshawe Hospital;

Cavendish ward is a male ward for patients with a diagnosis of a functional or an organic mental health problem.

When the Care Quality Commission last inspected the service in June 2016, we found that the service had breached regulations. We issued the provider with three requirement notices. These related to the following regulations:

- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The CQC rated the service as requires improvement in safe and effective, resulting in an overall judgement of requires improvement.

On this inspection, we looked at all five key questions. The inspection was unannounced.

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information. During the inspection visit, the inspection team:

- toured each of the seven wards including the clinic rooms

Wards for older people with mental health problems

- interviewed the ward manager or their deputy on each of the seven wards
- spoke to 34 other staff
- spoke to 38 patients and 11 carers
- reviewed the care records of 60 patients
- attended four ward rounds
- attended two handovers
- observed five activity sessions
- reviewed 74 prescription charts
- interviewed one service manager for later life
- interviewed two independent mental health advocates.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service had made improvements following our last inspection. Staff were now completing observations following rapid tranquilisation. The safety of the environment had been improved with better lines of sight and the use of parabolic mirrors and staff observations. The gender segregation on the two wards at Trafford was much improved. Documentation around patients capacity was clear and we saw good evidence of capacity being assessed when necessary and best interest decisions being made appropriately.
- There was adequate staffing levels to ensure patients were well looked after and able to spend one to one time with staff on a regular basis.
- There were good patient risk assessments on each ward. The service provided a safe environment and risks were managed well. Patients told us they felt safe on the wards.
- Staff deescalated aggressive and potentially violent situations well. Staff knew patients well and were able to use distraction and diversion techniques when they saw a patient becoming agitated. For example, the use of activity equipment that focused on patients interests and hobbies.
- There was effective multidisciplinary team working evident on all wards.
- Patients and carers gave universally positive feedback about the care and treatment they received on the wards we visited. Staff involved patients in decisions about their care where possible. They engaged with and supported families and carers where appropriate. Staff contacted them with updates on patient progress, held regular carers meetings, and invited them to ward rounds.
- Recent changes within the service had led to a positive change in staff morale. Staff focused on the needs of the people using their service, providing high quality patient centred care, which reflected the trust's vision and values. Senior managers were committed to improving the environment at the Manchester wards and had identified that the dormitories on those wards needed to be changed as a priority.
- Two wards at Woodlands hospital were AIMS accredited. The two wards at Trafford were going through the AIMS accreditation process with draft reports available at the time of our inspection.

Wards for older people with mental health problems

However:

- Staff were not always using the trust approved form for physical health monitoring following rapid tranquilisation.
- We found there were delays in requesting second opinion doctors when patients had been detained for three months and administered medication in order to complete a form T2 or T3 (dependent on whether the patient was able to consent to treatment). There were also delays in section 62 being completed (emergency treatment of a detained patient) with medication being administered without the correct legal framework across all of the Wards except Maple Ward. We also found examples of when a section 62 had been completed and medications were not on the list but being administered.
- On Cavendish Ward we found examples where patients had not been read their rights at the correct times or when there was a change in their detention status.
- There was a lack of privacy Bollin Ward where privacy screens on bedroom windows had been left open and there were no privacy curtains in the bathrooms on the main corridor.
- At Trafford the wards were very small with no quiet space for patients to use if they wanted to. Activities had to be done in the main lounge which meant that patients who wanted to sit quietly would either have to go to their rooms or listen to the activities.

Is the service safe?

Good ● → ←

Our rating of safe improved. We rated it as good because:

- There was adequate staffing to meet the needs of the service. This meant that staff were able to spend quality time with the patients. Vacancy and sickness levels were low and patients had access to regular staff who knew the ward and the patients well.
- Every patient had a risk assessment that was completed on admission and updated at appropriate times, for example, following an incident.
- The environment was safe. There were risk assessments for identified ligature points and staff knew where they were and how they were managed. This was done via the use of good quality risk assessments and observations.
- Risks created by blind spots were mitigated by staff observations.
- Staff had received mandatory training and compliance was good across the core service.
- Gender segregation was in line with guidance on mixed sex accommodation with separate areas for males and females.
- There were good systems in place for ordering, storage and dispensing of medications.

However:

- Although staff were not always using the trust approved form for physical health monitoring following rapid tranquilisation, staff were monitoring and recording observations
- At Woodlands, staff were unclear whether they were able to use rapid tranquilisation outside of the hours of 9am to 3pm, following a recent change in procedure The trust took immediate action to ensure staff understood that they could use rapid tranquilisation when needed.

Wards for older people with mental health problems

Is the service effective?

Requires improvement ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- We found that staff were not always taking action to ensure that the correct certificates were in place for administering medication.
- There were delays in requesting second opinion doctors when patients had been detained for three months. A second opinion appointed doctor is a doctor appointed to check that decisions by other clinicians are appropriate, especially in mental health.
- There were also delays in section 62 forms being completed (emergency treatment of a detained patient) with medication being administered without the correct legal framework across all of the wards except Maple ward. We also found examples of when a section 62 had been completed and medications were not on the list but being administered.
- On Cavendish ward we found examples where patients had not been read their rights at the correct times or when there was a change in their detention status.

However:

- There was good access to psychology across all of the wards.
- Multidisciplinary team working was evident and ward rounds were attended by a wide range of professionals.
- Staff received supervision and appraisal and these were meaningful and showed evidence of actions identified being carried out and supported.
- There was good physical health monitoring for example, blood samples being taken, height and weight being monitored and access to specialists when required. This included podiatry, dietitian and speech and language teams.
- There was access to a five day dementia training course for all staff and this was being rolled out across the new part of the trust for all the staff.

Is the service caring?

Good ● → ←

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

- There was universally positive feedback from patients about their care.
- Staff were described as respectful, genuine and “brilliant”.
- There was a good level of advocacy input across all of the wards with patients and relatives describing the support they had received in a positive way.
- Carers told us they felt involved in their loved ones care and were considered and listened to in decision making where appropriate.
- There were good systems in place to acquire feedback from all patients using innovative techniques such as utilising an iPad for questionnaires for patients with dementia.

Wards for older people with mental health problems

However:

- There was a lack of privacy Bollin Ward where privacy screens on bedroom windows had been left open and there were no privacy curtains in the bathrooms on the main corridor. There were however, knock before entering signs on bedroom doors and we saw staff observing this before entering patient bedrooms.

Is the service responsive?

Good   

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

- Staff had access to all the equipment required to support patients' needs. For example, fall sensor mats and dementia friendly signage.
- Leave beds were never used so patients had access to a bed on their return.
- On all of the wards except Bollin and Greenway at Trafford there was a wide range of rooms with access to a quiet space for patients.
- Patients had access to their bedrooms at all times of day and had access to a locked space for their possessions.
- Activities were available on all wards every day including evenings. At Maple ward the activity coordinators took the patients out for Sunday lunch together. At Woodlands they had "grab boxes" on the ward, these were boxes filled with items patients with dementia could use to either start a conversation, play games or do tasks such as sweeping.
- There was a good choice of food for patients including special dietary requirements whether that was for religious or health reason or just personal choice.
- Disabled access was available on all wards including access to outdoor space.
- Leaflets were available in different formats such as easy read and in different languages.

However:

- At Trafford the wards were very small with no quiet space for patients to use if they wanted to. Activities had to be done in the main lounge which meant that patients who wanted to sit quietly would either have to go to their rooms or listen to the activities.

Is the service well-led?

Good   

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

- Staff all told us they were happy in their jobs and felt supported by their managers.
- Staff who were new to the trust, felt they had been kept well informed of any changes and felt positive about their futures at the new trust.
- Staff told us that senior leaders were visible and this was the case during our inspection. Lessons learnt from incidents were shared widely across the service and positive learning events were held for all staff to attend.
- Staff felt that they could raise issues and that they would be listened to without any fear of retribution.

Wards for older people with mental health problems

- Woodlands hospital and the two wards at Trafford were going through the accreditation for mental health services process with draft reports available at the time of our inspection.

Areas for improvement

We found eight areas for improvement in this service. See the Areas for Improvement section above.

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

Requires improvement  

Key facts and figures

The trust provided acute wards for adults of working age and psychiatric intensive care units over five sites:

- Royal Bolton Hospital
- Moorside Unit
- Meadowbrook Hospital
- Park House
- Laureate House

At Royal Bolton hospital, there were three wards:

- Beech Ward, a 20 bed acute ward for males
- Oak Ward, a 22 bed acute ward for females
- Maple House, a six bed psychiatric intensive care unit for both males and females.

At Moorside unit, there were three wards:

- Brook Ward, a 22 bed acute ward for males
- Irwell Ward, a six bed psychiatric intensive care unit for both males and females
- Medlock Ward, a 21 bed acute ward for females.

At Meadowbrook hospital, there were four wards:

- Chaucer Ward, an eight bed psychiatric intensive care unit for both males and females
- Egleton Ward, a 23 bed acute ward for males
- Keats Ward, a 22 bed acute ward for females
- MacColl Ward, a 14 bed acute ward for males from Manchester

At Park House, there were six wards:

- Elm Ward, a 24 bed acute ward for females
- Redwood Ward, a 20 bed acute ward for males
- Mulberry Ward, a 20 bed acute ward for males
- Juniper Ward, a 10 bed psychiatric intensive care unit for males
- Laurel Ward, a 23 bed acute ward for males
- Poplar Ward, a 20 bed acute ward for females

At Laureate House, there were two wards:

- Bronte Ward, a 31 bed acute ward for both males and females

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

- Blake Ward, an eight bed psychiatric intensive care unit for females

At the last inspection in February 2016, there were four breaches of regulations and we issued requirement notices for:

- Regulation 18 HSCA (RA) Regulations 2014 Staffing
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance

On this inspection, we looked at all five key questions. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We reviewed all clinic areas and found the trust had met the requirement notice for Regulation 12 safe care and treatment. We found the equipment and oxygen were in date and staff acted on findings from audits.

We did not find any examples of patients secluded in de-escalation rooms without the protection of the safeguards of the Mental Health Act code of practice. Therefore, the trust had met the other requirement notice for Regulation 12 safe care and treatment.

The trust had met the requirement notice for Regulation 18. Qualified staff had received training in the Mental Health Act and the Mental Capacity Act and their understanding of the legislation and their role in relation to this had improved. Training levels of immediate life support were still low at 55%, however escalation procedures were in place to ensure there was an immediate life support trained member of staff available to respond on each shift, this could be the bleep holder or supernumerary manager on shift. The service had localised arrangements in place to identify this including use of rotas and bleep holder allocations to ensure staff were aware of whom to approach. We have issued a further requirement notice for Regulation 18 in relation to staff receiving all necessary training for their role and having regular supervision.

At our last inspection in February 2016, the Regulation 17 breach identified that staff were not completing environmental checks in a consistent way and acting on the findings immediately. At this inspection, we found that staff completed environmental audits in a consistent way; they all used the same format. However, there was no mitigation available on all wards. The service did not communicate risks to staff via their induction, it was not on the induction checklist and they relied on a verbal handover for the ward. We have issued a new requirement notice in relation to Regulation 12 safe care and treatment.

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information. During the inspection we:

- spoke with 62 patients and three carers
- received 27 completed comments cards
- spoke with 104 staff including doctors, nurses, health care assistants, occupational therapists, pharmacists, support time and recover workers and a physiotherapist
- spoke with 19 managers, including ward managers, acting ward managers, matrons and service managers
- reviewed 72 care records
- reviewed 171 prescription charts and associated documentation
- completed a tour of all 18 ward environments and clinic rooms

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

- observed four medication rounds
- observed four planning meetings with patients, either community meetings or mutual expectations meeting
- observed four activities on the wards including a music group and mindfulness and emotional regulation groups
- observed ward rounds on seven on the wards
- observed three handovers from one shift to the next.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Ligature audits did not include all ligature risks. Staff were not advised of ligature risks within the wards and how to mitigate these.
- There were environmental concerns with drainage difficulties on Keats and Eagleton wards at Meadowbrook Hospital and stains on ceilings at Blake and Eagleton wards. Anti-barricade doors did not open both ways for three of the rooms on Brook and Medlock wards. We found there were blind spots on Maple House, Eagleton, MacColl and Chaucer wards not mitigated.
- There were concerns with medicine storage, staff were not recording the minimum and maximum temperatures of medicine fridges. Staff were not following the trusts policy in relation to rapid tranquillisation, in relation to the timeliness of completing physical observations and the availability of these records.
- Lessons learnt were not shared across different parts of the trust. Team meetings and supervisions did not have standard agenda items to discuss learning.
- The service did not provide training for staff in how to support people who have a learning disability.
- Care plans were not always person centred and staff did not always make them accessible for people with a learning disability except on Juniper ward. Care plans were nursing led and did not include the involvement of other members of the multidisciplinary team. Less than half of the patients we spoke with had received a copy of their care plan and felt involved in the process.
- Staff did not receive regular supervision. Team meetings, handovers and supervisions varied in content across the wards.
- The consent to treatment policy, time out, seclusion policy and standard operating procedure and Mental Health Act 1983: information policy did not comply with the current Mental Health Act code of practice.
- There was limited access to psychology for patients. Patients had limited access to the gym at Meadowbrook hospital as only one member of staff was trained to enable patients to safely use the equipment.
- We could not find evidence in records that staff were always explaining section 132 rights to patients. Staff were not supporting patients to create advanced statements and decisions regarding their care and treatment.
- Seven patients told us that the agency staff who usually worked at night did not treat them well. They were dismissive, unresponsive and not approachable.
- There were dormitory sleeping arrangements at Poplar, Mulberry, Redwood, Elm and Laurel wards. There was no examination couch in the clinic at Poplar and Mulberry wards, patients would not have their privacy and dignity protected if they required an examination.

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

- Information advising patients how to contact the Care Quality Commission was not displayed on all wards.

However:

- Staff had received training in and had a good understanding of safeguarding. Staff liaised with professionals and attended strategy meetings for patients.
- Although staff training in immediate life support was low at 55%, the trust had systems in place to ensure that there was always a member of staff available who was trained in immediate life support.
- Patients had detailed, individualised risk assessments in place. Staff and patients received a de brief following incidents.
- The service managed medicines well, with daily visits from the pharmacy department to the wards. All clinic rooms were fully equipped with accessible resuscitation equipment and emergency medicines that were in date.
- Staff received an induction to the ward and had an appraisal.
- The majority of patients told us that staff were caring, supportive and responsive. We observed staff interacting with patients in a friendly, supportive and calm manner.
- Staff gave welcome booklets to patients to assist with their orientation to the ward and leaflets were available for carers and contact details of the carers support services.
- Staff responded to patients' needs. Morning meetings took place with the ward managers, service managers and community mental health teams to discuss patient's progress, discharge plans and support needs post discharge. Staff supported patients when admitted to acute hospitals, to provide consistency and mental health support. Staff booked interpreters to enable family members to be involved in the planning of care for their relatives. Patients had access to a variety of food and chaplaincy services.
- Ward managers and deputy ward managers we spoke with were knowledgeable, motivated and skilled when interacting with both staff and patients. They could locate required information, and were able to give clear guidance and advice to staff. Patients and staff told us that ward managers were supportive and approachable.
- The service implemented the recovery model of care, with patients being involved in staff training and recruitment and as peer mentors. Wards were recovery orientated with MacColl ward opening to meet the needs of Manchester patients. Recovery boards were in use to provide encouragement to patients.

Is the service safe?

Requires improvement ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- Ligature audits did not capture all ligature risks. The service did not communicate the contents of the ligature audits to staff.
- There were blind spots not mitigated in Maple House, Eagleton, MacColl and Chaucer wards.
- Staff were not following the trust's policy in relation to rapid tranquillisation. The monitoring forms for physical observations were not always available within records.
- There were environmental concerns. Eagleton and Keats wards had challenges with their plumbing and drainage systems. There were stains on the ceiling of Eagleton and Blake wards. The outdoor space at Maple House and Elm ward contained cigarette ends and rubbish at Maple House.

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

- Anti-barricade doors did not open both ways for three of the rooms on Brook and Medlock wards.
- Although staff usually recorded the temperatures of the medicine fridge, staff were not recording the minimum and maximum temperature as recommended. On Mulberry and Poplar wards, we noted there were occasions where the fridge temperatures were out of range and staff had not taken action. This was dealt with immediately by the trust.
- Positive learning events took place and the trust created posters however, the learning had not reached every ward and staff were not aware of learning from different parts of the trust. Learning from incidents was not a standard agenda item at team meetings or supervision.

However:

- Staff had received training in and had a good understanding of safeguarding. Staff liaised with professionals and attended strategy meetings for patients.
- Although staff training in immediate life support was low at 55%, the trust had systems in place to ensure that there was always a member of staff available who was trained in immediate life support. The trust was taking action to increase the training of qualified staff, as staff in the Manchester wards had not been routinely given this training.
- Staff and patients received a de brief following incidents.
- The service managed medicines well, with daily visits from the pharmacy department to the wards. All clinic rooms were fully equipped with accessible resuscitation equipment and emergency medicines that were in date.
- All wards complied with guidance on eliminating mixed sex accommodation.
- Staff responded to incidents on the ward in an appropriate and respectful way.
- Patient records all had completed risk assessments in place. Staff created detailed risk assessments, tailored to the individual.

Is the service effective?

Requires improvement ● ↓

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

- Although the multi-disciplinary meetings we attended were person-centred, records did not reflect this. Of the 72 care records we reviewed, we found that 23 care plans were not personalised; they used generic statements. Twenty-nine were not holistic and did not incorporate all assessed needs of patients. We could not find evidence in half of the records reviewed that staff offered patients a copy of their care plan.
- There was limited access to psychology provision, with none at Trafford, and part time provision at other sites.
- Staff did not receive training in how to support people with a learning disability. There were patients on the wards with a learning disability and staff told us there had been an increase in number of patients admitted with a learning disability. In five cases, care records were not accessible for patients with a learning disability.
- Staff were not receiving regular supervision.
- Handovers took place, however, there was not a set format across the wards and the service allocated a standard amount of time, without consideration of the size of the ward.
- Consent to treatment policy did not refer to the Mental Health Act code of practice 2015.
- There was no evidence in six out of 32 records that staff were explaining section 132 rights to patients.

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

- It was difficult to find evidence that staff assessed patient's capacity to consent to their treatment early in their admission.

However:

- Care plans were in place for patients, including epilepsy and falls care plans.
- Staff received an induction to the ward.
- Staff were receiving an appraisal.
- Informal patients were aware of their right to leave the ward and the process for this.
- Mental Health Act documentation was in the majority of the files of detained patients.

Is the service caring?

Good   

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

- The majority of patients told us that staff were caring, supportive and responsive.
- We observed staff interacting with patients in a friendly, supportive and calm manner.
- Within multidisciplinary team meetings, staff took time to explain to patients in a person centred way, their reason for admission, progress made and plans for the future.
- Staff gave welcome booklets to patients to assist with their orientation to the ward.
- On Juniper ward, staff provided patients with a learning disability, accessible information regarding the ward, their treatments and therapies. Staff individually tailored their care plans with plain English and photographs.
- Staff on MacColl ward booked an interpreter to enable a patient's mother to be involved in the ward round and understand the discussions.
- Leaflets were available for carers and contact details of the carers support services.
- Patients and past patients were involved in facilitating training at the Recovery College and interviewing staff.
- However:
- Less than half of the patients we spoke with had received a copy of their care plan and did not feel involved in the process.
- Patients with a learning disability on wards other than Juniper ward, did not receive accessible information, care plans were nursing led with medical language.
- Seven patients told us that the agency staff who usually worked at night did not treat them well. They were dismissive, unresponsive and not approachable.
- The service was not supporting and encouraging patients to make advanced decisions about their care and treatment.

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

Is the service responsive?

Good  → ←

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

- The trust had opened MacColl ward in Salford, a 14 bed male acute wards to care for patients of Manchester. This was to reduce the number of patients having to go out of their local area.
- Morning meetings took place with the ward managers, service managers and community mental health teams to discuss patient's progress, discharge plans and support needs post discharge.
- Staff supported patients when admitted to acute hospitals, to provide consistency and mental health support.
- Patients could make phone calls in private and were able to have their personal mobile phones on the ward.
- Wards had a variety of information on display for patients and embraced the recovery model with the use of recovery boards, positive quotes from patients at discharge and mutual expectations.
- The service endeavoured to support the specific needs of patients by offering a variety of food choices and accessing the interpreting service and chaplaincy service for patients.
- Managers managed complaints well locally, managers recorded issues raised and action taken in patients care records.

However:

- Accessible information and care plans for patients with a learning disability were only available on Juniper ward.
- There was only one staff member trained to support patients in the gym at Meadowbrook hospital. When they were not available, patients could not access the gym.
- Dormitory sleeping arrangements were in place at Poplar, Mulberry, Redwood, Elm and Laurel wards, which were taken over from a previous trust. However, the trust had plans in place to replace the dormitories.
- Examination couches were not available in Poplar and Mulberry wards, which had dormitory sleeping arrangements, this meant there was a risk that patients would not have their privacy and dignity protected if they required an examination.

Is the service well-led?

Good  → ←

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

- The service had acted on feedback following the last inspection and made improvements in relation to providing safe care and treatment, staffing and governance.
- Staff completed audits in a variety of areas to review practice and improve.
- Ward managers and deputy ward managers we spoke with were knowledgeable, motivated and skilled when interacting with both staff and patients. They could locate required information and were able to give clear guidance and advice to staff.

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

- Patients and staff told us that ward managers were supportive and approachable. We observed ward managers responding to patients in a knowledgeable, reassuring and positive manner when patients knocked on their office door.
- Staff we spoke with told us their managers supported them and found senior managers were approachable. Matrons and service managers visited the wards.
- The trust had plans underway to harmonise policies and remove dormitory accommodation.
- Eagleton, Keats and Chaucer wards had applied for accreditation with AIMS (Accreditation for Inpatient Mental Health Services)

However:

- Staff sickness levels for this service were 8%, compared to a trust target of 5.75%. This was above trust target.
- We found there were variations across the wards within the service, with different supervision agendas, team meeting agendas and handovers in use. This would make it difficult for staff if they were working across a number of different wards.

Areas for improvement

We found 18 areas for improvement in this service. See the Areas for Improvement section above.

Long stay or rehabilitation mental health wards for working age adults

Good   

Key facts and figures

We inspected long stay wards and rehabilitation services at seven locations.

- Acacia Ward at Park House was a 20-bedded service for adult men that was formerly provided by Manchester Mental Health and Social Care Trust.
- Anson Road was a 17-bedded service for adult men that was also formerly provided by Manchester Mental Health and Social Care Trust.
- Bramley Street rehabilitation unit was a 12-bedded inpatient unit for men formerly provided by Greater Manchester West Mental Health NHS Foundation Trust.
- Copeland Ward at Meadowbrook Hospital was a 15-bedded inpatient unit for men and women formerly provided by Greater Manchester West NHS Foundation Trust.
- Braeburn House was formerly provided by Greater Manchester West NHS Foundation Trust, and comprised three wards; Light Oaks ward was a 13-bedded adult men inpatient service. Buile Hill ward was a nine-bedded men inpatient service, and Crescent ward was a six-bedded men inpatient service. The Braeburn House service was run in partnership with an independent provider.

The evidence appendices included data from the Recovery First service. However, this service was taken over by an independent provider prior to the inspection. The data relating to this service will not be considered during the evaluation of data, nor will it be considered in the overall rating of the service.

The inspection was unannounced, with trust management being made aware of the inspection 30 minutes before the inspection was due to start.

Before the inspection, we reviewed information that we held about the service, and this was analysed and outlined in an evidence appendices, allied to this summary.

During the inspection, the inspection team:

- visited all seven wards within the trust providing rehabilitation services
- interviewed 30 patients in the service
- interviewed 39 members of staff, including doctors, psychologists, occupational therapists, trained nurses and health care assistants
- reviewed 37 sets of care records relating to patients within the service
- checked 28 prescription cards and folders
- attended four multi-disciplinary team meetings
- attended three handovers of information for staff
- attended seven other meetings, including team meetings and patient community meetings)
- completed tours of seven wards
- reviewed 13 sets of meeting minutes

Long stay or rehabilitation mental health wards for working age adults

- monitored one medication round
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The locations inspected were clean and equipped appropriately.
- Staffing levels showed that very few vacancies existed within the service, and that shifts were adequately covered.
- Care plans and risk assessments were completed in a holistic and comprehensive manner, taking into account the opinions of patients in the service.
- Staff mandatory training compliance averaged above 80% for the service.
- Activities for patients were meaningful, designed with an aim to not only keep patients engaged but to give skills for use in the community, including access to a recovery academy for both patients and staff.
- Patients were positive in their comments regarding care in the service, and we saw evidence of positive interaction between staff and patients at each location inspected.
- The Mental Health Act and Mental Capacity Act were observed and noted to be applied correctly.
- There were very few complaints across the service, and we saw evidence of shared learning from complaints that had been investigated.
- Key performance indicators were used to guide and improve practice across the service.
- The service was due for Accreditation for Inpatient Mental Health Services under the Royal College of Psychiatrists.

However:

- Acacia ward was in need of refurbishment and consideration for a total environment change: the trust had plans in place for implementation of such a change.
- We saw a table used to inform staff of mandatory training figures was not importing the correct data in relation to immediate life support training, giving an incorrect data set in regards to said training; this was dealt with immediately on identification of the problem.
- The sickness rate for staff was at 9%, but was only at 5% for the year to date.

Is the service safe?

Good ● → ←

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

- Blind spots throughout locations were adequately mitigated, and ligature risks were considered and assessed appropriately for a rehabilitation service.
- Staff had access to personal alarms, and were noted to be wearing the alarms during the inspection.

Long stay or rehabilitation mental health wards for working age adults

- Wards that admitted both male and female patients met Department of Health guidance on mixed-sex accommodation.
- Locations were clean and cleaning rosters maintained.
- Staffing levels at the time of inspection showed that staff vacancies were low across the service, and staff retention was high.
- Sickness rates of 6% and 13% respectively for both trust prior to the acquisition had been lowered to 9% overall since the acquisition, with the year to date figure at 5% for permanent staff.
- Information relating to patient care was stored securely across the service
- Mandatory training stood at 80% across the service. Shortfalls in training were in hand.

However:

- Acacia ward was in need of a full refurbishment, with dormitory accommodation, although the trust has identified this problem and was acting upon it.

Is the service effective?

Good ● → ←

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

- Care records were holistic and comprehensive, including risk assessments, comprehensive mental health assessments, care plans, physical health plans and consideration of consent and capacity.
- Physical health monitoring of patients was robust and regular.
- Staff from all disciplines were providing interventions in line with national professional guidance.
- Psychological input was available across the service, although on Acacia ward psychological input had to be requested from elsewhere within the service.
- Clinical audits were being carried out by staff across the service.
- The Mental Health Act and Mental Capacity Act were applied correctly, and documentation was up to date and accurate.
- There was a Mental Health Act and Mental Capacity Act compliance committee that audited compliance across the service.

Is the service caring?

Good ● → ←

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

- Patients told us that they were happy with the treatment they were receiving from the service.
- Carers told us they were happy with the service, and they were involved in the care of their family member.

Long stay or rehabilitation mental health wards for working age adults

- We observed patients and staff interacting, and saw that staff had a good understanding of each patient and their needs.
- We attended patient community meetings that gave consideration to patient ideas and suggestions, and reflected these ideas in practice.
- Care plans reflected patient involvement in their care.
- New patients were orientated to their new environment; one location used a buddy system, linking a new patient with an established patient in order to give them a patient view of the service.

Is the service responsive?

Good ● → ←

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

- There were no re-admissions within 28 days for the service.
- There were no delayed discharges for the service.
- Senior staff held regular morning meetings to discuss the previous 24 hours in the service, including planned leaves and staffing figures for the day ahead.
- All patients had access to their bedrooms without restriction.
- Blanket restrictions were at a minimum.
- The service provided lots of meaningful activities for patients, both indoor and outdoor, and provided access to community placements.
- The service had provided appropriate fittings and fixtures for use by disabled patients.

However:

- Acacia ward included four dormitories, with bed areas separated by curtains. This did not ensure privacy and dignity for patients, but the trust was aware of the situation and was acting upon it.
- The bed occupancy rate on Copeland ward was very high at 107% to 114%, in excess of the 85% guidance from the Royal College of Psychiatrists, but did not appear to effect admission, referral or discharge rates.

Is the service well-led?

Good ● → ←

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

- Staff told us that they valued their managers, and felt senior management listened to them.
- We observed interaction between senior managers, staff and patients that showed teamwork, consideration and understanding.
- Staff knew the values of the trust, and made an effort to aspire to those values.
- Staff morale was good across the service.

Long stay or rehabilitation mental health wards for working age adults

- We saw evidence of positive risk taking.
- Key performance indicators were used to gauge and improve performance across the service.
- The service recovery academy allowed for staff and patients to improve both professionally and in goals to return to the community.
- The service was in the process of applying for accreditation with the Royal College of Psychiatrists.

However:

- We noted that a report used to guide mandatory training was not accurately reflecting the efforts of staff; this was rectified immediately on discovery.

Areas for improvement

We found three areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

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

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Brian Cranna, Head of Hospitals Inspection, led the inspection. An executive reviewer, Jess Lievesley, Director of Delivery and Service User Experience supported our inspection of well-led for the trust overall.

The team included a head of hospitals inspection, two inspection managers, 14 inspectors, an assistant inspector, a Mental Health Act reviewer, a pharmacist specialist and a medicines inspector, a national professional adviser, 16 specialist advisers, and eight experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.