Greater Manchester Mental Health NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Inadequate**

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

During our last inspection of the trust between 13 June and 7 July 2022, we carried out an unannounced inspection of three mental health core services provided by this trust because we received information giving us concerns about the safety and quality of the services. We also carried out an announced inspection of the well-led key question for the trust overall.

As a result of significant patient safety concerns related to fire safety and the management of ligature risks we found during the inspection of the acute wards for adults of working age and psychiatric intensive care units, we issued the trust with a Section 29A Warning Notice on the 6 July 2022. We told the trust it was required to make significant improvements by 31 July 2022.

We also issued a further Section 29A Warning Notice to the trust at provider level on 23 September 2022 following the well-led inspection in relation to Regulation 17 (Good governance) and Regulation 18 (Staffing). We told the trust it was required to make significant improvements to staffing on the acute wards for adults of working age, psychiatric intensive care units and forensic wards by 31 December 2022 and significant improvements in relation to governance by the 31 March 2023.

The Commission served the Section 29A Warning Notices because the quality of health care provided required significant improvement in some areas identified during the inspection. The Warning Notices set out a legally set timescale for the provider to become compliant.

Prior to the publication of the inspection report, we suspended all the forensic core service ratings for the trust on 23 September 2022 and the well-led rating for the trust on 22 October 2022. We took this action because of concerns that came to light after we completed our well led inspection.

Our findings

During a focused inspection at HMP Wymott on 10 and 11 August 2022, we found that the management of medicines was unsafe, resulting in unnecessary risk of harm to patients. We issued the trust with a Section 29A Warning Notice in relation to Regulation 12 (Safe care and treatment). We undertook a follow up inspection at HMP Wymott in November 2022 to follow up on the Warning Notice. Improvements had been made in relation to the Warning Notice however, two breaches of regulation were identified of Regulation 17 (Good governance) and Regulation 18 (Staffing).

Between 4 and 6 October 2022, we carried out a focused inspection at three of the trusts' community mental health teams for adults of working age to follow up on a Section 29A Warning Notice we had issued to the trust in April 2022 following a focused inspection of two Community Mental Health teams in Manchester. This inspection focused on specific key lines of enquiry in the safe and responsive key questions. We issued a further Section 29A Warning Notice on 4 November 2022 in relation to Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 18 (Staffing). We told the trust it was required to make significant improvements by 4 January 2023.

We undertook a focused inspection of the trusts' three mental health wards for older people at Woodlands between 16 and 17 November 2022 following whistleblowing concerns we received about the unit. The inspection was focused on the safe key question. We subsequently issued to the trust a Section 29A Warning Notice in relation to Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 18 (Staffing). We told the trust it was required to make significant improvements by 30 March 2023.

Following our last inspection, the trust has faced significant, unprecedented challenges, especially in relation to the external scrutiny the trust has experienced since then. This scrutiny followed a number of serious safeguarding concerns and allegations which have come to light since our last inspection in relation to the Edenfield Centre which are subject to an on-going police investigation and further inspection activity we have undertaken which resulted in the above section 29A Warning Notices being issued to the trust.

At the end of November 2022, the trust were placed into Segment 4 of the NHS Oversight Framework which meant it entered the national Recovery Support Programme and was in receipt of mandated intensive support. A NHSE System Improvement Board was set up to support the delivery of the programme which was chaired by the Regional Director for Strategy and Transformation for NHS North West, with representatives from the trust, Greater Manchester Integrated Care Partnership, Care Quality Commission, Health Education England, Bury Local Authority (as safeguarding lead), General Medical Council and the Nursing and Midwifery Council.

The trust had declared a critical incident following the incidents at the Edenfield Centre and put in place a number of immediate actions to ensure the safety of patients and address the most urgent quality and safety issues. It had also developed a draft Improvement Plan which included a set of longer-term ambitions. The draft Improvement Plan was approved by the trust's board on 31 October 2022 and System Improvement Board on 1 November 2022. The trust obtained public views on the plan during February and March 2023. Following final approval, the Improvement Plan will be monitored through the System Improvement Board.

On 22 November 2022, NHS England North West wrote to Greater Manchester Mental Health NHS Foundation Trust, to inform the trust it would be commissioning an Independent Review.

On the 6 February 2023, NHSE announced they had appointed a chair to undertake this independent review. It will focus primarily on the Edenfield Centre, as well as the trust's other services, and will include a review of ward to board escalation, and oversight of patient safety and culture. The review is scheduled to conclude by 30 September 2023.

During this inspection, we inspected the following three mental health core services:

Our findings

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

The inspections were focused on checking the trust's progress in relation to the two Section 29A Warning Notices we had issued as a result of our inspection of the trust between 13 June and 7 July 2022 and the Section 29A Warning Notice issued on the 4 November 2022 regarding the community-based mental health services for adults of working age.

We also carried out an announced inspection of the well-led key question for the trust overall.

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

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

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

Our rating of services went down. We rated them as inadequate because:

- We rated the trust well led (leadership) as inadequate.
- One of the trust’s ten core services was rated as inadequate and three were rated as requires improvement. In rating the trust, we took into account the current ratings of the seven services not inspected this time.
- We rated the trust’s core services as inadequate overall for safe. The assessment of well led gave us some significant concerns about the assurance of the quality and safety of the trusts’ provision of services across the board.
- We rated the trust’s core services as requires improvement for caring, effective, responsive and well led overall.
- We rated caring as requires improvement as we found quite profound concerns in relation to poor governance and lack of oversight across the board.
- The trust had experienced significant changes at board level which had de-stabilised the board. These changes meant we were not assured that all senior leaders had the necessary experience, knowledge, and capacity to lead effectively.

Our findings

- Although there was some recognition of individual strengths in different leaders, there were significant concerns about leadership capacity and capability at board level, and the ability of the board to respond at pace to key areas of risk and effectively implement and embed the improvement plan.
- From board to ward, the trust had been operationally led and dominated to the detriment of the quality agenda.
- Leaders did not have sufficient oversight of services at point of delivery, and they did not respond effectively when staff raised concerns about safety and quality issues which impacted on patient care and service delivery.
- Risks issues were not always managed and acted upon by leaders in an effective or timely manner.
- We had significant concerns about fire safety in the acute, psychiatric intensive care and forensic wards. Leaders had not supported front-line staff to implement the trusts' no smoking policy and there was significant evidence of patients smoking across most of the wards. Some doors on the acute wards were not fit for purpose to prevent the spread of a fire as they had gaps in the top. This was an issue we raised during our last inspection.
- Ligature audits were poor in the acute, psychiatric intensive care wards because they did not identify all risks or effectively mitigate these. This was an issue we raised during our last inspection.
- Audits were not owned locally and were not effectively used to drive improvement.
- Leaders did not always identify and manage priorities in an effective and timely way.
- The trust did not always collect reliable data. IT systems were not always integrated to ensure provision of timely data and information and there was a reliance on manual data collection. The incident reporting system was out of date. This meant data could not be easily analysed accurately to identify themes or trends to improve performance. The board and leaders had lacked curiosity and had accepted reassurance from data rather than the assurance needed.
- The trust governance systems and processes did not ensure that all services provided safe and good quality care. The trust had recently reviewed the governance arrangements and implemented a new structure however; this was embryonic, and it was too early to determine if this would operate effectively.
- Dormitory accommodation remained in place in some services, and this did not protect the dignity and privacy of patients.
- Whilst the trust had systems in place to identify learning from incidents, deaths and complaints; these were not always effective or delivered in a timely way, which delayed any required improvements to patient care.

However;

- Staff at all levels reported the culture had significantly improved over the past few months and they felt able to speak up. Clinical staff felt able to raise concerns and were confident that their voices would be heard. All staff we spoke with knew about the freedom to speak up guardian.
- Staff felt supported by their immediate managers however, the trust still had work to do.
- Leaders were aware of the improvements which needed to be made which were incorporated into the improvement plan and accurately reflected within the board assurance framework.
- Within the community based mental health services for adults, actions had been taken to meet the Warning Notice we had previously issued. There were improvements to medicines management, improved oversight of the waiting lists and safeguarding referrals. A full-time senior pharmacist had been deployed within the Manchester community teams and this new post has been instrumental in the immediate and ongoing improvement of the service.

Our findings

- All staff were able to register and access the maintenance reporting system to support the self-reporting of ad-hoc repairs and maintenance. The trust reported that recent system changes had made it quicker and easier for staff to report where maintenance repairs were required.
- Within the forensic wards, at our last inspection we identified concerns about the management of ligature risks and clinic rooms which had now improved.
- Leaders continued to work well with stakeholders in continuing to drive forward the community transformation programme, although this was work in progress.
- The trust had an established strategy to engage with carers and service users which was co-produced following extensive engagement with service users, carers, families, staff and external agencies.
- The trust was on track in the delivery of its estate strategy to remove the use of dormitory accommodation with the Park House new build project. Work was also well underway to refurbish the seclusion suites across the trust and several of the forensic wards had been refurnished.
- The trust had implemented electronic care records across all in-patient services.
- The trust had a planned approach to taking part in national audits and research.
- The trust had a track record of strong financial governance, and robust data security and protection with substantial audit opinions from both external and internal auditors.

How we carried out the inspection

During this inspection we;

- talked with 69 patients and nine carers about their experience of using these services
- arranged for a bespoke survey to be sent to all staff within the trust
- visited all 10 forensic inpatient / secure wards
- visited all 22 acute wards and psychiatric intensive care units
- visited three community-based mental health teams for adults of working age
- attended a number of clinical based meetings such as safety huddle meetings, smoking free meeting and handover meetings
- spoke with a variety of staff in face to face or virtual meetings including; health care assistants, nurses, doctors, allied health professionals, advocates, managers, chief pharmacist, executive directors, non-executive directors and members of the senior leadership team
- reviewed a number of records relating to the care and treatment of patients
- reviewed a variety of documents relating to the management of the trust and the services it delivers
- held focus groups with staff side, governors, medical staff / consultants, non-executive directors, chairs of the staff equality networks and associate directors within the five care groups
- reviewed a variety of information we already held about the trust
- sought feedback from a number of the trust's stakeholders.

What people who use the service say

Our findings

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

Patients provided mixed feedback regarding their treatment by staff. A large majority were positive regarding the care they received and their interactions with the staff, stating that they felt safe and well supported. However, some were negative and did not appreciate some of the blanket restrictions in place. They felt unsafe at times and that some night staff were disrespectful in their attitudes or behaviour towards them.

Forensic inpatient or secure wards

Most patients said that staff were respectful and polite. One said that staff were rude but did not give any examples.

Some patients had copies of their care plans, but some told us they didn't want them. They understood their care plans and had been involved in developing them and making decisions about their care. They said that physical health issues were addressed, by contacting the GP, but one person said staff would do this for them and they preferred to do it themselves due to confidentiality.

Some patients described their care pathway and how they were working towards lower levels of security and discharge.

Patients had access to the advocacy service, and opportunities to give feedback about the service.

Staff encouraged patients to take part in activities on the wards that were relevant to their needs. Patients had access to education at an adult learning centre and local college. They told us that at the recovery academy, they could learn information technology skills, budgeting, languages and develop skills such as reading.

Staff supported them to build and continue their relationships with their families and friends.

Patients said they felt confident to raise concerns or complaints and told us they knew how to escalate their concerns.

One patient told us that staff had installed a blackout screen to protect against the bright sunlight but, as it went all the way to the floor, patients could not see out. We raised this with managers who agreed to address it.

Prior to the pandemic, patients had access to a bus service, which helped facilitate their leave from the unit. This stopped during the pandemic but had not been reinstated. Patients told us that this meant they had to walk from the unit to leave the site, which was a long distance, or use taxis. We raised this with senior managers, who agreed to investigate with a view to reinstating the service as soon as possible.

Patients told us how the events of 2022 had impacted on them. Some reported that things had improved, but the changes were unsettling.

One patient's relative told us they had been waiting to meet with a doctor to forward plan and discuss discharge, but no meeting had been arranged yet.

Community-based mental health services for adults of working age

Because of the focused nature of this inspection in following up specific issues, we did not attend any home visits or appointments.

Our findings

Areas for improvement

Action the trust MUST take to improve:

Trust wide

- The trust must ensure there are effective systems and governance processes in place to assess, monitor and improve the quality and safety of services provided (Regulation 17)
- The trust must ensure there are effective governance systems and processes in place to ensure that services operate safely and that risks to patients are assessed, monitored and mitigated (Regulation 17)
- The trust board must have effective oversight of quality, risk and safety concerns within services and ensure that these were being managed effectively (Regulation 17)
- The trust must ensure the governance structure is fully embedded, effective and operational (Regulation 17)
- The trust must ensure it has the capacity and capability which is required to implement and embed the improvement plan (Regulation 17)
- The trust must ensure leaders have effective oversight of services at point of delivery (Regulation 17)
- The trust must ensure frontline staff are supported to implement the trusts' smoke free policy across the acute, psychiatric intensive care units and forensic secure wards (Regulation 17)
- The trust must ensure delivery of the estate strategy to eradicate dormitory accommodation (Regulation 17)
- The trust must review the policy with regards immediate life support training and levels of training provided to staff (Regulation 17)
- The trust must ensure that staff are compliant with mandatory and essential training (Regulation 18)

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

- The trust must ensure there are systems and processes in place to effectively assess, monitor and mitigate environmental risks related to fire safety and ligature risks on all wards (Regulation 12)
- The trust must ensure that all ward premises, fittings and fixtures are clean, properly maintained and suitable for the purpose for which they are being used (Regulation 15)
- The trust must ensure that patients' privacy and dignity are protected at all time (Regulation 10)
- The trust must ensure there are effective systems and governance processes in place to assess, monitor and improve the quality and safety of services provided on the wards. (Regulation 17)

Forensic inpatient or secure wards

- The trust must ensure that the ongoing programme of ward refurbishments is completed (Regulation 15)
- The trust must ensure that patients have access to nurse call alarms (Regulation 12)
- The trust must ensure that physical health care and physical health observations are personalised and meet individual need (Regulation 12)

Our findings

- The trust must ensure that missed doses of medicines are kept under review (Regulation 12)
- The trust must ensure that staff are compliant with mandatory and essential training. (Regulation 18)
- The trust must ensure that staff receive regular supervision and appraisal (Regulation 18)
- The trust must ensure that staff who work solely on the bank have completed prevention and management of violence and aggression training (Regulation 18)
- The trust must ensure that patient confidentiality is protected at all times (Regulation 10)
- The trust must ensure that new governance structures, systems and processes are fully embedded (Regulation 17)

Community-based mental health services for adults of working age

- The trust must ensure that staff complete mandatory training (Regulation 18)
- The trust must address the gaps in posts relating to physical health (Regulation 18)
- The trust must ensure that physical health assessments are undertaken and recorded as per the physical health policy (Regulation 12)
- The trust must ensure it identifies all clients within community services who require additional monitoring, including those on high dose antipsychotic therapy, and ensure a process is developed to ensure that monitoring takes place (Regulation 12, 17)
- The trust must ensure that improvements are made to adherence to the timescales for referrals and assessments (Regulation 17)

Action the trust SHOULD take to improve:

Trust wide

- The trust should continue to build on the improvements made within the Manchester community teams and ensure that level of oversight, governance and assurance is replicated across all the community teams.

Forensic inpatient or secure wards

- The trust should ensure that the programme of ward refurbishment is delivered within timescales.
- The trust should ensure that all patients have the opportunity to have regular one-one sessions with nursing staff.

Community-based mental health services for adults of working age

- The trust should ensure that ongoing improvements continue, including completion of the standard operating procedure, review of referral pathways and processes, discharge planning and medicines management plans.
- The trust should continue to audit unallocated contacts in the community teams and ensure improvement where needed.
- The trust should consider a standard process to identify clients who have not received an annual physical assessment in primary care and prioritise completion of these.
- The trust should continue developing processes to assess waiting lists and prioritise those most in need/at risk

Our findings

- The trust should improve collecting client and carer feedback
- The trust should ensure that all incidents that need to be are reported, including missed depots.

Is this organisation well-led?

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

Leadership

Not all members of the trust board had the appropriate range of skills, knowledge and experience for the board to perform its role. The trust had experienced significant changes at board level which had destabilised the board. These changes meant we were not assured that the board had the capacity and capability which was required to implement and embed the improvement plan which consisted of over 300 actions.

Leaders did not have effective oversight of services at point of delivery or the impact of the issues we had found on both staff and patients**.** This meant leaders were out of touch with what was happening on the front line.

The board comprised of seven executive directors including the chief executive who had been in post since April 2018. The substantive executive director positions included a chief nurse, director of human resources, deputy chief executive, director of performance and strategic development, chief operating officer, medical director and a director of finance, information management and technology.

Since our last inspection in June/July 2022, there had been some significant changes at board level. The previous chair had stepped down at the end of the year and a new interim chair had been appointed from January 2023 until the end of 2023. The substantive chief operating officer had been absent from work for a number of months as had the chief nurse. The chief operating officer was leaving the organisation in February 2023 and an interim chief operating officer was in place, who was supported by a substantive deputy chief operating officer. The deputy chief nurse was providing cover in the absence of the chief nurse, this was in addition to continuing to carry out their deputy chief nurse role. The deputy chief nurse was also providing support to the deputy safeguarding lead as the safeguarding lead for the trust had been absent from work for several weeks.

The deputy chief executive had also held the role of director of human resources during our last inspection however; they had recently been appointed as the executive sponsor for service improvement which included the implementation of the improvement plan trust-wide with specific oversight in relation to the Edenfield Centre. The associate director of human resources had been acting director of human resources since September 2022. The medical director had announced their intention to retire in July 2023 and recruitment was underway to find a replacement in preparation of their retirement.

The portfolio of the deputy chief executive had been amended to be able to take on the responsibility as executive lead for the response to the incidents at Edenfield and the Improvement Plan supported by the establishment of a Programme Management Office.

This had resulted in the deputy chief executive carrying much of the pressure to drive the improvements and this was not sustainable in the long term. Likewise, the continued absence of a chief nurse to support the deputy chief nurse to lead and drive forward the quality strategy was not sustainable.

Our findings

As part of the inspection, we sent a bespoke staff survey questionnaire to 6,600 staff within the trust prior to the well led inspection; 1,165 staff completed this, equating to a return rate of 18%. The survey focused on the following four themes: staffing levels, safety, demand and flow and leadership and culture. The survey was based on the experiences of staff within the previous 12 months between February 2022 to February 2023.

The survey categorised staff by the following roles: allied health professional, doctor, executive/senior management, health care support worker, manager, Mental Health Act administrator, nurse and other.

Overall, only one in five staff who responded agreed that they had confidence in the executive team. This was consistent across all locations and services. For the executive / senior management team response, out of 34 respondents, eight respondents disagreed, and eight respondents strongly disagreed that they had confidence in the executive team, five agreed and five strongly agreed and eight neither agreed nor disagreed.

Nurses were the staff group which reported the highest percentage of lack of confidence in the executive team with 26.3% disagreeing and 33.2% strongly disagreeing.

As part of the inspection, we received feedback from external partners, stakeholders and commissioners. We also interviewed members of the board and senior leadership team. There was a collective recognition that the trusts' reputation had been significantly damaged as a consequence of the abuse and safeguarding allegations which have come to light and this had significantly impacted on staff confidence in the leadership within the trust. Members of the board and trust leaders accepted full responsibility for the failings. The chair apologised to the public at the trust Board meeting held on 31 October 2023, which was the first public meeting of the Board following the allegations being raised. That public apology was included in the stakeholder briefing on 1 November 2022. More recently, the trust apologised again via a stakeholder briefing paper dated 28 March 2023. This followed the publication of an independent Governance and Assurance Review commissioned by the Trust from the Good Governance Institute which was published in March 2023.

The key findings from the report were;

- The executive team provided a positive picture; however, subsequent events tested the leadership, and showed weaknesses and areas of being ineffective
- A disconnect between the top tier, middle management and especially the staff in the lower tiers of the organisation (Band 8a and below)
- Clear systems of accountability to support good governance were not always in place and communication was seen as 'patchy'.

The review made the following seven recommendations to the trust:

- Rethink leadership style to enable the board and executive team to know their organisation better
- Be visible and create a credible and transparent environment
- Implement the new structures to fully establish the set up clear systems of reporting
- Complete the design of the care groups and relate to the new assurance structure
- Focus the board development work on how the committees add value, and the way in which the assurances within the board assurance framework are scrutinised

Our findings

- Review and improve communication
- Balance the need for responding to regulators with the need to continue to address the root causes of underperformance

The trust had eight voting non-executive directors including the chair. The non-executive directors had diverse backgrounds including nursing, legal, higher education, voluntary sector, finance, NHS Confederation and planning inspectorate.

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

We asked the trust for details of, 'walk about' visits to services by board members for the previous six months. We were provided with a report for quarter 1 (2022) which showed one visit had been undertaken by a non-executive director and another by a governor and 10 by members of the executive team. The report stated that all feedback received had been provided to the relevant department and was shared with the care group leadership team however; there was no evidence to demonstrate that action had been taken as a result of the visit findings. We were not provided with evidence of visits for quarter 2. For quarter 3, there was one non-executive director visit to Edenfield in December 2022 however; it was not clear what action had been taken following this visit where issues had been identified.

During January and February 2023, members of the executive team had undertaken 18 visits to services. The chair had undertaken eight, including three to the Edenfield Centre, and the chief executive had undertaken five of these. We were not provided with information about what the findings from these visits were or any subsequent action taken in response. Staff at Park House told us senior executives had visited the wards in the months before the inspection however; there was no evidence to show that their visits had resulted in immediate changes or improvements.

The non-executive directors and governors were not able to fully operate effectively within their roles. They told us they did not always receive the information they needed to fulfil their roles and did not always feel they were being heard. They identified they would benefit from training to support them in their roles which they felt was lacking currently, especially for those new into post.

The trust had 30 seats on its council of governors, of which 24 were elected seats and six were appointed to by trust partners.

The elected governors represented public constituencies across the five areas within the trust footprint, a service user/carer constituency and trust staff. At the time of inspection, 22 of the elected seats were filled and six of the partner seats were appointed to making a total of 28 governors. Of these, four were elected public service user/carer governors and seven were elected staff governors.

The governors had meetings scheduled for 2023 and reported they had met regularly with the previous chair of the board and had recently met with the new chair. They met with the non-executive directors five times a year. They described the new chair as inclusive and felt that communication had improved since their appointment, which some described as being poor previously. One described how they had been made aware of a significant event which had involved the trust via the media rather than within the trust.

In the focus group we held with the non-executive directors, they also praised the new chair stating there had been a marked change in the trust since their appointment, and it felt like a refreshed organisation with a much more open and inclusive approach.

Our findings

Board members attended the council of governor meetings and governors were also able to attend board meetings. They also provided feedback to the non-executive directors as part of the annual appraisal process.

The programme in place at the time of the inspection for governors to undertake walkabout visits had not been implemented effectively. Although some had recently visited some clinical areas, this was on an 'ad hoc' basis and meant that the governors had not gained a real understanding of the challenges facing front-line staff and the experiences of people using services directly. As a consequence, their ability to fully represent their constituents was limited. They had raised with the executive team that they wanted to set up a programme including unannounced visits to clinical areas, but this had not been implemented at the time of the inspection.

The trust had a corporate lead for child and adolescent mental health, a lead for learning disability and autism and a lead for physical health. The lead for safeguarding had been absent for several months and the deputy lead nurse was providing cover with the support of the deputy chief nurse. The trust had safeguarding leads in each locality to align with the local authorities. The trust had established safeguarding policies and procedures in place.

All the senior leaders we spoke with were able to discuss the trusts' identified priorities and the challenges the trust had faced in achieving these particularly over the past 18 months.

Leaders were transparent and open when discussing the challenges and risks were captured within the recently up-dated board assurance framework. However, although the leadership team had identified the significant challenges and risks, actions taken had still not ensured that the quality and safety of all services were maintained despite this.

We had significant on-going concerns in relation to how fire safety and ligature risks were not being effectively managed and mitigated on some wards we inspected. These were issues we had raised in our previous inspection which had resulted in the issuing of a Section 29A Warning Notice. The trust had developed and begun to implement action plans to address the actions required of it by CQC, however, during our inspection we remained concerned at the pace in the delivery of those planned actions.

Fit and proper person checks were in place. We reviewed two files of staff who were appointed to the Trust board since our last inspection. We observed that fit and proper person checks were carried out and documented accordingly. There was a checklist to ensure all required checks were completed prior to staff commencing in their role and throughout their employment.

When senior leadership vacancies arose, the recruitment team had not effectively reviewed capacity and capability needs. The trust had not effectively reviewed leadership capacity and capability on an ongoing basis and succession planning was not in place throughout the trust. The trust had continuing significant issues with the recruitment and retention of staff. The recruitment of consultants, registered nurses and care co-ordinators was their biggest challenge. Both recruitment and retention were escalated on the trust's board assurance framework as extreme risk for the trust scoring 16 each.

The trust had identified that it needed to strengthen clinical leadership across the trust, especially for ward managers who were new to post, and plans were in place to roll out a leadership development programme underpinned by a leadership strategy to drive this forward.

The trust had submitted a formal bid through the Recovery Support Programme for financial support to provide a leadership programme for the matrons, in recognition that these were key roles which needed strengthening to develop and re-balance the focus from operational management to the quality agenda.

Our findings

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

Vision and Strategy

Whilst the trust had a vision and strategy which was set out in the trust's five-year strategy 2019 - 2024 ('Delivering Excellent Care and Supporting Wellbeing'), which included five key strategic objectives, delivery of the strategy and plans had not been consistently or effectively monitored or reviewed and there was little evidence of progress. Leaders at all levels had not always been held to account for the delivery of the strategy.

A well led review completed by the Good Governance Institute published in January 2023 had found that staff had been unaware of the trusts' strategy and that communication about the strategy had not been effectively delivered to staff below band 8a/8b.

Trust leaders had focused their energy on developing relationships with external partners and engaging with service users. The trust had developed a Greater Manchester Mental Health Together Strategy 2022 to 2025 to bring together the previous two separate carer and service user engagement strategies they had implemented between 2018-21. Underpinning the new strategy was a focus on how the trust aimed to work in collaboration with everyone including the wider community to meet service users and carers needs. The strategy was co-produced following extensive engagement with service users, carers, families, staff and external agencies with the pro-active involvement and support of the trust's service user and carer governors.

However, they had failed to engage effectively with their own staff in the same way. Despite this, staff within the core services we inspected demonstrated a good understanding of the vision and values of the trust and were able to articulate how these linked to their work. The trust values were incorporated into staff induction, the recruitment process, policies, appraisal system, board assurance framework and board meetings.

Following our last inspection, a System Improvement Board had been set up as part of the requirement by NHSE's recovery support programme. This met monthly and and included key stakeholders including; Greater Manchester Integrated Care Partnership, Care Quality Commission, Health Education England, Bury Local Authority (as safeguarding lead), General Medical Council and the Nursing and Midwifery Council. The board had supported the trust to develop an improvement plan and engagement approach which had taken priority over the trusts' existing strategy. The improvement and engagement plan was published by the trust on the 17 February 2023.

The five key priorities of the plan were;

- Patient safety: including safe staffing, reducing restrictive practices, medicine management, safe environments and sexual safety
- Clinical strategy and professional standards: including model of care and clinical strategy (for the adult forensic service and wider inpatient services and community mental health teams), clinical skills training, development of clinical networks and accreditation
- Empowering and thriving workforce: including staff safety, staff engagement, education, training and leadership development and appraisals and supervision.
- An open, listening organisation: culture, empowerment and equality, freedom to speak up, strengthening service user and carer voice

Our findings

- A well governed and well led trust: corporate governance review and development, quality governance review and development, leadership and board development, data quality and board visibility.

The trust had proposed the campaign name, 'Building Our Future Together' to underpin the improvement and engagement plan. There were a number of engagement events planned over the following six weeks from publication with key stakeholders and service users to seek feedback on their views. It was expected that the plan would be agreed in mid-April with a recognition that it would continue to evolve. An easy read booklet version of the plan was available on the trusts' website.

As the plan was still in the early stages of being approved and implemented, it was too early to determine the sustainability of the plan or the impact it would have on people who used services their carers, staff and the wider local system.

The trust had a medicine optimisation strategy in place which was reviewed annually as part of the annual business plan.

The trust had a strategy for meeting the physical healthcare needs of patients. The head of physical health care was supported by locality physical healthcare leads however; both of the Manchester adult community mental health teams had been unable to fill the vacancies for these roles. Audits of the physical health monitoring tool in use across the trust showed low levels of completion across these teams which meant it was difficult to monitor whether clients had regular assessments of their physical health completed.

Physical health care monitoring of patients within the forensic wards was also inconsistently monitored across the wards.

The trust had identified that a failure to improve the assessment and treatment of physical health conditions was a risk on their board assurance framework with a risk score of 16 (extreme).

The trust had approved the Advancing Equalities Strategy 2022 to 2025 in June 2022 which set out four objectives to achieve over the following three years. These were:

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

The trust had an advancing equalities forum established to support the implementation of the strategy. Each objective had three priorities for action which the trust planned to reflect in an associated advancing equalities action plan 2022-25 which would be used to support the monitoring and reporting on progress of the strategy to the board.

Our findings

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

From October 2021, the responsibility for planning secure services for adults with mental illness and/or learning disabilities transferred from NHS England to the Greater Manchester Adult Secure Provider Collaborative. The trust was appointed as the lead provider of the collaborative, which required working in partnership with neighbouring trusts and independent health providers.

The trust was continuing to work with service users, carers, system partners and other local stakeholders to implement and embed the community transformation programme. This involved the remodelling of primary and community mental health care through the delivery of phase 1 and phase 2 of the Salford Living Well (National Vanguard Site), which focused on adults too complex for primary care and psychological therapy services, but who did not meet the threshold for secondary care. The programme was independently evaluated, and findings of the report noted a high proportion of people showed significant improvement in personal safety, leisure and community activities, jobs/ occupation and quality of life scores.

The trust had established living well collaborative design groups to support the implementation of the 'Living Well' development programme working collaboratively with Greater Manchester Health and Social Care Partnership, Innovation Unit, voluntary sector, those with lived experience and the clinical commissioning groups.

The trust had developed an estates strategy 2022-2025 which included productivity and development of an infrastructure strategy, rationalisation and capital improvements. The trust had successfully completed the full business case for the replacement of Park House which was approved by HM Treasury in November 2021 securing capital investment of £91.3m. Work on the new inpatient accommodation in North Manchester was in progress and was due to be completed in the next 18 months and would, when completed, eradicate all remaining dormitory accommodation and address the mixed sex accommodation in the existing facility.

Work was well underway to refurbish the seclusion suites across the trust and several of the forensic wards had also been refurnished.

Culture

Staff had not always felt respected, supported and valued. Staff had not always felt comfortable raising concerns and when they had, they were not always taken seriously, appropriately supported, or treated with respect. However; staff at all levels reported the culture had significantly improved over the past few months and they now felt able to speak up. Clinical staff felt able to raise concerns and were confident that their voices would now be heard.

We reviewed the latest national staff survey results for the trust from 2022. The response rate was 36% (2198 staff) which was lower than the 2021 response rate of 47% (2,916 staff). The survey compared trust staff responses to nine statements against the national average. Each of the statements had a set of sub-themes. Of the nine statements, the trust scored below the national average for all the statements and the worst nationally for some sub-themes.

Against the statement, 'We are compassionate and inclusive', the trust scored 7.1 overall. The national average score was 7.5 with the worst being 7.0.

Our findings

The trust scored the worst score nationally for the sub theme, 'compassionate culture' with 6.2 against the national average of 7.2. This was significantly lower than the score of 6.8 the trust received the year before. The trust also scored below the national average for compassionate leadership, equality and diversity and inclusion.

In the NHS staff survey results 2022, for the statement, 'Care of patients / service users is my organisation's top priority', there was a decline from 2021 from 68.7% to 61.2% against an average of 78.3%.

Only 40.1% of staff reported that if a friend or relative needed treatment they would be happy with the standard of care provided by the trust which was the lowest score nationally (national average was 63.6%). This is significantly lower than the 55.1% of the previous year.

Only 45.6% of staff stated they would recommend the trust as a place to work against the national average of 62.8, which was a significant reduction from the 56.2% the trust scored last year.

In the NHS staff survey results, for statements related to how staff felt supported by and listened to by their immediate line manager, scores were similar to last year and around the national average.

For statements related to the teams staff worked in, scores remained below average overall. For the statements, 'The people I work with are understanding and kind to one another' and 'The people I work with are polite and treat each other with respect', scores were the same as last year and in line with the national average. However; the trust scored the worst nationally for the statement, 'My team has enough freedom in how to do its work' at 53.6% against the national average of 62%.

Trust-wide, the overall staff appraisal rate was 77% against a trust target of 85%. Of the 4672 staff who required an appraisal, 3610 had received one. This was lower than the 84% compliance rate during our last inspection.

In the NHS staff survey results 2022, staff responses indicate that the quality of staff appraisals was an issue. For the statement, 'It helped me to do my job', responses were below average at 16.8% against an average of 22.5%. For the statements, 'It helped me agree clear objectives for my work', and 'It left me feeling that my work is valued by my organisation', both scored lower than last year and lower than average.

Compliance rates for clinical supervision and line management supervision were 71% and 72% respectively against a trust target of 85% in January 2023. Of 3992 staff who required clinical supervision, 2853 had received it and of 5686 staff who required line management supervision, 4091 had received it. There had been a downward trajectory from September 2022 from 75% down to 68.5% in December with an increase to 71% in January 2023. Divisions with the lowest level of compliance included: Deaf mental health services (50%), Adult Forensic services (54%), North Manchester (62%) and Salford (63%).

Compliance for mandatory training figures were: Infection prevention awareness: 93%, basic life support: 65%, conflict resolution 94%, equality, diversity and human rights 94%, Fire safety 83%, health and safety 95%, infection prevention for clinical staff 84%, infection prevention for housekeeping staff 94%, information governance 95%, Mental Capacity Act 79%, Mental Health Act Code of Practice 82%, moving and handling-inanimate objects 92%, moving and handling-inpatient 49%, physical management of violence and aggression (PMVA) including breakaway 74% PMVA- later life 62%, Prevent level 2, 95%, Prevent WRAP 76%, safeguarding adults levels 1,2 and 3, 95%, 90%, 75% respectively, safeguarding children levels 1,2 and 3, 95%,90%, 76% respectively. Total overall compliance rate was 87%.

Our findings

However; in the core services we inspected, there were wards and teams where the compliance rate for some mandatory training was much lower. Trust leaders told us they had faced particular challenges in delivering training which required staff to attend courses in person. They told us they were looking at ways they could deliver this type of training to staff within their clinical areas to make them more accessible to improve attendance.

The trust had experienced significant challenges recruiting and retaining staff over the past 18 months. The staff turnover figure was 14.02% in June 2021 rising to 16.29% in May 2022. In August 2022 the figure had risen to 16.66% and increased slightly month on month up to December 2022 where it reached 17.26%. This had reduced in January 2023 to 16.85%.

The trust had also persistent challenges recruiting qualified staff across several services including acute, psychiatric intensive care, child and adolescent mental health, forensic and older people's wards. The trust had also faced significant challenges recruiting and retaining care co-ordinators within their adult community mental health teams.

From August 2022-December 2022, figures for all staff trust wide based on actual number against planned fluctuated between 111% to 117% however for the same period, the figure for registered nurses fluctuated from between 81% to 89%. The trust had consistently been using higher than establishment levels of non-registered staff to cover shifts where they were unable to meet the two registered nurses per shift on days which had been the case since April 2022. For nights, the required minimum was for one registered nurse per shift. Trust wide figures for nights fluctuated between 84% in October 2022 to 94% and 93% for November and December 2022.

The trust was heavily reliant upon the use of agency and bank staff to fill shifts. Agency costs for the financial year to January 2023 were £18.9m and increase of £1.6m for the same time-period the previous year. Bank costs had also increased by £5.6m to £26.1m compared to the previous year.

Almost two thirds of staff who responded to our CQC survey reported they felt there were not enough staff in the trust for them to be able to do their job properly. This was consistent across most staff types and locations but was especially high at Trafford and Wigan in-patient services (93% and 90% respectively).

Almost two thirds of staff also reported that they had felt unwell as a result of work-related stress. This was similar across all locations and services although it was notably higher at Manchester acute wards for adults of working age and psychiatric intensive care wards at 84%.

This was consistent with the NHS staff survey results for the statement, ‘During the last 12 months have you felt unwell as a result of work-related stress?’ with 53.2% of staff reporting they had an increase from 48.8% the previous year and much higher than the national average of 41.8%.

Staff sickness levels had generally stabilised over the past six months between August 2022 and January 2023 with the lowest rate recorded in September 2022 at 6.32% and a peak in December 2022 at 8.06%.

However; over two thirds of staff responded that in the last three months they have gone to work despite not feeling well enough to perform their duties. This was consistent across all locations and services, although notably higher at Bolton and Wigan inpatient services (83% and 79% respectively), and at wards for adults of working age and psychiatric intensive care units (83%).

There had been an increase in sickness absence in recent months due to a significant increase in short-term absence which had particularly affected adult forensic services, Salford and Trafford.

Our findings

The NHS survey results showed that 61.6% of staff had reported that in the last three months, they had come to work despite not feeling well enough to perform their duties which was the worse score nationally and no improvement from last year. All seven statements in the NHS staff survey related to staff burnout scored worse than the national average and worse than 2021 scores.

Staff reporting they had personally experienced physical violence at work from patients, relatives or other members of the public was 22.1% which was within the highest scores nationally and showed no improvement from the 21% the previous year. Scores for staff personally experiencing harassment, bullying or abuse at work from managers had increased from 10.4% the previous year to 12.2% against an average of 8.5% nationally. From other colleagues, scores were average.

Almost half of staff reported they often thought about leaving the organisation. This was consistent across all locations and services. At Wigan and Trafford inpatient service, this was notably worse (66% and 64% respectively). This was also reflected in the NHS staff survey results with the number of staff reporting they often thought about leaving the trust increasing year on year. In 2020, 26.6% of staff said they did against a national average of 24.9%, in 2021 it worsened to 31.2% (average 27.8%) and again in 2022 to 38.7% (average 29.1%).

Around a quarter of staff responded that as soon as they could find another job, they would leave the organisation. This was consistent across all locations and services, although notably worse at Wigan inpatient services (41%). The child and adolescent mental health services had the highest staff turnover rate.

Around a third of staff responded that they would probably look for a job at a new organisation in the next 12 months. This was consistent across all locations and services, although notably worse at Wigan inpatient services (52%). 'Work life balance' was the main reason given for staff leaving across the Trust.

We held a focus group with a range of trade union representatives. They told us that the flexible working arrangements which the trust had made available to staff where possible during the pandemic, through the launch of the new wellbeing policy on the 1 April 2022, which provided a person-centred approach to supporting staff wellbeing, were now much less available. They attributed this to the limitations and inflexibility of the rostering system. They told us for example; that if a staff member wanted to work four hours one day instead of a full shift, the system would not support this therefore staff who wanted to work flexibly, were not always able to do so. They felt this had a major impact on staff well-being and retention. The NHS staff survey results for the statement, 'we work flexibility' was significantly worse than the national average with support for work-life balance scoring 6.3 against an average of 6.7, and for flexible working, the trust scored 6.4 against an average of 6.8. The trust had scored average against both statements the previous year.

The interim director of human resources told us they were exploring ways to gain feedback from staff before they left the trust rather than the current system of contacting leavers after they had left the trust to see if there were interventions they could put in place to support staff to stay to improve retention. In addition, the trust had implemented a new induction model for all healthcare support workers in September 2022 which included all mandatory training. The acting director of human resources told us that the evidence-based feedback they had received so far was very positive and staff turnover was being tracked to assess the impact of the new model.

Our findings

The trust had also employed a lead nurse for safe staffing who reviewed all incidents staff reported through the trust's datix system using the 'unsafe staffing' category on datix. They were responsible for ensuring that quality impact assessments were undertaken where required. They were also reviewed by local managers. The trust had also established a new safe staffing steering group which was supported by the NHSE improvement team and work had commenced on the Mental Health Optimal Staffing *Tool* (MHOST) programme.

The trust had also recently established a mental health workforce group, with a dedicated workforce lead role, to address recruitment and retention issues.

The trust recognised staff success by staff awards and through feedback. Some wards had ward- based staff recognition and star of the week.

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

We reviewed five staff records where staff had raised a grievance and found in each case the trust policy had been followed.

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

At our last inspection, the trust's freedom to speak up guardian was a member of the human resources team. Subsequent to our inspection, staff had reported through a number of internal and external forums and reviews that they had not felt comfortable raising concerns as they were concerned the freedom to speak up guardian may not be impartial due to their substantive role.

From the NHS staff survey results, the trust scored 6.1 against an average of 6.8, which was significantly worse than the 6.6 they scored the year before. Scores for staff feeling secure raising concerns about unsafe clinical practice, feeling safe to speak up and being confident the trust would address their concerns were all significantly lower than the previous year and the national average. However; overall, staff we spoke with on inspection told us they felt able to raise concerns without fear of retribution. Staff within the acute wards and psychiatric intensive care units were able to provide examples of concerns they had raised with the freedom to speak up guardian and explained how these had been resolved.

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

Since our last inspection in July 2022, there had been 29 staff who had raised a concern through the freedom to speak up guardian in quarter 2 between July and September 2022 which had increased to 73 cases in quarter 3 between October and December 2022.

Our findings

Of the 29 cases raised, the majority (19) were categorised as “work issues”. Two were categorised as “staffing” and another two were categorised as “grievance”. The rest were categorised as “other” which included queries about pensions, the role of FTSU and in one case a patient concerned about their own care. All the cases raised were closed only when the person raising the concern indicated that this was appropriate, and the case had been dealt with.

Of the 73 cases raised between September and December 2022, the majority (46) were categorised as “work issues”. Of these, 14 were given a subcategory of “culture” in order to capture more relevant data in response to the issues raised at the Edenfield Centre. A further 10 were each categorised as “grievance” and “other”. Five related to staffing, one related to discrimination and one was around perceived detriment after raising a concern in an open forum.

The trust had 24 cases, all from quarter 3 that were still logged as “Ongoing” rather than complete. This was not due to any delay in responding but mainly due to discussions continuing. In five of these cases concerns were raised anonymously about ongoing concerns at the Edenfield and as the work there was still underway it was decided to keep them open until there could be greater assurance that they had been addressed. Most of the rest were due to them being raised late in the quarter.

The significant increase in cases in quarter 3 was largely a result of staff raising concerns from services other than the Edenfield. There was not a particularly high volume of concerns from any one particular service and there had not been a need to escalate any concern(s) because it was not being responded to.

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

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

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

Staff had access to support for their own physical and emotional health needs through occupational health and external counselling service to support their wellbeing.

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

Data from the 2022 Workforce Race Equality Standard (WRES) report (published in February 2023) showed the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public was 29.6% for White staff, an increase from 28% in 2021. This compared to 35.3% of staff from ethnic minority groups which had improved from 40.3% in 2021.

For the same metric, data from the 2022 Workforce Disability Equality Standard (WDES) report (published in February 2023) showed this figure had increased from 35.6% in 2021 to 36.3% in 2022 for disabled staff.

Our findings

According to the same 2022 WRES data, the number of staff experiencing harassment, bullying or abuse from other staff had increased across the board from the previous year. This stood at 21.3% of White staff (an increase from 20.5% in 2021) and 23.2% of staff from ethnic minority groups (an increase from 20.8% in 2021).

In 2022, 20.7% of disabled staff reported experiencing harassment, bullying or abuse from other colleagues. This had risen from 17.4% in 2021. The figure for reporting these instances was lower for disabled staff at 62.8%, compared to 66% of non-disabled staff.

The percentage of staff from ethnic minority groups who had experienced discrimination from managers, team leaders or other colleagues had reduced from 15.7% in 2021 to 14.4% in 2022. However, this had increased/worsened for White staff from 6.6% to 9% in the same period, although this figure still remained below that of staff from ethnic minority groups.

The percentage of staff who had reported they had experienced discrimination due to their ethnicity had decreased year on year from 2020, when this stood at 43.5%. In 2021, this was 38.3%, and in 2022, 35%. In the same period, the national average had increased slightly overall, from 39.7% in 2020, to 38.1% in 2021, and 40.6% in 2022.

The percentage of staff who had reported they had experienced discrimination due to their religion had also decreased year on year, from 7.1% in 2020 to 3.7% in 2022 (which was lower than the national average of 4.2%).

However, the figure for discrimination related to sexual orientation within the trust was the worst nationally at 11.2% (against an average of 6%). Disability discrimination had also increased/worsened to 15.8% (against a national average of 12.8%). Age discrimination was slightly worse than the average at 27.5%.

In 2022, 17.3% of disabled staff reported experiencing discrimination from managers or team leaders, an increase from 15.4% in 2021.

The figures for staff with a long-term condition experiencing harassment, bullying or abuse from other colleagues had also increased from 17.4% in 2021 to 20.7% in 2022. In these cases, the percentage of staff who had reported the discrimination was 62.8%. This was slightly lower than the 66% figure for staff who had experienced discrimination who did not have a long-term condition.

The figure for all staff within the trust who reported they had experienced discrimination at work from patients, their relatives, members of the public, their manager or colleagues had also increased from the previous year and was above the national average. The number of staff who thought the trust respected the individual differences of staff (e.g. cultures, working styles, backgrounds, ideas, etc.) had also reduced from 70.1% in 2021 to 63.8% in 2022, which was much worse than the national average of 74.7%.

In 2022, the percentage of staff believing that the organisation provided equal opportunities for career progression or promotion had decreased across the board, with 54.9% of White staff in agreement (previously 61% in 2021), compared to just 41.4% of staff from ethnic minority groups. background from 2021 to 2022.

For disabled staff, this figure had reduced from 56.5% in 2021 to 46.7% in 2022.

This was reflected in the overall percentage of staff in 2022 who felt the trust acted fairly with regards to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age. This stood at 53.1% (against a national average of 59.8%), which had fallen from 58.6% in 2021.

Our findings

In 2022, the number of disabled staff who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties, stood at 22.8%. This had reduced slightly from 24.8% in 2021, although still remained above the national average of 18.9%. For non-disabled staff, this figure was lower at 17.2%, but remained above the national average of 12.7% and had increased from 14.7% in 2021.

Both disabled and non-disabled staff felt increasingly less satisfied their organisation valued their work since 2020. For disabled staff, this was only 36.9% in 2022 (falling from 44.5% in 2020), whilst for non-disabled staff this was 45.3% (falling from 54.9% in 2020).

In terms of reasonable adjustments, 74.8% of disabled staff agreed the trust had put these in place, compared with 78.8% of non-disabled staff.

Staff networks were in place across the trust. The trust had three established staff networks, for staff from ethnic minority groups, a staff disability network and a LGBT+ network. During a focus group we held with the leads, they told us that they did not feel fully supported in their roles and were not linked in with the wider trust agenda and strategy regarding diversity and inclusion. There was a lack of corporate support and oversight of the groups, which operated as standalone groups with a dependency of on the motivation of leads to enable them to continue to function. This disconnect meant that there were limited avenues for escalating or receiving feedback from issues raised by members of the groups.

Staff were supported by managers to attend meetings in work time.

Governance

Our findings from our inspection activity showed that the trust's governance systems and processes were ineffective in ensuring that patients received safe and effective care in appropriate environments. Services did not operate safely and risks to patients were not effectively assessed, monitored and mitigated.

The trusts' governance structure was not fully embedded, effective and operational.

The board and leaders had lacked curiosity and had accepted reassurance from unreliable data rather than the assurance needed. This meant data could not be analysed accurately to make improvements.

The trust had revised and made changes to the board governance structure which was agreed by the executive management team on the 22 February 2023. The new structure had eight board committees and a strategic equality, diversity and inclusion working group which fed directly into the board. The committees included: finance and investment, charitable funds, commissioning, quality improvement, audit and remuneration and terms of service committee. Since our last inspection, the trust had implemented a new people, culture and development committee to replace the existing workforce development committee. This was in addition to implementing a new trust management executive committee which the Park House project board fed directly into.

Each committee chair presented the board with a progress report. This was linked to the key priorities of the committee and identified challenges faced and plans in place to address these.

With the exception of the remuneration and terms of service and commissioning committees, each of the committees had specific groups/sub-committees which linked into them to support the delivery of the trust's strategy.

Our findings

The structure from the board to the groups/ committees was displayed on a single sheet which provided a clear overview of the board's overarching governance structure.

The new chair held their first board meeting within the trust on 30 January 2023. We attended both this meeting and the following meeting which took place on 27 February 2023 and reviewed a range of minutes from the board and sub-committee meetings.

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

Each triumvirate team included an associate medical director, associate director of operations and an associate director of health professionals and quality.

Following our last inspection, the trust had implemented a further triumvirate team specifically for the adult forensic service which had created five care groups across the trust.

The five teams were accountable and responsible for the delivery of services within the following care groups: specialist services, Wigan, Addictions and Bolton, improving access to psychological therapies (IAPT), Salford and Trafford, Manchester and rehabilitation and an adult forensic service care group. Each team had an associate medical director, associate director of operations and an associate director of health professionals and quality. Under each team there were distinct divisions which were split by service and/or geographical location. The care group triumvirate model had been implemented to provide clearer lines of accountability and responsibility from the board to wards/teams and specialist services.

At the time of our inspection, these new structures were still not effectively embedded. The triumvirate model had been operationally managed since our last inspection to the detriment of the quality agenda. Leaders told us that the focus on operational delivery had resulted in an imbalance developing, with the 'voice' of clinicians becoming lost, which had directly impacted on the quality of care patients received.

Local leaders had not ensured that environmental issues directly impacting on patient care had been identified and addressed through existing governance arrangements. An external quality spot check review undertaken in 2022/2023 on the acute and psychiatric intensive care wards found recurrent issues in relation to ward cleanliness and maintenance, fridge and clinic room temperature monitoring, record keeping of controlled drugs and a lack of a systematic approach for matron walkabout visits. The report noted an improvement to the management of ligature cutters on the wards but concluded systems and processes reviewed were not operating effectively in all ward areas and therefore they were not assured that recommendations from previous audits had been fully implemented. The issues identified were basic and should have been picked up through internal governance arrangements without the requirement of them being brought to the attention of leaders through an external audit. This demonstrates that internal governance arrangements were not operating effectively on these wards.

Our findings

The trust had submitted a formal bid through the Recovery Support Programme for financial support to provide a leadership programme for the associate directors of health professionals and quality in recognition that these were key roles which needed strengthening to develop and re-balance the focus from operational management to the quality agenda.

We held a focus group with the leaders within the triumvirate models which was attended by 11 people with representation from all care groups. The group explained that since the introduction of the original four care groups, there had been a lot of movement within the groups, which meant that the care groups had not all had the full complement of staff in the triumvirates. The new care group roles for the forensic services were being recruited to. The group told us they had received support from the executive team through meetings with them, individual coaching and opportunities to enroll in the NHS Clinical Leadership Programme.

The group were clear about their roles and responsibilities and felt they had a voice within the organisation and that there was good communication between the care groups. However; they did acknowledge that it is was difficult to be as visible as they needed to be in the divisions within the care groups due to size and geography they covered, and that the quality governance structure needed to be enhanced with a need for standardisation to enable the embedding of the improvement plan.

The deputy chief nurse was covering the chief nurse as the lead for the Mental Health Act and the trust had a head of mental health legislation and policy. Governance arrangements were in place in relation to the Mental Capacity Act and Mental Health Act administration and compliance which was monitored through the trusts' Mental Health Act and Mental Capacity Act compliance group which fed into the quality improvement operational delivery group. Outcomes of Mental Health Act monitoring visits were reviewed for any themes.

Staff were aware of who the Mental Health Act administrator was for their clinical area and how they could contact them if required.

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

The trust had a restrictive interventions reduction programme in place, which met best practice standards. The trust had started to consider the Mental Health Units (Use of Force Act) 2018 but had not made significant progress in its implementation. The chief nurse was nominated as the responsible person to ensure accountability with the medical director as nominated support in the chief nurses' absence. There was no overall implementation plan or strategy for the organisation to be compliant with the Act and its statutory guidance other than for training. The organisation was on the 'working towards certification' list on the Restraint Reduction Network website. The training self-assessment document was RAG rated but had no implementation or target dates, there were also gaps and no supporting documents. There was not an up-to-date policy which included the Mental Health Units (Use of Force) Act.

The trust had local medicine management groups at Wigan, Bolton, Manchester and a combined

Trafford and Salford group. There was also a trust wide monthly medicines management group which reported into the trust board.

Our findings

The trust had a robust system in place to investigate complaints. There was an option for service users and their families to either raise a complaint or a concern. Data for both concerns and complaints were reviewed at the trust quality committee which met on a quarterly basis. Emerging themes from concerns and complaints were discussed as well as the number of complaints, and if this was an increase or decrease since the previous quarter. The number one theme across community services was care coordination and the associated level of support, and a range of concerns linked to quality of care for some inpatient services. There had been an upward trend in the number of concerns and complaints since the last inspection across all services. The number of complaint responses outside of timeframes has increased since the previous quarter across all services.

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

In the NHS staff survey 2022, only 59% of staff felt the trust acted on concerns raised by patients / service users against an average nationally of 74%. This was a significant worsening from the 70.9% from the previous year.

The trust did not have effective systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. Managers did not always share learning about serious incidents with their staff and across the trust. Some staff said that information was shared with them at team meetings or via emails, but others said they did not receive information. We reviewed team meeting minutes and saw little evidence that learning was shared from other parts of the trust. The trust said that information was shared via multiple mechanisms including safety alerts, newsletters, trust wide learning events etc. However, there was no monitoring of the impact on practice of the information shared by these bulletins, emails and newsletters.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person.

Four out of five staff responded to our bespoke staff survey, reported that they felt the organisation encouraged them to report errors, near misses or incidents. This was consistent across most staff types and locations and a significant improvement on the latest NHS staff survey where the trust scored the worst score nationally for this statement.

However, staff we spoke with told us that they did not always receive feedback when they raised concerns and shared ideas and felt despondent about continuing to do so due to a perceived lack of action from senior leaders. Only half of staff stated that when errors, near misses or incidents were reported, the organisation took action to ensure they did not happen again. This was similar to the NHS staff survey results where the trust scored the worst nationally at 52.9% against an average of 70.3% and was worse than the previous year's score of 56.4%.

From our survey, one in three staff stated that they were given feedback in response to reported errors, near misses and incidents. Half of staff at inpatient services at Wigan said this did not happen.

Again, this was similar to the NHS staff survey results where the trust scored 51% against an average of 63.9 and indicated there had been no improvement over the past six months since the NHS staff survey was completed.

Our findings

Management of risk, issues and performance

The trust board did not have effective oversight of quality, risk and safety concerns within services and did not ensure that these were being managed effectively. Meeting operational targets had been seen as a priority at the expense of safety and quality. Risks, issues and poor performance were not always dealt with appropriately or quickly enough. The risk management approach was applied inconsistently or was not linked effectively into planning processes.

Our inspection findings from the in-patient wards we inspected evidenced that significant safety issues we had previously raised with the trust through issuing section 29A warning notices in relation to ligature risk and fire safety had not been effectively managed or mitigated on all wards. The trust had developed and begun to implement action plans to address the actions required of it by CQC, however, during our inspection we remained concerned at the pace in the delivery of those planned actions.

The trust had continued to fail to support frontline staff to implement the trusts' smoke free policy across the acute, psychiatric intensive care units and forensic secure wards.

Since our last inspection, the trust had appointed a tobacco dependent treatment lead and established a team to support them to launch a treatment dependent service in April 2023. The trust was also in the process of implementing the CURE programme. The CURE program offers a more supportive approach to smokers and treats smoking as an addiction. The trust had recently started to provide patients who did not wish to engage with nicotine replacement therapies an electronic vape. Staff told us the introduction of vape for patients had helped to manage risk of fire and reduce incidents of violence and aggression due to not being able to smoke.

The trust had an action plan with a completion date of 30/04/2023 to embed the smoke free policy and develop and implement a trust wide communication strategy to support the embedding of the revised smoke free policy. However; progress against this action plan had not been effectively prioritised by the trust and the momentum for implementation had been lacking. Application of the No Smoking Policy varied across the acute, psychiatric intensive care and forensic wards, and there was substantial evidence of smoking on these wards.

There had been a significant number of fire and smoking related incidents on the acute and psychiatric wards. In the six months leading to this inspection, the trust supplied data about the number of fires recorded in this core service. The data we received indicated that there were 66 incidents of actual fire and 114 false fire alarm incidents due to smoking of e cigarette.

The trust had not ensured that warning notices served following our last inspection of acute inpatient services had been met and improvements maintained across the acute and psychiatric intensive care wards and had not taken all actions to mitigate ligature risks.

Staff did not update risk assessments as necessary for all patients and risk management plans were not consistently developed in response to identified risks and safety incidents.

During this inspection, we found that although some ligature and anchor points had been removed on some wards, some ligature points remained, and these were not always captured on the ligature audits. The action for the uncompleted items in the ligature audits were documented on the maintenance reporting system as "job to be submitted", however; there was no timescale for completion.

Our findings

At Park House, senior managers told us that many environmental works were not prioritised as the trust was building a new hospital next to the existing one with a completion date of 2024. The trust had however completed 5136 of planned and reactive maintenance requests at Park House, an increase of 5% from the previous year.

There had been a significant number of ligature incidents in the last six months on the acute and psychiatric intensive care wards. On the wards in Wigan and Bolton there were 561 ligature incidents, the wards in Salford and Trafford there were 192 ligature incidents and the ward in Manchester there were 410 ligature incidents.

There had been three deaths on the wards over the past 12 months by use of a suspended ligature which had resulted in the deaths of the patients. One of these had been by use of unfixed drawers and two had been by bathroom doors. Since the on-site inspection, we were informed of a further suspended ligature death within the acute and psychiatric intensive care wards.

This demonstrates that the actions to mitigate ligature risks and incidents by clinical and operational management had not been effective on these wards.

However; we found on the forensic wards that action had been taken since our last inspection to ensure that environmental risks on the wards were identified and acted on to maintain patients' safety.

During our last inspection of the mixed sex acute wards, we had concerns about how staff were managing sexual safety risks to keep people safe on the wards. Staff informed us that they managed the risk through staff observing communal areas and access to male and female corridors. We saw this in practice on the mixed wards we visited with staff presence in the corridors and communal areas which was an improvement from our last inspection.

The trust had an established mortality review group which were led by the medical director who provided a summary of the learning from deaths report to the quality improvement operational delivery group. The reports included an analysis of themes, trends and learning to improve practice across the trust. These processes had now been fully embedded since our last inspection.

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

The trust had a backlog of 72 hour reviews across the trust which was impacting on the number of serious incident investigations being commissioned. This meant that there were delays in identifying potential learning from incidents and ensuring this was delivered at pace across the trust. A significant number of serious incident investigations had not been concluded in line with trust policy time-scales with some taking up to a year.

The trust had put a tracker in place which all managers had access to which showed where 72 hour reviews were open or overdue. The patient safety team was in the process of recruiting to a pilot project of an investigation team for six months to support the completion of serious incident reviews.

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

Our findings

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

The impact of escalation of risk was often diluted by the time it reached the board. It had been recognised through the discussion at board in reviewing the board assurance framework (BAF) in July 2022 that work was necessary to improve the confidence of the board in the content of and mechanisms of the board assurance framework. Each risk within the BAF had a designated executive director lead, whose role included routinely reviewing and updating the risks, and a designated lead committee with responsibility for testing the accuracy of the current risk score.

Following the review, each sub-committee which was responsible for a BAF risk(s) had reviewed the risk(s) by adopting the principle of defining and assessing the score of a strategic risk through the consequence of the risk materialising, the likelihood of the risk occurring, describing the controls in place to mitigate the likelihood of the risk occurring and identifying the strength and effectiveness of the controls and negative or gaps in assurance as identified through both internal and external sources.

As a result of the reviews, a number of target risk scores had been reset in accordance with these principles. A target date and performance trajectory were provided for each individual risk. These indicated when the identified controls and actions were expected to have reduced the risk to the target risk score. These were presented at board in November 2022 and incorporated into the BAF for 2022/23. There were 15 strategic risks on the corporate risk register which were included in the revised board assurance framework as of February 2023. These were all linked to a strategic objective. Ten of these were classed as extreme risks and five were classed as high. The trust had set the risk tolerance score at 10. Four of the extreme risks were rated 20 which were:

- Edenfield Centre - The incident at the Edenfield Centre, creates a patient safety and reputational risk to the Trust impacting on the confidence of the Trust to effectively deliver services.
- Adult Secure Commissioning – Failure to commission safe, effective and financially sustainable Adult Secure services could result in ineffective/poor quality services for service users and financial risk for GMMH
- Performance – Failure to meet national and local targets and regulatory standards will impact on quality of care, reputation and could incur financial penalties and/or intervention from regulators
- Financial Sustainability – Failure to deliver the Trust's annual financial plan and longer-term financial strategy will impact on the Trust's sustainability, ratings and ability to deliver quality improvements

Six extreme risks were rated 16 which were:

- Safe Staffing – Failure to achieve the agreed safe staffing levels in the Trust's bed-based services and community services will impact on clinical quality and safety.
- Positive and Safe – Failure to minimise the use of restrictive practices will impact on patient safety and experience
- Failure to reduce out of area placements to a zero position can impact on patient safety and experience and act as a barrier to recovery and also contribute to non-achievement of the integrated care system target to eradicate out of area placements
- Recruitment - Failure to recruit high quality substantive staff will impact on quality of care and lead to increased bank and agency spend

Our findings

- Retention - Failure to retain high quality substantive staff will impact on quality of care and lead to increased bank and agency spend
- Capital and Estates – Failure to invest to improve the standard of the Trust's estate and environments will impact on patient experience and quality of care

Five of the risks were rated high at 12 which were:

- Physical Health - Failure to improve the assessment and treatment of physical conditions will impact on service user wellbeing and outcomes
- Mandatory Training – Failure to achieve compliance with mandatory training requirements will impact on quality of care and staff satisfaction
- Digital – Failure to invest in appropriate digital technology and fully embed digital solutions across the organisation will impact on service user and carer experience and our ability to transform services and support staff to respond to changing needs
- Engagement – Failure to engage effectively with service users and carers will impact on the Trust's ability to transform services for the benefit of the wider population and Failure to engage effectively with service users and carers from communities that experience inequalities will impact on the Trusts ability to transform services and tackle health inequalities.
- Future Commissioning Arrangements – The move towards integrated care systems and the devolvement of specialised commissioning budgets to Lead Provider Collaboratives may impact on the resources available to the trust.

The board assurance framework was considered in each board meeting. The risks on the board assurance framework reflected the current risks the trust faced. The trust did not have a separate corporate risk register.

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

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

The trust also had divisional business continuity plans in place.

The trust had a track record of strong financial governance, with substantial audit opinions from both external auditors and internal auditors. The income received to run the trust's services in 2022-23 was expected to be £489m, and it was forecast that it would achieve a surplus of £3.9m. In addition, the trust planned to invest £36.9m in its estates and infrastructure. Financial planning within the Trust was undertaken in conjunction with integrated care board's finance colleagues to support the achievement of system financial targets.

The chair of the audit committee told us that although assurance about the operation of financial controls was strong, there was limited assurance about the operation of controls to ensure quality. A recurrent theme from internal audit was that in some areas there were weaknesses in design and inconsistent application of controls; and the achievement of some aspects of system objectives were therefore at risk.

Our findings

The trust described to us how its relatively limited capital resources were prioritised and deployed to best effect taking into account quality and safety concerns. Progress had been made in reducing ligature risk; and investments were being prioritised to increase the sexual safety of patients and those in seclusion.

Information Management

Trust leaders were open and honest about the challenges they faced with the IT systems they currently had which was escalated onto the board assurance framework with a score of 12 which was high.

The board, leaders and staff did not always receive information to enable them to challenge and improve performance. IT systems were not always integrated to ensure provision of timely data and information and there was a reliance on manual data collection. The incident reporting system was out of date and did not enable staff to record key patient information such as ethnicity data. This meant that trust leaders were not able to monitor and track the use of rapid tranquilisation, seclusion and restraint by patient's ethnicity for example. The trust was therefore not easily able to identify themes or trends which may indicate specific patient groups were more or less likely to experience health inequalities. The trust had started a procurement process for a new system and were writing a specification for tender at the time of inspection.

The trust was continuing to develop Power Bi performance dashboards, and these were in use within the in-patient services.

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

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

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

3. Improving our ability to make informed and intelligent decisions

4. Improving the efficiency and digital safety of our organisation

5. Supporting our workforce to become digitally enabled.

The trust had experienced issues with the role out of electronic prescribing of medicines.

Since our last inspection, the trust had moved the Wigan services they had acquired on to trust information systems so they were now aligned with the rest of the trust's services with the exception of Health and Justice Prison services which are required to use the NHSE/Prison information system.

The trust submitted required notifications and shared information of concern with CQC and commissioners.

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

Our findings

Not all staff were able to access the electronic patient record system. Some agency staff and external bank staff were unable to access these and staff on the acute and psychiatric intensive care wards told us that this led to them having to input agency staff's daily notes. This meant there was a risk that information could be entered incorrectly or not at all.

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

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

Engagement

The trust had a structured and systematic approach to engaging with people who used services, those close to them and their representatives. The trust had a Greater Manchester Mental Health Together Strategy 2022-25 to bring together the previous two separate carer and service user engagement strategies they had implemented between 2018-21. Underpinning the new strategy was a focus on how the trust aimed to work in collaboration with everyone including the wider community.

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

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

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

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

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

Patients, carers and family members had opportunities to give feedback on the service they received.

Our findings

The trust submitted monthly friends and family test data to NHS England. The number of responses had increased from 379 in December 2022 to 463 in January 2023. Eighty seven percent of respondents in December reflected a positive experience and 84% had in January 2023.

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

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

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

However, we found that the trusts' strategy and approach to engaging with staff within the trust required further work, to ensure that the voices of all staff were heard and acted upon to shape services and improve the culture. For example, equality network leads did not feel fully supported in their roles and were not linked in with the wider trust agenda and strategy regarding diversity and inclusion. There was a lack of corporate support and oversight of the groups, which operated as standalone groups with a dependency of on the motivation of leads to enable them to continue to function. This disconnect meant that there were limited avenues for escalating or receiving feedback from issues raised by members of the groups.

Learning, continuous improvement and innovation

Improvements were not always identified; actions were not always taken, or learning disseminated effectively across the trust. The organisation did not react sufficiently to risks identified through internal processes in a timely way, and often relied on external parties to identify key risks before they start to be addressed.

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

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

Our findings

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

In 2021-22 the trust was the highest recruiting trust within Greater Manchester into Clinical Research Network studies with 14,679 participants.

External organisations had recognised the trust's improvement work. In the trusts' psychosis research unit, over a third of staff were employed on the basis that they had lived experience of psychosis.

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

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

Key to tables

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ➔➔ Jul 2023	Requires Improvement ➔➔ Jul 2023	Requires Improvement ↓ Jul 2023	Requires Improvement ➔➔ Jul 2023	Inadequate ↓↓ Jul 2023	Inadequate ↓↓ Jul 2023

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

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based mental health services of adults of working age	Requires Improvement ↑ Jul 2023	Good Jan 2020	Good Jan 2020	Requires Improvement →← Jul 2023	Good Jan 2020	Requires Improvement →← Jul 2023
Long stay or rehabilitation mental health wards for working age adults	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Mental health crisis services and health-based places of safety	Good Nov 2022	Good Nov 2022	Good Nov 2022	Good Nov 2022	Good Nov 2022	Good Nov 2022
Wards for older people with mental health problems	Inadequate Feb 2023	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Requires improvement Feb 2023
Child and adolescent mental health wards	Good Apr 2022	Good Apr 2022	Outstanding Apr 2022	Good Apr 2022	Good Apr 2022	Good Apr 2022
Forensic inpatient or secure wards	Requires Improvement ↑ Jul 2023	Requires Improvement →← Jul 2023	Requires improvement Nov 2022	Requires improvement Nov 2022	Requires Improvement ↑ Jul 2023	Requires Improvement ↑ Jul 2023
Acute wards for adults of working age and psychiatric intensive care units	Inadequate →← Jul 2023	Requires improvement Nov 2022	Requires improvement Nov 2022	Requires improvement Nov 2022	Inadequate →← Jul 2023	Inadequate →← Jul 2023
Community-based mental health services for older people	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Substance misuse services	Good Feb 2018	Good Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018
Specialist community mental health services for children and young people	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020

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

Community-based mental health services of adults of working age

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Safe and clean environment

All clinical premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Not all interview rooms had alarms. Since previous inspections, the trust had made arrangements for these to be fitted in the Central West team premises, which were leased.

All areas were clean, well maintained, well-furnished and fit for purpose.

Staff followed infection control guidelines, including handwashing. Personal protective equipment, including sanitiser, masks and gloves were available for staff to use at all services visited. Masks and sanitiser were available in each reception area for visitors to use.

Staff made sure equipment was well maintained, clean and in working order. Clinical equipment at all three teams was clean and had been serviced.

Safe staffing

Nursing staff

The service had enough nursing and support staff to keep clients safe. There had been improvements across the three teams we visited since the previous inspections. However, there were not enough staff to effectively coordinate people on waiting lists. Staff told us caseloads were manageable and changes to the duty systems and safeguarding case allocations meant they were able to better focus on client's needs. There were still difficulties recruiting to care co-ordinator posts. This meant there were still waiting lists particularly for allocation to care co-ordinators. Waiting lists were now monitored with cases being prioritised and regular reviews taking place to assess risk.

The service had high vacancy rates. The central east and central west team had the most substantive vacancies, with 13 vacancies each, predominantly for nurse care co-ordinators. Vacancies in the central west team had risen over the course of the last year whilst the vacancy rate had fallen in the South Mersey team to 3 vacancies, with over-recruitment of staff at certain grades which helped mitigate vacancies.

Both central east and central west teams had vacancies for physical health care nurses and assistant practitioners, with these posts proving difficult to fill.

The service had high rates of bank and agency nurses. However, staff were block booked for bank and agency work and the services had been targeting recruitment via agencies which specialised in community staff.

Managers made arrangements to cover staff sickness and absence. Sickness levels were reducing. Sickness levels varied across the 3 teams. Covering the last three months of 2022 the average sickness rate for South Mersey was 17%, Central East was 11% and Central West was 2%. By the time of this inspection, the sickness rate at South Mersey had started to reduce. Managers supported staff who needed time off for ill health.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We spoke to bank and agency staff at two of the teams. They had been well supported by managers and the teams they worked in and had received a comprehensive induction.

The service had high turnover rates. Central west had a turnover rate of 46% at the end of 2022, with rates of 26% at South Mersey and 19% at central east.

Medical staff

The service had enough medical staff. Doctors were based within each of the team bases. They attended team meetings and zoning meetings which was reported positively by community staff and managers. Zoning meetings took place every day to discuss clients who required more intensive support and where individual risks had increased. The service could get support from a psychiatrist quickly when they needed to. Care co-ordinators and community staff told us they could access support quickly when needed.

Doctors said they were well supported by managers and teams and there was good multidisciplinary team working. Doctors described teams as being more stable recently in terms of staffing and that having access to a clinical pharmacist based within the teams had been positive and beneficial.

Mandatory training

Most of the staff were not up to date with their mandatory training, however the figures overall showed improvement with staff more able to complete training modules since previous inspections. We also noted that, for example, whilst not all staff had completed training modules, there was significant expertise and experience within the teams for support, including Safeguarding leads who could provide support with potential safeguarding issues and approved mental health professionals, for advice and guidance in relation to Mental Health Act queries.

The trust's target for mandatory training was 85%. The Central East teams were compliant in 59% of the modules, central west team were 61% compliant and the South Mersey team were 75% compliant.

The mandatory training programme was comprehensive and met the needs of clients and staff. However, compliance for modules such as basic life support, Mental Health Act Code of Practice, Mental Capacity act and Safeguarding level 3 remained low. For basic life support training, 40% of staff across the teams were up to date, 63% of staff were up to date with fire safety training and 75% of staff had completed health and safety training. For Mental Capacity Act training, 54% of staff were in date and for Mental Health Act training 52% of staff were in date.

The trust had received assurance that bank and agency staff were 100% compliant with mandatory training requirements.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Community-based mental health services of adults of working age

Assessing and managing risk to clients and staff

Assessment of client risk

Staff completed risk assessments for each client on assessment, using a recognised tool, and reviewed this regularly, including after any incident.

We reviewed 31 records across the three teams, including 14 clients assessed and awaiting allocation. All records reviewed had a risk assessment completed. Senior managers reviewed each week for risk assessments in date and across all three teams the percentage in date was 79% at the start of February 2023. South Mersey completion rates were highest at 89%, with the central east team the lowest at 71%.

All unallocated records reviewed showed evidence of regular reviews and escalation of issues of concern. Where risks were increasing, plans were made, and clients discussed at team zoning meetings.

At the previous inspection in October 2022, we had been concerned that unallocated clients were mostly contacted by support workers and that whilst managers had developed a template for these calls, support workers were not aware of these, and this was not being used.

At this inspection, a standard operating procedure was under development to guide staff across the trust. This was concise and practical. It included a clear template to follow for calls which included risk, physical health and current mental state and escalation of concerns. Whilst the procedure was still being developed, the call template had been introduced and used.

An audit tool was developed from this, and the first two audits of contacts had been completed in January 2023 for the community teams across Manchester. These both showed contacts were being completed well and escalated appropriately in South Mersey with broad compliance with the procedure, but that contacts in both central teams were less detailed in records and there were issues raised in some contacts which were fed back to team and service managers.

Support workers had received training around their hub roles, which included mental health theory, risk assessment, maintaining professional boundaries, communication skills and escalating concerns.

Staff used a recognised risk assessment tool. The trust used the Salford tool for assessment of risk assessment tool across all services.

Management of client risk

Staff responded promptly to any sudden deterioration in a client's health. All teams had daily zoning meetings where clients who were assessed as higher risk were discussed. We attended a meeting at each team and the meetings were well organised, well attended and action focused. Staff could dial in remotely if they were off site to ensure they were kept up to date.

Changes to duty cover in some teams meant that a permanent duty worker enabled continuity in cases where there were concerns for clients or more frequent contact was needed.

In client records we reviewed, we could see individual actions, often in progress notes, taken in relation to deteriorations in client's health, including liaising with primary and secondary care.

However, we were concerned that it was difficult to monitor whether clients had regular assessments of their physical health completed.

The trust used a tool built into the electronic client record, the physical health intervention tool (PHIT), to monitor physical health, which included physical health history, alcohol and substance misuse brief screening, BMI (Body Mass Index) scoring, cardiac risk and routine investigation results. These were completed for some clients but not all. They were also not calculated as complete when audited if the tool had not been closed on the system. This meant some assessments may have been completed and not closed, and some may be open for prolonged periods with additional information being added.

Physical health care staff told us they were now able to check GP data to identify clients who had not had an annual physical assessment completed by the GP so that this could be completed and recorded using the PHIT tool. However, there was no central process to check this for clients so those who had not seen their GP for an annual physical assessment were not being prioritised for completion of these except where teams individually checked these.

The most recent audits of PHIT tools showed that the average numbers of PHIT completion was low across all teams. In South Mersey, 27% of clients had a PHIT tool completed in 2022/2023. In Central west it was 18% of clients and in Central East it was 10% of clients. However, some physical health monitoring, including electrocardiogram results and blood testing, may be recorded in progress notes and whilst some PHIT documents had been started in 2016 some had more recent results recorded within.

We requested checks from the trust about six clients who had significantly elevated indicators of diabetes within the PHIT tool audit which had not been actioned. These were split evenly between Central East and Central West. In South Mersey, we saw all clients with indicators of diabetes were referred on to primary or secondary care and numbers of referrals to primary/secondary care were significantly higher.

Staff continually monitored clients on waiting lists for changes in their level of risk and responded when risk increased.

At the last inspection, managers had outlined a template for calls, but these were not being followed. At this inspection, staff undertaking calls told us they used the templates and felt more confident to escalate concerns or issues to senior staff.

All teams had started work to prioritise clients currently awaiting allocation, using a red, amber, green triage. We found examples were this had prioritised some clients who did not necessarily require urgent prioritisation over other clients who had elevated levels of risk and clinical need. These prioritisation methods were new and being reviewed and refined at the time of this inspection.

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

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role.

Not all staff were up to date with their safeguarding training. Across all three teams, 37% of staff were up to date with level 3 safeguarding adults and children training. Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Community-based mental health services of adults of working age

At previous inspections, we had noted that the community teams carried responsibility for investigating any mental health related safeguarding concerns within their catchment area, including within other services and for clients who were not under the care of these teams. There were high numbers of safeguarding referrals at the time which were not being actioned in a timely way.

The trust had arranged with the local authority that only safeguarding concerns related to clients of the teams would be investigated by them. Managers and staff felt this had made a difference in making the workload of the teams much more manageable and in ensuing that investigations and meetings could be completed in a timelier way.

Since our inspection in April 2022, the number of ongoing safeguarding enquiries had fallen and referrals for safeguarding input had fallen dramatically. Cases were tracked and monitored and a weekly report flagged to senior leaders to ensure the trust had oversight.

We observed a weekly safeguarding meeting at one of the teams where current cases were discussed and tracked. This was well attended, professional and purposeful. Each team had experienced safeguarding leads who they could approach for advice and supervision of cases.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff within the teams had good links with local authority safeguarding teams and specialist teams.

Managers took part in serious case reviews and made changes based on the outcomes. Learning from these was disseminated at team meetings.

Staff access to essential information

Staff kept detailed records of clients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Client notes were comprehensive and all staff could access them easily. The service used an electronic client record system which was in use across the trust. When clients transferred to a new team, there were no delays in staff accessing their records within the trust.

Multidisciplinary team meeting and zoning meeting records were well completed, and staff could access these if they had not been able to attend a meeting.

Staff had laptops which they could use if working remotely to access client records and to join teleconferences and meetings remotely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines.

At the previous inspection in October 2022, there had been significant medicines management concerns. At this inspection, this had improved. A full-time senior pharmacist had been deployed within the Manchester community teams and had led rapid improvements in practice. This included addressing out of date depot prescriptions, allergies not completed, issues with storage of medicines including use of depot bags, storage of medicines, overordering and unsafe storage of prescription cards.

We reviewed 27 depot cards, visited all three clinic rooms and spoke to physical health staff, nurses and the pharmacist.

Community-based mental health services of adults of working age

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

Prescriptions were now all completed and signed within the last six months. Training and education had taken place with prescribers and nurses to ensure they were aware of good practice guidance. The processes for ordering and storing medicines had been reviewed and changes made. This included preventing overordering and potential waste and the fitting of additional storage in one area to ensure sufficient space.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. Staff had access to medicines information that could be printed for clients. Clients being treated under a community treatment order had documentation and copies of capacity assessments stored with their prescription cards.

Staff completed medicines records accurately and kept them up to date.

Medicines recording had improved since the last inspection. Where there were queries about depot medications being given later than indicated, there were clear explanations in the client records. There were arrangements in place to proactively contact clients who did not attend for their medicines and contingency plans for ensuring clients could have medication at the earliest opportunity.

Staff stored and managed all medicines and prescribing documents safely.

All medicines checked at this inspection were stored correctly and in date. Prescription pads were also stored securely in each service.

Staff completed fridge and room temperature checks to ensure medicines were being stored at the correct temperatures. The pharmacist had completed training with nurses about the importance of fridge temperatures, resetting fridges and actions to take if the temperatures were out of range. There had also been a review of practice when completing home visits to administer depot medication and ensuring medicines were stored safely whilst in transit.

Staff completed records when ordering medicines, receiving medicines and when taking medicines out to use.

Staff learned from safety alerts and incidents to improve practice. Staff training had taken place following issues highlighted by the pharmacist review. There were plans for further training to be undertaken.

Staff reviewed the effects of each client's medicines on their physical health according to NICE (National Institute for Clinical Excellence) guidance. We were concerned that monitoring may not always be taking place for clients prescribed high dose monotherapy or combinations of antipsychotic medication. The trust acknowledged that there was no way currently to gather data on either the number of clients prescribed high dose medication or to be sure that additional monitoring was taking place. The trust had participated in the national high dose monitoring audit but this was focused on inpatient wards and did not audit community services. The trust told us they were developing a new high dose care document which they anticipated they would be able to roll out across the trust later this year and from this they would be able to report on how many clients were subject to high dose treatment. This did not provide assurance that clients are identified now as subject to high dose treatment or receiving the correct monitoring currently.

We did see good practice followed in relation to a female client of childbearing age who had been referred into service and was prescribed sodium valproate, with a rapid plan to review and change this medicine in line with the valproate pregnancy prevention programme.

Community-based mental health services of adults of working age

The senior pharmacist had been able to complete comprehensive medication histories for clients to assist when requests were made for changes to medicines to enable decision making informed by previous response to medicines or doses.

Track record on safety

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff we spoke with at inspection were confident about this, and a staff survey completed by CQC prior to inspection showed over 80% of Manchester community staff agreed that the trust encouraged reporting errors, near misses or incidents.

Staff did not raise all concerns or reported incidents and near misses in line with trust/provider policy. We reviewed the last three months of incident data and saw that staff reported incidents including administration errors, delays in admission to inpatient services, accidents and verbal or physical aggression or abuse. Whilst reviewing depot cards, we noted missed depots were a weekly occurrence across all teams, but this was not reflected in incident data. Across both central teams, only one incident form for each team was related to overdue or missed depot medication in the last three months and these were completed by the pharmacist whilst summarising reviews of medicines. In the South Mersey team, there were two incidents which included missed depot dates and subsequent steps taken by staff.

Staff reported serious incidents clearly and in line with trust policy. Staff recorded when they received reports of a client death from other agencies and their immediate actions.

Staff understood the duty of candour. They were open and transparent and gave clients and families a full explanation if and when things went wrong. Of overall Manchester community staff surveyed by CQC prior to inspection, 66% of staff felt they were encouraged to be open and honest with clients and staff when things went wrong, with 22% undecided and a smaller percentage of 12% who disagreed.

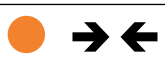
Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. The trust held learning events for investigations once completed that staff could attend. Of overall Manchester community staff surveyed by CQC prior to inspection, 44% of staff felt the trust took action following incidents to ensure they did not happen again, with 33% undecided. Less than half of all staff surveyed, 42%, reported being given feedback about changes made in response to errors, near misses and incidents.

We saw improvements being made, for example, following medicines issues raised by the recent pharmacy audit. This included the development of a local procedure for managing missed depots, which guided staff through a series of steps to follow. The trust had also started to develop a policy and guidance for the use of depot medication trust wide, which would guide staff in ensuring prescriptions were completed correctly and that medicines were stored and being used correctly.

Is the service responsive?

Requires Improvement 

Community-based mental health services of adults of working age

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

Access and waiting times

The service was easy to access. However, staff did not always assess and treat clients who required urgent care promptly, and clients who did not require urgent care sometimes waited too long to start treatment.

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

Anyone could refer for CMHT (Community Mental Health Teams) via the trust referral service, known as the Gateway service. Services received high numbers of referrals from clients and carers, as well as other organisations including the police, primary care services, local authority services etc. Considerable time was spent gathering further information prior to assessing clients due to little information provided by referrers. Clinicians also spent time reassigning referrals to more appropriate services, for example, crisis and home-based treatment teams or early intervention teams. This process and referral pathway was acknowledged as being unique to Manchester within the trust and clinicians and managers identified that this could work far better.

The trust had developed a trust wide workstream with aims to streamline current pathways and processes and identify areas for improvement. The aim of this work was to produce a standard operating procedure for all the trust's community services.

The service did not always meet trust target times for seeing clients from referral to assessment and assessment to treatment. The target for referral to assessment was 28 days. None of the teams were meeting this target at the time of inspection, with a decrease in performance over the last three months in both central teams, but an improving picture in South Mersey. The figures to December 2022 showed that the target was met for 25% of referrals in central west, 32% in central east and 48% in South Mersey.

To mitigate waiting lists the service placed accepted clients into manager's caseloads which were known as the Unallocated Hubs. At the time of our inspection the Central West had 129 clients, South Mersey had 74 clients and Central East had increased since our last inspection with 306 clients in the Unallocated Hub. This caseload also included people whose care coordinator had left or was on long-term sick leave.

Clients waiting for allocation had contact from the team whilst they were on the waiting list. This allowed the teams to check if client's circumstances had changed or risks had increased. The service had targets of contact being made every 28 days with clients who were waiting. We checked 14 unallocated client case records and found evidence of routine contact (although some were slightly over the 28 days) and escalation when needed in all records.

The trust monitored contact figures for clients awaiting allocation. In the last three months this showed growing numbers of clients not being contacted within timescale. The trust told us that having recognised this was linked to several staff leaving within both central teams, they had been able to receive approval to recruit additional staff to cover vacancies and they had already started to see the number of contacts improve.

The trust had also started to monitor the length of times that people were waiting for allocation. At the time of this inspection, the average waiting time at both central teams was 200 days and the average at South Mersey was 83 days. We saw at inspection that some clients were in transition from other teams and a care co-ordinator remained involved, or there was significant support for some clients from other services or supported accommodation.

The trust was working on systems which would enable the lists to be prioritised, but these were still in early stages and for some clients who had been prioritised as highest need we could not identify how this had been assessed, whereas we saw other client records indicating a much higher need for care co-ordination.

There was a waiting list for psychology input at the central west team, with two people on the list. Neither of the other two teams had a waiting list for psychology provision. The trust had noted the difficulty of recruiting to psychology posts and was in the process of looking to advertise a senior post across the community and home-based treatment teams. Clients could also access psychology provision via specialist psychology and psychotherapy services provided by the trust.

The trust was developing a process to standardise internal waiting list management for psychology, occupational therapy and support time recovery worker input across the trust wide teams.

Duty cover arrangements had changed in all three teams since the last inspection, with a member of staff specifically recruited for duty cover for Central West and South Mersey teams. This had improved consistency and management of risk and enabled other staff to complete appointments, assessments and home visits. The central east team was looking to adopt a similar approach.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. One of the teams co-ordinated the assertive outreach pathway, which had flexibility for frequent visits including some weekend visits. Staff tried to contact people who did not attend appointments and offer support. A new procedure had been developed to ensure that clients who missed depot appointments were followed up.

The services were starting to assess client's readiness for discharge through case supervision and management oversight of caseloads. Sensitive discussions were evident in team meeting minutes about client and staff anxieties relating to this. There was a focus on services being more recovery orientated rather than clients remaining with care co-ordination for extended periods with ongoing needs which could be met by other agencies.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. We had no concerns about reasonable adjustments at this inspection. We saw that home visits were arranged where clients had requested these rather than appointments in service. Staff offered flexibility around client's own needs and preferences.

Staff made sure clients could access information on treatment, local service, their rights and how to complain. Information was displayed at each team location.

The service provided information in a variety of accessible formats so the clients could understand more easily. The service had information leaflets available in languages spoken by the clients and local community. Managers made sure staff and clients could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

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

Community-based mental health services of adults of working age

The trust provided figures for complaints for these three teams for three months between November 2022 – January 2023. There were 36 concerns and complaints received across the teams (17 for Central East, 14 for Central West and 5 for South Mersey). The main themes for nearly 40% of complaints was overall care, with poor communication a theme in 25% of complaints.

Clients, relatives and carers knew how to complain or raise concerns. Information was displayed in each service.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints and compliments were discussed in team meetings. The service used compliments to learn, celebrate success and improve the quality of care.

The trust used the friends and family test to gather feedback, although numbers of feedback received were extremely low, with just 18 feedback forms returned for the three teams over three months from November 2022 to January 2023. One feedback form was from a carer. Six responses were overall positive, with 10 overall negative and two gave mixed feedback. The most positive items related to being treated with dignity and respect and staff being welcoming, caring and kind. Lower scores were related to employment and education support, health and wellbeing needs and involvement in care. The one piece of carer feedback was negative.

Forensic inpatient or secure wards

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

The wards were clean and safe, but they were not always well equipped, well furnished, well maintained and fit for purpose. However, there was a full programme of refurbishment in progress. The service had recruited a quality matron, with part of the role being to review and evaluate environmental issues and report to the senior leadership team.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We saw up to date ligature risk assessments for each ward. Mitigation of identified risks included clinical and operational management and recommendations for action required to eliminate or reduce the risk. Each risk was assessed as high, moderate or low via a scoring system.

Staff could observe patients in all parts of the wards. Where areas were not within direct lines of sight, risks were mitigated with parabolic mirrors and staff in positions where they had a clear view.

The ward complied with guidance and there was no mixed sex accommodation. All wards were male or female.

Staff had easy access to alarms. They all carried alarms, and visitors to the wards were also issued with alarms. However, patients did not have easy access to nurse call systems. Most of the wards did not have nurse call systems in patients' bedrooms. Staff told us the only way of checking on patients was via observations. Security checks were carried out at regular intervals.

Maintenance, cleanliness and infection control

Ward areas were clean. However, not all wards were well maintained, well-furnished or fit for purpose.

There was an ongoing refurbishment plan to improve the ward environments. The improvements required were included on the risk register and were reviewed regularly. At the time we inspected, the next review was scheduled for 1st March 2023. Progress was well under way and several wards had already been refurbished. However, at the time of our inspection not all of the wards had been addressed. On wards that had not yet been refurbished furnishings and fittings were old and needed to be renewed. Décor was tired and wards needed to be refreshed.

The improvements required were included on the service's risk register and were reviewed regularly. The service also introduced a relocation checklist for ward closures or relocations during the refurbishment programme.

Forensic inpatient or secure wards

The leadership team had introduced quality walkarounds and environmental audits. For example, clinic and bedroom audits had been completed and the outcomes included the wards adopting a weekly clean to meet the service cleanliness standards. Patients were involved, for example, by being encouraged to change their own bedding

All staff were able to register and access the maintenance reporting system to support the self-reporting of ad-hoc repairs and maintenance. The trust reported that recent system changes had made it quicker and easier for staff to report where maintenance repairs were required.

Staff made sure cleaning records were up-to-date and that premises were clean. They followed infection control policy, including handwashing. During our inspection we observed staff complying with infection control protocols. Staff had access to training, policies and a trust team to support them with infection control.

When we visited the wards out of hours, we found evidence of patients smoking on the wards, and there was a strong smell of smoke in some areas. We raised this with managers, who agreed to address it.

Seclusion rooms

Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock.

The seclusion suites had been identified as outdated and environmentally risky. Fixtures were old, worn and in need of repair. The rooms needed repainting. The intercom systems had interference, which meant it was difficult to communicate clearly. In one, there was visible evidence of a door having been repaired. There was a programme of refurbishment in progress that was due to be completed by February 2024. Capital expenditure had been allocated for these refurbishments.

Managers implemented controls to manage current risk, such as quality walkarounds to check suitability, and data capture of seclusion use to ensure least restrictive practice. Twice daily seclusion audits, so that required improvements to the environment, care planning and documentation could be addressed immediately. The seclusion rooms need for refurbishment was included on the service risk register and reviewed every month.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment. The provider introduced a weekly safety audit that identified, for example, whether fridge temperature monitoring or controlled drugs checks had been missed.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not always have enough staff to keep patients safe. Shift fill rates for registered nurses remained below the trust target and we found incidents where shifts had operated without a dedicated registered nurse.

At our last inspection we identified significant concerns in relation to safe staffing. We found that the service had not accurately calculated or reviewed the number and grades of staff needed for each ward. The service was also carrying a high level of vacancies which meant that wards regularly operated below minimum safe staffing levels. We identified several incidents where wards operated shifts without a qualified member of staff.

Forensic inpatient or secure wards

At this inspection we found that the service had taken steps to improve these issues.

Vacancies remained high but had reduced from our previous inspection. The service had reduced the number of safe staffing incidents where shifts operated below minimum numbers or without a registered nurse.

Managers had worked to improve the planning, monitoring and day to day management of staffing. Following the events of 2022, the service had closed four wards and reduced the number of beds within the service. This increased the staffing resource for the remaining wards.

Managers had calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. The new service management has engaged with the national lead for safer staffing and used the mental health optimal staffing tool to calculate the required staffing levels of each ward. The mental health optimal staffing tool was developed with the support of Health Education England to calculate patient acuity and dependency in order to inform evidence-based safe staffing decisions.

At the time of our inspection ward establishments were:

Borrowdale ward

Qualified staff – 9 wholetime equivalent staff

Unqualified staff – 15 wholetime equivalent staff

Delaney ward

Qualified staff – 10 wholetime equivalent staff

Unqualified staff – 17 wholetime equivalent staff

Derwent ward

Qualified staff – 7.5 wholetime equivalent staff

Unqualified staff – 9 wholetime equivalent staff

Dovedale ward

Qualified staff – 10 wholetime equivalent staff

Unqualified staff – 18 wholetime equivalent staff

Eskdale ward

Qualified staff – 10 wholetime equivalent staff

Unqualified staff – 20 wholetime equivalent staff

Forensic inpatient or secure wards

Ferndale ward

Qualified staff – 8 wholetime equivalent staff

Unqualified staff – 16 wholetime equivalent staff

Hayeswater ward

Qualified staff – 8 wholetime equivalent staff

Unqualified staff – 22 wholetime equivalent staff

Isherwood ward

Qualified staff – 9 wholetime equivalent staff

Unqualified staff – 17.06 wholetime equivalent staff

Silverdale ward

Qualified staff – 8 wholetime equivalent staff

Unqualified staff – 16 wholetime equivalent staff

Ullswater ward

Qualified staff – 8.34 wholetime equivalent staff

Unqualified staff – 8 wholetime equivalent staff

At our last inspection we identified that the service had high vacancy rates. At this inspection we found that vacancy rates remained high but had reduced. At the time of our inspection the service had 29.39 wholetime equivalent vacancies (11.9%). This broke down to 2.21 wholetime equivalent vacancies (2.5%) for qualified staff and 27.18 wholetime equivalent vacancies (17.25) for unqualified staff. Vacancy rates had improved since the time of our last inspection.

At our last inspection we identified concerns over staffing and shift fill levels. At our last inspection the median shift fill rate for qualified staff on day shifts over the previous six months was 84.1%. At this inspection we found that the median shift fill rate for qualified staff on day shifts had increased slightly to 87.6% in December 2022. At our last inspection we found that the median shift fill rate for qualified staff on nights shifts was 103%. At this inspection that had increased slightly to 109.8%. At our last inspection the overall shift fill rate for both qualified and non-qualified staff was 110.6%. At this inspection that had increased to 123.7%.

Forensic inpatient or secure wards

At our last inspection we identified that the service had a high number of shifts that did not have a qualified staff member. At this inspection we found this had improved and the service was reducing the number of shifts reported without a qualified staff member. In the weeks between 7 November 2022 to 30 January 2023 the service reported that 54 out of 3,528 shifts did not have a qualified staff member (1.5%). However, in the eight-week period 2 January to 26 February 2023 the service reported that only 1 of 2016 shifts did not have a qualified staff member (0.05%).

The service had high turnover rates. In the six months prior to our inspection the average staff turnover across the ten wards was 13.95%. Turnover rates had increased slightly. In August 2022 the average turnover rate was 13.45%. In January 2023 the turnover rate was 15.75%. At the time of our last inspection turnover rates varied across wards from 7% to 27%.

The ward managers could adjust staffing levels according to the needs of the patients. The service had introduced twice daily safety huddles which enabled senior managers and ward managers to assess staffing levels on each ward against establishment, acuity, and activity. Managers could move staff between wards to help meet safe staffing levels. The service completed a daily situation report on safer staffing numbers, including reporting situations where there had been no registered nurse on shift or any gaps in staffing levels.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service offered shifts to ward staff before putting them through the bank. They used bank rather than agency staff. Many bank staff were employed substantively by the trust, and some wards had block bookings, which meant that the staff filling shifts were familiar with the service and patients. In the six months before this inspection, across all the wards 66% of the shifts requiring cover were filled by bank staff and only 2% by agency staff.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. However, we found that only 12% of staff who worked solely on the bank had completed prevention and management of violence training.

Managers supported staff who needed time off for ill health. Levels of sickness were high. Sickness levels had increased between October and December 2022 to 18% but reduced in January 2023 to 14%. At our last inspection the trust reported a sickness rate for the previous 12 months of between 8 and 14%. The trust target was 5.6%.

Most patients had regular one to one sessions with their named nurse. Of the 39 records we reviewed, three did not contain evidence that patients had regular one to one sessions with nursing staff. Two of those were on Isherwood ward and one on Silverdale.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. The service had not previously utilised a standardised approach in the recording of cancelled section 17 leave. However, as part of the improvement programme, the leadership team introduced a system in January 2023 for reporting section 17 leave cancelled due to staffing levels and recording of cancelled patient activities, to establish staffing impact on care. The system was still being embedded across the wards. The service was working with the national 'Get it Right First Time' lead in the development of quality dashboards. Once developed, the instances of cancelled section 17 leave or activity would be monitored through senior leadership team meetings to address areas of concern, hotspots, themes, and trends for local action. A quality development group had been introduced to monitor and prioritise actions against improvement plans and to review timescales of the implementation of this system.

Managers were incorporating the system into handover documents, daily ward checklists and situation report templates.

Forensic inpatient or secure wards

At this inspection we did not find evidence that section 17 leave or activities had been cancelled due to staffing levels. Staff told us that they prioritised leave and activities, and the patients we spoke with told us their leave and activities had taken place. There were recovery workers and occupational therapy staff allocated to the wards to support with activities.

The service had enough staff on each shift to carry out any physical interventions safely. Managers used the twice daily safety huddles to identify suitably trained staff on each shift on each ward. Staff on each ward were allocated response duties, which meant they attended other wards in an emergency if needed.

Staff shared key information to keep patients safe when handing over their care to others. Managers completed a handover standards audit. Learning had been shared, standards were implemented on the wards and a quality assurance process set up.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. There were regular weekly ward rounds, and the staff and patients we spoke with said they had not experienced any problems getting doctors to visit the ward if they were needed.

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

Mandatory training

Most staff had completed and kept up to date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training, using a dashboard.

At our last inspection we identified concerns around compliance with mandatory training. We found compliance with 14 mandatory training courses across the wards was below 75%. At this inspection we found that compliance with mandatory training had improved but that there were still areas below 75%.

Four of the 22 mandatory training courses remained below 75%. This included basic life support (63%) and moving and handling training for inpatient staff (36%). Compliance with safeguarding training level three (for band 5 and above) was 73% for safeguarding adults level three and 58% for safeguarding children level three.

76% of staff had completed prevention and management of violence and aggression training. However, amongst staff who were not substantive and worked solely as bank staff compliance with the prevention and management of violence and aggression was 12%. All substantive and bank staff had completed conflict resolution training which included sessions on the appropriate type of interventions to use in a conflict situation. The December 2022 board meeting described plans to offer prevention and management of violence and aggression training to all block booked bank staff.

In addition to mandatory training staff also completed essential training which was specific to their role. Essential training included courses such as immediate life support. At our last inspection we found that compliance with this training was below 75%. At this inspection we found compliance with immediate life support had improved to 79%. We saw that local systems ensured there was a nurse trained in ILS on every ward on every shift. We observed a safety huddle where this was discussed, and ILS trained staff were identified on each ward for each shift.

Forensic inpatient or secure wards

Compliance with essential training was lower than compliance with mandatory training. Seven of 14 essential training courses had a compliance rate below 75%. These included care programme approach awareness (68%), clinical risk assessment for qualified staff (38%), physical health training (62%) and training around rapid tranquilisation (74%).

The mandatory and essential training programme was aligned to the UK core skills training framework, which offers relevant guidance and sets out statutory and mandatory training topics for all staff working in health and social care settings. It was comprehensive and met the needs of patients and staff. Managers described how the training was evaluated, how each course met the needs of patients and staff, and any additional requirements to map to the core skills framework. Each course listed included a narrative of the aims and objectives of the training, together with the skills and knowledge staff would gain from the training.

Managers monitored mandatory training and alerted staff when they needed to update their training, using a dashboard. Training was discussed at meetings, from ward to senior leadership level. Staff told us that they usually had time to attend training and that this had improved in recent months. Staff told us about time for training being made available; for example, preceptorship nurses had a protected week.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. Ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

We reviewed 39 care records, including risk assessments. Staff completed risk assessments for each patient, using a recognised tool, and reviewed this regularly, including after any incident. They used a recognised risk assessment tool, the historical clinical risk management–20, which provides a guided clinical approach to risk assessment. The assessments included risks such as violence and anti-social behaviour, substance misuse and symptoms of mental disorder, and level of insight and response to treatment.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. They identified and responded to any changes in risks to, or posed by, patients, for example by increasing observation levels in response to patients' recognised risks. Staff were encouraged to record when observations did not take place, to identify the reasons why. Care records we saw contained suitable management plans designed to reduce individual risk. Staff we spoke with were able to explain individual patients' management needs. On Hayeswater, a patient told us how they made a plan to reduce risk to others. Staff were engaged with this and working with the patient to implement it.

On some wards, we found that doors were locked, for example, to kitchen and laundry areas. Staff told us that this was for safety reasons, such as patients needing supervised access to areas where there were ligature points

There were policies that provided guidance for staff if they needed to search patients or bedrooms, such as if a risk was identified.

Forensic inpatient or secure wards

Ward managers and duty managers met in a safety huddle twice daily. We observed one of these meetings. Managers reviewed each ward and discussed risks such as staffing levels, the activity and acuity of each ward, including observations levels and any staff movement needed for cover. It was agreed that details of the meeting would be emailed out afterwards to ward managers and the senior leadership team.

Staff followed procedures to minimise risks where they could not easily observe patients. There were parabolic mirrors in areas where lines of sight were not direct, and staff were positioned where they had a clear view.

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

Use of restrictive interventions

The service was working to reduce levels of restrictive interventions. Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation.

The service was involved in the second phase of the provider's reducing restrictive practices quality improvement project, in which wards were focussed on reducing restrictive interventions. Ideas for change were shared across the trust, through the healthy wards group.

The service utilised two tools for reviewing restrictions.

The Mental Health Act managers completed quality assurance checks every month. They reviewed all aspects of restrictions, including section papers and legalities, consent to treatment and patient rights.

Ward staff completed ward audit templates to review compliance with key areas of the Mental Health Act, including detention paperwork, patient rights and consent to treatment. This had recently been adapted to include informal service users.

In addition, there was a positive and safe team that used a dashboard to review the use of restrictive interventions. This included every incident in which restraint, seclusion or rapid tranquilisation had been used. The team offered advice and support where necessary, and any concerns were highlighted and escalated appropriately.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. The service had introduced an independent seclusion panel that reviewed service users in seclusion for longer than seven days, to support plans to reintegrate them to the wards and review the seclusion decision. Care plans focused on exit from seclusion. The service ordered electronic tablets to support the recording of seclusion documentation. Occupational therapy staff were working on activities that could be continued whilst in seclusion. There was also work around the language used in relation to seclusion, so that it was not seen as a punishment.

Staff carried out twice daily seclusion audits, so that required improvements to the environment, care planning and documentation could be addressed immediately.

The service introduced a new specialist multi-disciplinary team review and a weekly seclusion review group, which included advocacy.

Forensic inpatient or secure wards

Eskdale ward worked collaboratively with service users admitted from prisons and who required seclusion, to reduce the length of time they spent in seclusion. Positive feedback had been received about this.

Eskdale ward effectively facilitated patients accessing fresh air within the ward's secure courtyard. Following initial success, this was routinely planned in seclusion care records to be facilitated if safe to do so.

Hayeswater ward worked collaboratively with a service user who used a specific room as a space in which they felt safe and comfortable. The service user had developed an approach with staff on the ward by using coloured cards to identify their needs, which enabled least restrictive practice. The patient used the safe space as and when they felt the need. It was not locked when they used it and they left when they felt safe to do so. Staff were clear that the patient was not considered to be in seclusion or segregation in these circumstances.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role but not all were up to date with their safeguarding training. Compliance with level one and level two training courses for the safeguarding of adults and the safeguarding of children were above 75% However, compliance with level three safeguarding adults training was 73%. Compliance with level three safeguarding children training was 58%.

Staff understood how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. They could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They followed clear procedures to keep children visiting the ward safe. They knew how to make a safeguarding referral and who to inform if they had concerns. They described the types of issues they would be looking out for and how they responded appropriately.

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

Staff access to essential information

Staff had easy access to clinical information. However, paper records were not always uploaded to the electronic records system in a timely manner.

Patient notes were comprehensive. The service used a combination of electronic and paper records. Staff could access notes but not all paper records were saved to the electronic records system

The provider completed an information governance audit in November 2022 that set out recommendations for improvements across the service. The findings had been included on the risk register and were reviewed regularly. The audit identified gaps where paper records had not been transferred to the electronic system. For example, observation records for patients in seclusion were completed on a paper form but had not routinely been uploaded to the electronic system.

The service had agreed a process and additional administrative support to address this issue. These actions were due to be implemented and training for staff was arranged. There were longer term plans to provide staff with tablets so they could record directly not the electronic records system

When patients transferred to a new team, there were no delays in staff accessing their records. Staff had completed a handover standards audit. Following the recommendations of the audit managers has implemented new handover standards across the wards and put a programme of audit in place to ensure compliance.

Records were stored securely. However, on some wards, personal information was sometimes visible on desks or computer screens, and patients on the wards could see through the office windows.

Medicines management

Staff did not always personalise physical health monitoring to patients' individual needs and did not always complete to the prescribed timescales to keep patients safe. However, the service had systems and processes to safely prescribe and administer medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Doctors reviewed medicines at patients' ward rounds. Nurses supported and monitored medicines self-administration. The trust was planning to review the medicines safe self-administration policy to improve the self-administration assessment and care planning. The target for this was quarter one of 2023-2024.

At our last inspection we identified concerns around physical health care and physical health observations not being personalised to meet individual patient's needs. At this inspection we found that the issue had not been fully addressed. For example, staff did not accurately record in care plans for two patients how their diabetes would be monitored and on one occasion there were gaps in the monitoring records. The care plan for another patient did not correctly reflect the frequency of heart rate and blood pressure monitoring recorded in a physical health note. Staff were not completing the increased checks. There were gaps in recording the increased monitoring needed to support the safe initiation of a medicine for another patient.

Staff reviewed each patient's medicines regularly. We saw one example where a patient at high risk of developing diabetes was prescribed a treatment in line with current guidance (Managing a healthy weight in adult secure services – practice guidance PHE NHS February 2021). However, pharmacist support to the ward multidisciplinary team varied across the wards; two of the wards we visited reported no regular support to the multidisciplinary team. GP consultation notes for another patient clearly recorded a discussion about the risks of constipation as a side-effect of one of their prescribed medicines. Staff treated the patient for constipation; however, their care plan was not updated to reflect this risk.

Staff completed medicines records accurately and kept them up to date. However, we saw examples where patients occasionally missed doses of medicines because they were sleeping. It was not always clear how this was kept under review.

Staff managed medicines and prescribing documents safely. However, a recent trust audit, reported in February 2023, identified overall poor adherence with trust standards for safe and secure handling of medicines at Edenfield. The provider introduced a weekly ward 'safe and secure handling of medicines' check, overseen by ward managers. We saw that these were effective in identifying any shortfalls for example, gaps in fridge temperature monitoring or controlled drugs checks. During our visit we saw information to support fridge temperature monitoring was being circulated to the wards to help support improvement.

Forensic inpatient or secure wards

Track record on safety

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents serious incidents and near misses clearly and in line with trust policy.

The staff we spoke with told us they felt able to recognise and report incidents, including near misses. They described the reporting process, and many said they felt that issues and incidents were more appropriately addressed in recent months.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. The records we saw showed this and patients we spoke with also told us staff talked with them about any incidents.

Managers debriefed and supported staff after any serious incident. Debriefing included access to psychologists if needed.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Incidents were followed immediately by a 72-hour review that looked at concerns, identified positive practice, actions likely to reduce recurrence and considered how learning would be shared. A panel of senior leaders met fortnightly to review incidents.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff said they received emails from the trust, and issues were discussed at team meetings or in supervision.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result. The service recruited a patient safety practitioner, who commenced in post in January 2023. They initiated quality improvement programmes to improve patient safety, such as the development of clinical handover standards, use of ‘my passport’ for patients in seclusion, and a patient safety group.

Is the service effective?

Requires Improvement 

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

Skilled staff to deliver care

Forensic inpatient or secure wards

Managers did not always ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Only 12% of staff who worked exclusively for the bank had completed prevention and management of violence and aggression training.

Managers did not supported staff through regular, constructive clinical supervision of their work or regular appraisal. In the period between August 2022 and January 2023 the average monthly compliance with both clinical and managerial supervision was 50%. The services compliance rate with staff appraisals over the same period was higher at 76%. However, compliance with staff appraisal had fallen from 82% in August 2022 to 67% in January 2023.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

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

Following the events of 2022, a new leadership team had been introduced. They established a new senior leadership team meeting every week, and established clear senior leadership links with each ward, which strengthened the relationship between the wards and the senior leadership team. This included an improved out of hours senior leadership rota to support staff.

They introduced a weekly communications brief, disseminated to staff via email.

Staff described a culture of openness. There had been significant increase in staff reporting incidents and episodes of unsafe staffing. Staff told us they felt supported to report and were listened to when they did.

The leadership team was visible and inclusive. Their focus was in being present on the wards, engaging and being visible. We saw this throughout our inspection, and there were posters of the leadership structure on the wards.

There was a strong emphasis on improving patients' experiences. The leadership team described plans to address recognised problems and support development and how they were working together to improve the service. They encouraged and supported progress and improved care.

There were clear approaches to address problems and support staff, building good relationships and capacity. They recognised staff and patients' anxieties, such as concerns about instability due to the level of change. They engaged with the Edenfield 'Service for Us' group and introduced listening events for all the wards, with plans to follow up with a 'you said, we did' campaign.

The leadership team ensured continued engagement with the ongoing investigations. They kept staff updated and assured about learning from them.

Forensic inpatient or secure wards

Vision and strategy

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

The vision and values were shared with staff in the induction programme and displayed at the unit entrance.

Staff we spoke with during the inspection understood the vision and values. They told us how they felt proud of their team, and how their work linked with the values. Staff respected each other and worked well as a cohesive team.

From the care we saw being delivered, the conversations we had with staff and observing them with patients, we could see how the values were integral to the care they provided, focused on recovery and independence.

Culture

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

The atmosphere on the wards was peaceful and calm.

Many staff told us that they felt the culture had improved a lot over recent months, that they felt able to raise concerns and that their voices would be heard. They said communication and trust was better, there was a palpable difference in the atmosphere, issues were discussed, and they could see matters being addressed. They said they had better support from their managers and team cohesion was much improved. This mutual support had a positive impact for staff. There was good communication and staff felt listened to. Managers told us they felt more confident that staff were speaking up if necessary; for example, we heard about staff challenging managers about the skill mix on the ward during a visit.

There was a 'speaking up' policy that provided guidance for staff. It encouraged them to speak up so that a culture of openness and learning was created. Staff told us they felt confident to report any concerns. They were aware of the whistle blowing policy and the Freedom to Speak Up Guardian.

Some staff described instances where they had raised concerns and had been listened to and supported to address the concerns.

Staff told us they were involved in decision making on the ward. For example, on Borrowdale ward, a member of staff raised concerns about the appropriateness of the security system. Several staff had not received training to take on the security role, and those who had were feeling stressed as they frequently had to take on the role. The security room was not being used appropriately. Managers listened to the concerns and supported the staff member to take a lead in developing and implementing a system to improve security across the ward, including training for staff. This was now being rolled out to other wards across the adult forensic service.

Some staff told us how they felt traumatised by events at the service during 2022. They said support had been good at first, but they felt it diminished as time went on. We raised this with the senior leadership team and there was discussion around how to ensure staff still felt able to access the support they needed. There was a range of support opportunities for staff, such as a wellbeing hub, an employee assistance programme, occupational health, fast track to physiotherapy, addiction support, talking therapies, counselling and nutritional advice. Other support included financial resources, a fuel card scheme and early implementation of the living wage foundation rate in October 2022.

There was a good team ethos that focused on improving patients' care and enhancing their experiences. Managers encouraged positive relationships so that staff felt appreciated and supported.

Forensic inpatient or secure wards

Escalation of risk was part of the work to improve the service culture, such as the twice daily safety huddles and daily situation reports.

Governance

At our last inspection we identified significant concerns in relation to governance. We identified that managers did not have sufficient oversight of the service and did not understand the challenges faced by staff. Oversight of environmental risks, medicines management and physical health was lacking resulting in a failure to identify or address concerns.

At this inspection we found that the new senior management team had identified shortfalls in the services governance and had begun to address these. They had introduced a new governance structure including twice daily safety huddles. weekly senior leadership team meetings and weekly, monthly and quarterly forums reviewing incidents, clinical interventions and health and safety. Additional administrative resources had been provided to wards to improve governance systems and data reporting. New performance and incident dashboards had been or were being developed.

However, we found that new governance structures, processes and tools were not yet fully embedded. As a result, although the governance and managerial oversight of the service had improved, we still found concerns that had either not yet been identified by the service or that were repeat issues from our last inspection.

For example, we found that physical health observations and record keeping was still not personalised or comprehensive. We identified an information governance breach on wards where patient data was visible to individuals looking through the window of nursing offices. Training compliance had improved since our last inspection, but elements of the mandatory and essential training programme were still below 75% compliance including level three safeguarding courses.

In addition, we found that at the time of our inspection some identified actions or programmes of improvement were either ongoing and not yet completed or were yet to start. For example, refurbishment of wards was ongoing and an identified project to improve the transfer of paper records to electronic systems had not yet started although it was due to be implemented and training dates had been identified.

However, we did see examples where governance processes had identified concerns and generated improvements. For example, following an audit staff now had direct access to the facilities reporting system for maintenance work needed on the wards. This meant issues could be reported and dealt with more quickly. In addition, the service had introduced a weekly ward 'safe and secure handling of medicines' check, which was overseen by ward managers. This was following a recent audit that had identified poor compliance with safe and secure handling of medicines. At our last inspection we identified concerns about the management of clinic rooms and the monitoring of clinic room and fridge temperatures. We did not identify the same concerns on this inspection.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care.

The senior management team had begun the development of new performance dashboards which would support the delivery of care. However, the majority of the planned dashboards were still in development. For example, the service was working with the national 'Get It Right First Time' lead in the development of quality dashboards which would better capture information on cancelled section 17 leave and on cancelled ward activities. In addition, work was ongoing to develop dashboards that captured performance against local and national targets.

The new management team had worked to improve the management and escalation of risk. Staff were able to escalate risk through daily safety huddles, daily situation reports, incident reporting, team meetings and the service's risk register. The service's risk register was reviewed and updated regularly. The register captured risk such as the ward environments, staffing and the impact of adverse publicity following national media coverage. However, not all staff were aware of the risk register or its content.

During the inspection we spoke with the senior management team. They were aware of the challenges the service faced and were able to discuss plans to address these. However, at the time of our inspection not all action plans or improvement programmes had started or been completed. For example, planned programmes to improve the uploading of paper records to the electronic records system and to provide prevention and management of violence and aggression training to bank staff had not yet started. The project to ensure accurate recording of the cancellation of section 17 leave due to staffing pressures had only just been implemented. The programme of refurbishment across the wards was still ongoing.

Information management

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

The service used key performance indicators and audit information to monitor performance. The service collected data on areas such as training compliance, supervision, incident reporting and adherence with the Mental Health Act. However, the structures and processes to effectively report, analyse and respond to the data were not fully in place or embedded. For example, the governance structure was new and still being implemented. Some performance dashboards were still in development.

The service engaged with national quality improvement activities. For example, the service was working with the national Get It Right First Time lead to better capture data on cancelled section 17 leave and cancelled ward activities. The service had worked with the national safe staffing lead to review staffing requirements.

The service made notifications to external bodies.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership. [WJ3]

The service was the lead provider of the Greater Manchester Adult Secure Provider Collaborative. NHS-led Provider Collaboratives are local partnerships of organisations that provide specialised mental health services. They have responsibility for commissioning regional Adult Secure Mental Health Services, in line with national policy and the NHS Long Term Plan. This gives the partnership clear opportunity to improve care and outcomes in Adult Secure Mental Health Services, by ensuring people using services are central in decision making, reducing the length of time people need to stay in secure services, keeping people closer to home, and delivering better quality services and outcomes for people using services and their families and carers.

Forensic inpatient or secure wards

Learning, continuous improvement and innovation

The service was making a range of improvements, such as using learning from audit information to drive development; for example, following bedroom audits, the wards adopted a weekly clean, which involved patients in keeping up cleanliness standards, and staff carried out twice daily seclusion audits, to make immediate improvements regarding the environment, care planning and documentation.

The leadership team carried out quality audits, reviewing the environments and issues that had been identified, and took improvement action immediately. Observations were fed back through senior leadership team meetings.

There was a regular Mental Health Act paperwork audit, with the outcomes shared at senior leadership meetings.

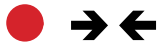
The provider had completed an audit of ward handovers. As a result, handover standards were implemented across each ward, learning was shared and a quality assurance process put in place.

An information governance audit made several recommendations that were being implemented, such as a relocation checklist for ward closures or relocations, additional staff members given direct access to the facilities reporting system for maintenance work needed on the wards, and structured training for all staff in the electronic care systems being used, followed by information management staff being available on wards to provide support.

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

Inadequate 

Is the service safe?

Inadequate 

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

Safe and clean care environments

The ward environments were not maintained and monitored in a way to mitigate risks. Not all wards appeared clean and some were poorly furnished and in need of repairs. The trust did not act promptly to mitigate or remove identified environmental risks.

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

During our last inspection in July 2022, we found the fire safety operating procedures and processes were routinely not being followed by staff within the service. This meant that patients were at risk of avoidable harm. Concerns about fire safety included; access and signage relating to the storage of fire extinguishers, gaps to the tops of fire doors, broken fire panels and broken fire alarm bells. During this inspection we found that the trust had made some improvements. On each ward there were clear signage to where fire extinguishers could be found and kept, fire panel and fire alarm bell were replaced. However; some of the fire doors on Mulberry and Laurel ward at Park House and on Brook ward at Moorside still had gaps at the top of the doors which had not been addressed. There was no further detail to describe actions to mitigate the associated risks or an action plan to remedy this.

Application of the No Smoking Policy varied across all sites, and there was substantial evidence of smoking on wards. We saw patients smoking at the Meadowbrook site, Rivington Unit, Atherleigh Park and Park House. Only two wards clearly enforced the no smoking policy at Laureate House. We were concerned that lack of adherence to the policy significantly increased the risk of fire. At Meadowbrook, Rivington Unit, Moorside Unit and Park House we saw evidence of patients smoking in communal areas both inside and outside the wards. There was evidence of ash, burn marks, cigarette butts and we witnessed patients smoking in the gardens or courtyards. Staff across the trust told us there was no practical support in how to effectively manage the fire risk of patient's smoking, and to comply with the trust policy. The trust had a smoke free policy, outlining the health implications of smoking for patients and staff and the legal framework around smoke free legislation. The policy advised staff to respond to breaches sympathetically and not place themselves in a position of risk in order to manage non-compliance.

Staff and managers we spoke with told us that patient are made aware of the smoke free policy on admission and patients who smoke were offered nicotine replacement therapies and a care plan was populated to address this need. We were also told that smoking and nicotine replacement therapies were discussed in patient`s ward round as a multi-disciplinary discussion with the physical health nurse/ leads. However; in the patients records we reviewed there was very little evidence of these discussions, and the care plans were generic and not individualised or reviewed.

We spoke to the tobacco dependent treatment team leader and the physical health lead. We were told that each location has their own smoke free action plans. The trust was in the process of launching a treatment dependent service in April. We were also told the trust was in the process of implementing the CURE programme. The CURE program offers a more supportive approach to smokers and treats smoking as an addiction. The programme offers all inpatients who

smoke, immediate and comprehensive medical treatment to stop smoking during their admission. Additionally, the programme also provides ongoing support post-discharge. The trust had recently started to provide patients who do not wish to engage with nicotine replacement therapies an electronic vape. Staff told us the introduction of vape for patients had helped to manage risk of fire and reduce incidents of violence and aggression due to not being able to smoke. However, there was no clear guidance on vaping on the wards. We observed that patients were allowed to vape in communal areas on the wards we visited.

The training data we received post inspection indicated that Elm ward compliance with fire safety training was at 87%, Juniper ward was at 77%, Laurel ward was at 70%, Mulberry ward was at 75%,Poplar ward was at 79%, Redwood ward was at 85%,Blake ward was at 78%, Bronte ward was at 100%, Brook ward was at 87%, Irwell ward was at 100%, Medlock ward was at 91%,Chaucer ward was at 85%, Eagleton ward was at 89%, Keats ward was at 81%, MacColl ward was at 92%, Beach ward was at 83%, Maple House was at 76% and Oak ward was at 83% . This meant Juniper, Laurel, Mulberry, Poplar, Blake, Keats, Beach, Maple and Oak ward did not meet the trust benchmark compliance rate of 85% of fire safety mandatory training. There had been a significant number of fire and smoking related incidents on these wards. In the six months leading to this inspection, the trust supplied data about number of fires recorded in this core service. The data we received indicated that there were 66 incidents of actual fire and 114 false fire alarm incidents due to smoking of e cigarette.

In the patients records we reviewed we found that not all patients who required a personal emergency evacuation procedure plan had one. For the patients who had a personal emergency evacuation procedure plan, these were very generic on the wards at Park house and Laureate House. Following the inspection, the manager told us they had ensured all plans were up to date and available within the care records.

Each ward had a ligature audit. The audits were stored on a shared drive and in a paper format. Agency or bank staff were able to access these, and staff discussed the ligature points with agency and bank staff in their induction. Some of the ligature folders contained pictures of ligature points to help staff as a visual aid. However, the ligature audits were not updated consistently. ' Further evidence provided by the trust showed the ligature audits across the wards dated from April to June 2022. These ligature audits were dated before our last inspection in July 2022 and had not been updated since.

The additional evidence we received included ligature assessment tools where potential ligature and anchor points were graded between 1-5 depending on the level of risk it posed to patients and a mitigation plan to ensure the risk was mitigated. In these ligature assessment tools it was documented “clinical and operational management” as the mitigation process.

Some of the wards had an action plan to address or remove the ligature/anchor points. These were RAG rated. On Mulberry wards ligature action plan, it was documented on the maintenance reporting system as, “job to be logged” on Bronte ward it was documented “job to change all the toilets to anti ligature standard”, on Beech ward it was documented “to remove all magnetic hooks” as the action required. However; none of the action plans had a date by when these actions had to be completed.

During this inspection we found some ligature and anchor points had been removed on some wards for example; paper and soap dispensers, curtain rail tracks were replaced. However, some ligature points remained, such as not all toilets or en-suite doors had been replaced. The action for the uncompleted items in the ligature audits were documented on the maintenance reporting system as “job to be submitted”. There was no timescale for completion. Senior leaders and ward managers discussed the priority criteria but there was not clear evidence of these being chased or followed up.

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

At Laureate House all the windows were replaced, however bedroom doors remained without observation window and much of the furniture remained unattached or fixed to the wall and floor. The service manager told us that the mitigation for the ligature was through patient`s risk assessment and observation. We were told the biggest challenge at Laureate House was that the building was a private finance initiative building (PFI) which meant work could not be completed without the landlord authorisation. A private finance initiative is a way for the public sector to finance big public works projects through the private sector. At Park House senior managers told us that many environmental works were not prioritised as the trust was building a new hospital next to the existing one with a completion date of 2024.

Following our visit during this inspection, we asked the trust to provide us with additional information regarding the number of ligature incidents in the last six months on the acute and PICU wards. The data we received showed that for the ward in Wigan and Bolton there were 561 ligature incidents, the wards in Salford and Trafford there were 192 ligature incidents and the ward in Manchester there were 410 ligature incidents.

Maintenance, cleanliness and infection control

Ward areas were not all clean or well maintained. This included stains and marks to walls and ceilings, and scratched observation windows. Flooring was in poor repair, with gaps at the wall joins which were visibly dirty. Ceiling tiles were stained and damaged. At Laureate House, on Bronte ward, the glass panel of the doors on the main corridors were broken and boarded but there was no timescale for when these would be fixed. On Bronte and Blake ward, the bedroom doors were a standard “leaf and a half” acute hospital design which meant there were no observation panels. At Park House, staircases to the garden were dirty and marked. All external staircases to garden areas at Park House were dirty, with evidence of smoking and ingrained ash and cigarette debris. Some bedroom floors were dirty. One bathtub was blocked, and one bathroom was unclean.

Seclusion room (if present)

We looked at three seclusion rooms across this core service, they were of differing quality. There was a seclusion room/ suite in each of the psychiatric intensive care units. Each room was of a different layout and design, but all had adjoining toilets and showers and controllable lighting and heating, as per the Mental Health Act Code of Practice criteria.

At all sites we visited, there had been use of S136 suites as seclusion rooms, when these were not designed for this purpose. However, the Trust told us these were only used in an emergency with the prior approval of senior clinicians and managers.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. All wards had clinic rooms, with some having equipment and space to undertake physical observations, venipuncture and electrocardiogram monitoring. Clinic rooms all contained resuscitation equipment and emergency drugs; nurses checked these regularly to ensure equipment was in working order for when needed.

Safe staffing

There were high levels of nursing staff vacancies across all the wards. Vacancies on the acute wards had increased over the previous 12 months. There were agency staff working on most shifts for all wards, and these staff were not always familiar with the wards.

Nursing staff

All wards had nursing and healthcare worker vacancies. A data request was made post this inspection regarding the service staffing number, sickness and turnover. However, this was not provided to us.

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Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Each location held daily safety huddles to assess staffing on each unit and consider any shortfalls. This enabled management at the locations to move staff where necessary or request additional staff to attend. Nursing staff described how staff were moved across wards to meet minimum staffing levels. Staff said that this was disruptive and impacted on patient care.

Some staff reported that they did not always feel safe on the wards, particularly when there were fewer permanent staff on shift. Staff noted that bank and agency staff were predominantly not trained in the prevention and management of violence and aggression (PMVA) which reduced the number of staff available to support during an incident. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover.

Mandatory training

Staff had not all completed and kept up to date with their mandatory training. We found that there were a number of mandatory training courses which not all staff had completed. This included basic and intermediate life support, prevention and management of violence and aggression, safeguarding, fire safety and infection prevention and control. There were not sufficient levels of staff trained in basic life support. None of the wards we visited met the trust compliance rate of 85% for basic life support. The lowest was Medlock and Westleigh with 13% of staff trained. Training figures for infection prevention and control training showed two wards met the trust compliance rate. The lowest was Medlock ward where 61% of staff were compliant. All the wards had less than 85% of staff trained in the mandatory Mental Health Act code of practice as per the trust target. Mandatory training levels for Mental Capacity Act training were also below the 85% trust target.

Not all qualified nurses were trained in immediate life support. Ward managers told us that this training was aimed for Band 6 and 7 trained nurses. We saw that ILS trained staff consideration was part of the safety huddle. Juniper ward, Laurel ward, Mulberry ward, Poplar ward, Bronte ward, Brook ward, Irwell ward, Eagleton ward had 100% compliance rate for immediate life support training.

Assessing and managing risk to patients and staff

On the acute wards, staff did not update risk assessments as necessary for all patients and risk management plans were not consistently developed in response to identified risks and safety incidents.

Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff did not always complete risk assessments for patients on admission, or update these in response to new risks and following safety incidents. This included risks such as increased suicidal ideation, violence and aggression and patients absent without leave

Management of patient risk

We found that risk management plans were not always developed in response to identified risks. Staff did not always develop individualised risk management plans and goals and interventions were often generic.

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Staff did not respond adequately and develop effective management plans in response to fire and ligature risks and following incidents. Staff had not reviewed the patient's risk management plan in response to this and the management plan in place did not have any specific interventions identified to mitigate these risks. During this inspection we reviewed 29 patients care records. Out of these only 12 had a risk management plan for identified risk.

On Juniper ward we found that a patient had become absent without leave (AWOL) the day before our visit. Staff had suspended the patient's leave following this incident but there was no evidence of how long this would be suspended and had not updated the section 17 leave forms. Staff had not updated the patient`s risk assessment, or risk management plan. At Laureate House; on Bronte and Blake wards the risk management was variable we saw some evidence of regular reviews and risk assessments, and robust, individualised risk management plans.

We noted in a further patients care record that their engagement and observation frequency had been increased due to suicidal ideation. However, there was limited information regarding, by who and how this decision had been made. The patient's risk management plans had not been reviewed in relation to increased risks.

Staff on the mixed sex acute wards told us that they managed sexual safety risks through having staff observing communal areas and access to male and female corridors. We saw this in practice on the mixed wards we visited where there was staff presence in the corridors and communal areas.

During the last inspection in July 2022, we identified that patient's privacy and dignity was not considered in the guidance, nor the impact on already limited space. During this inspection we observed that this had not been fully addressed. On Maple ward a mixed at the Rivington unit, staff told us that the area adjacent to the seclusion suite was regularly being used as a surge bed. During this inspection we saw that a patient was admitted and had slept in that area because there was no bedroom available. Staff told us sometimes patients could be there longer than just one night. The room was sparse and had no furnishings apart from a seclusion bed and two chairs. There was nowhere to store personal belongings including clothes. This compromised patients' privacy and dignity. A senior manager told us following this inspection that the trust had closed all surge beds. The service has sought an agreement to access PICU beds from other locations if this situation should arise.

During the last inspection in July 2022 patients at Park House raised concerns about dormitories. During this inspection we saw that the dormitory facilities remained. Although we saw there were curtains separating each bed area, this also compromised patient privacy and dignity as these bed areas were not fully enclosed.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff had received training to support them in reducing or preventing the use of restraint in prone (face down) position.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

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

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

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

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Safeguarding

Staff took sufficient action to protect patients from abuse. Staff had training on how to recognise and report abuse.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and mostly worked well with other agencies to protect them.

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Not all staff had easy access to clinical information.

Patient notes were not always comprehensive, actions and management of risk incidents were not always detailed. Some agency staff were unable to access electronic records. Staff told us that this led to them having to input agency staff's daily notes.

Medicines management

Staff that prescribed and administered medication consistently use systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff completed medicines records accurately and kept them up to date. Staff stored and managed all medicines and prescribing documents safely.

Pharmacists followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Doctors reviewed patients' regular medications during multidisciplinary meetings.

Track record on safety

The trust had not ensured safety concerns raised during the last inspection of acute inpatient services had been resolved and improvements maintained across the trust.

Reporting incidents and learning from when things go wrong

Learning from recent significant incidents' initial reviews and root cause analysis had not been implemented across all wards.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff reported serious incidents clearly and in line with trust policy.

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Staff understood the duty of candour. They were open, transparent, and gave patients and families a full explanation if and when things went wrong. Managers debriefed and supported staff after any serious incident.

Managers and matrons in the service outlined support including check ins with staff involved in incidents, either by phone or in person, local debriefs with everyone involved took place. Matrons and unit managers ensured staff were supported at work. The services had also accessed psychology led reviews held with staff. Staff had access to short term external counselling and support through an employee assistance programme. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff did not always receive feedback from investigation of incidents, both internal and external to the service. In some of the wards, staff meetings were used to provide feedback to staff about incidents and learning from incidents.

Is the service well-led?

Inadequate 

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles but there had been and continued to be gaps in the leadership team on some wards.

Leaders had a good understanding of the services they managed and the current challenges they face. Ward managers and matrons took action to respond to challenges for their wards but did not always feel that timely or effective action was taken when concerns were escalated to more senior managers or other divisions within the trust.

There had been recent changes to the ward mangers at Park House and staff told us the ward needed more stability with the management team.

Site leaders were visible in the service and approachable for patients and staff. Staff told us that they could approach leaders on the ward and more senior leaders, such as locality matrons, clinical leads and operations directors. Managers and matrons completed regular walk arounds of their services. They could explain clearly how the teams were working to provide the appropriate care within the constraints of staffing challenges and poor environment.

Staff at Park House told us senior executives had visited in the months before inspection. However, although senior leaders spent time on the wards, we did not see that their visits resulted in immediate changes or improvements.

Vision and strategy

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

Staff told us they identified with the trust's vision and values. Staff told us that they were able to apply these within the work of their team and identified team objectives to align with these values.

The trust values were displayed throughout services and were printed on staff lanyards. Some staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff at Park House told us they had been involved in service planning and meetings about the new service being built.

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

Culture

Staff felt respected, supported and valued.

Staff said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression.

The culture amongst clinical staff on the wards was positive and centred on the needs and experience of people who use services.

Although staff experienced some stress in their roles, most staff felt that the ward teams were happy and worked well together. Figures for the staff survey showed out of 115 participant who took part for this core service 18.3% strongly disagreed and 29.6% disagreed that they had job satisfaction.

Staff felt able to raise concerns without fear of retribution and knew how to use the freedom to speak up process. All staff knew about the freedom to speak up guardian. Staff provided examples of concerns they had raised with the freedom to speak up guardian and how these were resolved. In the staff survey for this core service; 40.9% strongly agreed and 36.5% agree that the felt comfortable raising concerns with their line manager. 18.3% of staff survey participant strongly disagreed and 31.33% disagreed on staff involvement in important decisions from senior managers. Just over twenty five percent of the participants strongly disagreed and 27.8% disagreed in their confidence in the trust executive team.

Teams generally worked well together and when there were difficulties managers dealt with them appropriately. Data from the staff survey showed that 34.8% of the participant were very satisfied and 49.6% were satisfied with the support they received from their work colleagues.

Managers we spoke with recognised the importance and value in developing their own staff by offering training and progression. Staff provided examples of training courses and opportunities they had taken to develop and progress in their career.

Governance

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

Although managers attended a range of meetings to monitor the performance and quality of the wards, this had not ensured that issues we found on the ward had been identified and acted on.

Ward staff told us they were completing audits of clinical records, and this included a review of the quality. However, we found that the risk assessment and management of patients was poorly documented.

There were systems and checks in place to maintain the safety and cleanliness of the wards. However, we found that these systems and checks were not always followed and leaders within the wards had not identified or acted to resolve this.

We held a meeting with the service line senior managers and leader to seek assurance and understand their oversight of performance and safety of the wards, especially in regards to ligature. We were told that the audits and action plans were shared with them, and these were escalated and discussed with executive leaders through various platforms and summits and was part of the board assurance framework. We reviewed various meeting minutes submitted to us; these

included the board assurance framework, the executive management team meeting minutes, the risk management committee meeting minutes and ligature group meeting minutes. Although we noted that ligature safety and smoking cessation were discussed there was no clear plans outlined to how these were being address and no time by when these would be completed.

Our findings demonstrated that governance processes did not operate effectively. Despite senior leaders visiting the wards, we identified a number of concerns during the inspection where governance systems had not ensured the safe running of this service. Wards were not safe and clean, environmental risks such as fire safety relating to smoking and management of ligatures had not been acted upon. Leaders had not acknowledged or proactively taken action to address these issues.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Each location held daily safety huddles to assess staffing on each unit and consider any shortfalls. A data request was made post this inspection regarding the service staffing number, sickness and turnover. However, this was not provided to us.

Management of risk, issues and performance

The identification, management and review of risk, issues and performance was not always sufficiently implemented to provide assurance of a safe and quality service.

Ward managers and matrons had access to and maintained ward level risk registers. Items on these risk registers could be escalated to a locality risk register by matrons. There was little understanding or management of risks and issues, and there were significant failures in performance management and audit systems. A number of areas of risk identified during our last inspection in July 2022 had not been managed and mitigated.

Information management

Staff collected analysed data about outcomes and performance.

The service used systems to collect data from facilities and directorates that were not over-burdensome for frontline staff. Data was collected from the electronic records system and incident reporting systems.

Staff did not always have access to the equipment and information technology needed to do their work. Agency and external bank staff couldn't access the records systems and they were unable to access information on the trust intranet or the incident recording system. This meant they were dependant on permanent staff being available to print information they needed which was not an effective system to mitigate the risks. Information technology worked well with the use of virtual meetings for patient reviews, enabling carers and care co-ordinators to dial in to meetings and allowing flexibility for attendance. Information governance systems included confidentiality of patient records. Staff made notifications to external bodies as needed. All information needed to deliver care was stored securely.

Engagement

Information about the ward and local services was on display in the wards. Patients were given an information pack about the ward when they were admitted. Patients and carers were able to give feedback about the service, either directly to the ward staff or through its patient advice and liaison service or complaints team. There was information on the trust website for patients and carers. Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients told us that they were able to provide feedback either directly to staff or through ward community meetings.

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

Learning, continuous improvement and innovation

The managers worked together as a team to make improvements in the running of the service. Staff were encouraged to develop their skills in this area and contribute to the quality improvement programme. Staff said they were given the time and opportunity to learn and progress in their career. Locality leaders were responsive to concerns raised and performance issues and sought to learn from them to improve services.

All staff spoke with passion and determination to improve their service and felt confident they were able to improve the lives of people on their ward.