Greater Manchester West Mental Health NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units (PICUs)	Meadowbrook Rivington Moorside Unit	RXV17 RXV60 RXV80
Long stay/rehabilitation mental health wards for working age adults	Recovery First Bramley Street Meadowbrook Greater Manchester West Mental Health NHS Foundation Trust - HQ	RXV13 RXVA9 RXV17 RXV00
Forensic inpatient/secure wards	Greater Manchester West Mental Health NHS Foundation Trust – HQ Wentworth House	RXV00 RXV20
Child and adolescent mental health wards	Greater Manchester West Mental Health NHS Foundation Trust - HQ	RXV00
Wards for older people with mental health problems	Moorside Unit Woodlands	RXV80 RXV15
Community-based mental health services for adults of working age	Greater Manchester West Mental Health NHS Foundation Trust – HQ	RXV00

Summary of findings

Mental health crisis services and health-based places of safety	Greater Manchester West Mental Health NHS Foundation Trust – HQ Rivington Moorside Unit Meadowbrook	RXV00 RXV60 RXV80 RXV17
Community-based mental health services for older people	Greater Manchester West Mental Health NHS Foundation Trust – HQ	RXV00

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for services at this Provider	Good 
Are Mental Health Services safe?	**Requires improvement** 
Are Mental Health Services effective?	**Good** 
Are Mental Health Services caring?	**Good** 
Are Mental Health Services responsive?	**Good** 
Are Mental Health Services well-led?	**Good** 

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We have rated services provided by Greater Manchester West NHS Foundation Trust overall as **good.**

This was because we rated six of the eight services as good. We rated two service as requires improvement. These services were; child and adolescent mental health ward and wards for older people.

The trust did many things well and we saw good practice across most services.

The main areas which were positive were as follows:

- Staff were caring, professional and worked to support the patients using the services.
- The trust was supporting patients with their physical health well. People had their health assessed in a comprehensive manner and were being supported to have any health care needs addressed.
- Staff, patients and carers had access to a wide range of opportunities for learning and development, which was helping improve care.
- Patients and carers had the opportunity to be involved in how services were provided and their input was leading to changes.
- The trust was aware of best practice and was using guidance and research to inform their work. Access to psychological therapies was good in the child and adolescent mental health wards and acute wards.
- Patients could access care in their local service when they needed it. Services were designed to be accessible for all patient groups and the trust worked hard to ensure that hard to reach groups were engaged.
- The trust had excellent working relationships with external agencies and stakeholders. An example was the work of the community team for older people working to reduce admissions into the acute trust.
- Patients were cared for in the least restrictive way in the forensic service with patients self-medicating and positive risk management.
- There was strong, effective and visible leadership. Staff knew the trust values and vision and their importance in the work of the trust. There was an effective governance system in place at board level so that the trust knew where action was needed.

However;

The main areas for improvement were:

- Patients were not always having physical observations recorded when they had received medicines for rapid tranquilisation.
- Patients were sometimes being secluded without the checks and safeguards of the MHA code of practice being applied.
- In wards for older people, accommodation was not always being provided in line with same sex guidance.
- Staff were not always recording decisions, and how they had been made in patients' best interests on older people's wards.
- Not all staff were able to use the new electronic record system confidently and staff struggled to find records at times.
- Not all staff had completed mandatory training and there were low numbers of staff who were up to date with their basic life support, immediate life support training, MHA and MCA training.
- Not all staff were receiving regular supervision.

We will be working with the trust to agree an action plan to assist them in improving the standards of care and treatment.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of the services.

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- In four of the eight services we visited, we rated safe as requires improvement.
- Staff were not up to date with mandatory training which included life support training and children's safeguarding level 3 training.
- De-stimulation rooms on Junction 17 (CAMHS) and in acute wards for adults of working age and psychiatric intensive care units were used to calm patients. However, patients were prevented from leaving or not aware they could leave which meant that they were being secluded. Staff did not recognise this as seclusion therefore they were not implementing trust policy or following the Code of Practice guidance.
- The system for monitoring levels of training was not reliable because centrally and locally held records did not match up.
- In older people's wards, same sex accommodation was not always being provided on all wards in line with the Department of Health guidance.
- Staff were not always following trust policy and recording observations when rapid tranquilisation had been given. We saw this on forensic services, wards for older people and in the child and adolescent mental health service (CAMHS).
- Risks created by the environment were not always reduced effectively. On wards for older people there were no clear lines of sight. In some acute wards, staff managed risks by using higher levels of observation than was clinically needed to keep patients safe.
- There was not always a sufficient number of staff on the CAMHS ward(s) to care for patients.
- On Junction 17 ward in the CAMHS services there were restrictive practices in place which were not based on individual risk.
- Staff were not always completing records when patients were being observed in CAMHS.
- On two acute wards we found that oxygen for use in an emergency was out of date.

However,

- Patient risks were generally well managed with up to date risk assessments in place. Staff used recognised risk assessment tools which were reviewed regularly and updated.

Summary of findings

- Overall, the reporting and analysis of incidents of harm or risk of harm, and learning from incidents was managed well within the trust. Staff knew how to report incidents and the trust had a number of ways to share learning.
- Risks were recognised and reported internally and services had up to date local risk registers. Risks were escalated appropriately. Overall, we found that most services had comprehensive risk assessments in place to assess, manage and reduce risks to individuals and within the clinical environments.
- Staff we spoke with understood the principles of the duty of candour and its relevance to their work. This involves staff explaining and apologising to patients when things go wrong.
- The trust had effective procedures in place to protect patients from abuse. Staff had a good understanding of safeguarding issues and followed trust policies to report it.
- The systems in place to reduce infection worked. Wards and community clinics were clean and well maintained. Staff followed hand washing procedures.

Are services effective?

Good

We rated effective as **good** because:

- The trust had met or exceeded all Monitor compliance framework targets for 2014/2015 and achieved all of the quality improvement priorities it set out in the 2014/2015 Quality Account.
- Regular and effective multidisciplinary team meetings and handovers of care took place throughout all services.
- The teams were using evidence-based assessment tools and national guidance, such as from the National Institute for Health and Care Excellence, to identify and meet patients' health and treatment needs.
- Patients had access to psychological therapies.
- Policies were in place to address staff performance and poor staff performance was addressed promptly and effectively.
- Staff received a comprehensive induction when they joined the trust. Some 82% of staff had received an appraisal.
- The trust managed physical health well. Staff had access to the Physical Health Intervention Tool to ensure all physical health checks were completed as necessary.
- Patients had access to MHA advocacy services and were encouraged to use them.
- Staff were supported to access specialist training.

However,

Summary of findings

- Training rates for the MHA were low at 19%. In two of the services, staff were caring for patients in destimulation areas which they were not allowed to leave. Staff did not recognise this as seclusion and therefore were not following the guidance in the MHA Code of Practice.
- Recording in relation to the MHA was not always well completed in relation to rights, section 17 leave and patients' wishes.
- Although training rates for the MCA were low across the trust, generally staff had a good understanding of the Act and the five underpinning principles. However, records did not always reflect actions taken such as best interest meetings.
- Not all staff were receiving supervision six times a year as described in the trust policy. Overall, 63% of staff were receiving regular supervision. Within services, there was wide variation; ranging from 13% (Salford community team for older people) up to 100% on many of the forensic wards.
- In some services staff were struggling to locate records in the new electronic records system. The trust acknowledged that there were some difficulties with their information technology system, which had been added to the board assurance framework risk register with actions to deal with them.

Are services caring?

Good

We rated caring as **good** because:

- Care was delivered by staff who were caring, compassionate and determined to give good care.
- Feedback from patients and carers was generally positive. We saw patients were treated with dignity, respect and kindness and warmth.
- Patients told us they felt supported and felt staff cared about them.
- The trust gathered feedback from patients and their carers in a number of ways. Services held a range of patient community meetings to gather feedback and encourage involvement which fed into the trust's governance structure.
- The trust had received a second star for the 'triangle of care' initiative. This was developed nationally to improve carer engagement in mental health acute inpatient and home treatment services.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

Summary of findings

- Services were providing care when it was needed, with most patients being able to be admitted to their local hospital or being cared for in the community.
- The redesigned acute care pathway meant patients had shorter admissions to hospital.
- The trust served a diverse population and there were many examples of the trust making the service more accessible to patients with differing needs and backgrounds.
- Although some of the buildings were older, facilities were generally good and appropriate for the service being delivered.
- Patients knew how to complain or raise a concern. Complaints and concerns were answered in a timely way and listened to. The trust apologised when things went wrong and were open and transparent. Improvements were made to the quality of care as a result.
- There was a pilot service with mental health nurses working in police stations at some localities to support the police to better signpost and manage people who regularly contacted the police.
- The trust proactively worked with a range of stakeholders to improve service provision for patients
- The John Denmark Unit hosted the only deaf readers' group for people with mental health problems in the country. The initiative was introduced in 2015 and was fully subscribed.

However;

- Bed occupancy at the trust was 91% with eight wards having occupancy rates above 100%.
- On the acute wards for people of working age, activities and leave were sometimes not taking place.

Are services well-led?

Good

We rated well-led as **good** because:

- The trust had a strong executive and non-executive team
- The trust vision was known by staff working across the trust
- The board assurance framework provided the board with the information they needed to perform their role
- The leadership team recognised the importance of strong engagement with patients, staff and external stakeholders
- The trust had two services which had been shortlisted for national awards and three services which had received national accreditations
- The trust was committed to involving patients and their carers in service development and improvement initiatives

However;

Summary of findings

- On the child and adolescent mental health wards the governance systems had not been effective at identifying performance issues. The trust took immediate action to address this during the course of the inspection.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett, retired medical director.

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leader: Sarah Dunnett, inspection manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists:

- Family carer "experts by experience"
- Consultant psychiatrists
- Doctor in training
- Mental health nurses
- Mental Health Act reviewers
- Occupational therapist
- Senior NHS managers
- Social worker

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, the inspection team:

- Requested information from the trust and reviewed the information we received
- Reviewed a range of information we hold about the provider and asked other organisations to share what they knew. These organisations included Monitor, NHS England, clinical commissioning groups, Healthwatch, Health Education England, Royal College of Psychiatrists, other professional bodies and user and carer groups
- Sought the views of carers and service users at seven focus groups
- Spoke with 22 patients being cared for in hospital and in the community
- Received information from patients, carers and other groups through our website
- Held 24 focus groups for staff across the trust which were attended by 220 staff.

We carried out an announced visit between 8 and 12 February 2016. We carried out an unannounced visit on 23 February 2016.

During the inspection visits the inspection team:

- Visited **58** wards, teams and clinics
- Spoke with **161** patients and **37** relatives and carers who were using the service
- Collected feedback from **390** patients, carers and staff using comment cards
- Spoke with **310** staff members
- Attended and observed **42** hand-over meetings and multi-disciplinary meetings
- Joined care professionals for **11** home visits and clinic appointments
- Joined **five** service user meetings
- Attended **seven** focus groups attended by **63** staff
- Interviewed **seven** senior executive and board members
- Looked at **275** treatment records of patients
- Carried out a specific check of the medication management across a sample of wards and teams

Summary of findings

- Carried out **four** visits to check how the trust cared for people who were detained under the MHA
- Looked at a range of policies, procedures and other documents relating to the running of the service
- Requested and analysed further information from the trust to clarify what was found during the site visits.

The team inspecting the mental health services at the trust inspected the following core services:

- Acute wards and the psychiatric intensive care units
- Long stay rehabilitation wards
- Forensic inpatient wards
- Wards for older people with mental health problems
- Ward for children and adolescents with mental health problems
- Community based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Community based mental health services for older people

We did not inspect substance misuse services or specialist services including liaison psychiatry, in reach services to prisons or improving access to psychological therapies services as part of this comprehensive inspection.

The team would like to thank all those who met and spoke with inspectors during the inspection.

Information about the provider

Greater Manchester West (GMW) Mental Health NHS Foundation Trust provides community-based and inpatient mental health care and treatment for people living within Salford, Bolton and Trafford. The trust also provides a wide range of more specialised mental health and substance misuse services across Greater Manchester, the North West of England and beyond. The trust provides in reach services to prisons across the north of England. The trust has one of three national sites providing care for people who are deaf.

The trust provided eight core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient/secure wards
- Child and adolescent mental health wards
- Wards for older people with mental health problems
- Community based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Community based mental health services for older people

Greater Manchester West Mental Health NHS Foundation Trust has a total of nine registered locations serving mental health needs. There are 584 beds across the trust. Of the nine registered locations, eight were open and providing care at the time of our inspection:

- Bramley Street
- GMW trust headquarters
- Meadowbrook
- Moorside Unit
- Recovery First
- Rivington
- Wentworth House
- Woodlands

The ninth location, Braeburn House was due to reopen in March 2016, following the inspection. The trust also provides community mental health services.

Greater Manchester West Mental Health NHS Foundation Trust was registered with CQC on 1 April 2010. The organisation now provides services from more than 70 sites with an income of about £166.5 million, and employs almost 3000 staff. A further 200 staff are seconded from partner organisations.

Within the last 12 months the trust has provided care to almost 40,000 patients.

The trust is commissioned to provide services by a number of organisations with 41% of their services commissioned by NHS England for specialist commissioning of forensic and children and young people's services. The three local clinical commissioning groups which the trust work with are at Bolton, Salford and Trafford.

Summary of findings

Greater Manchester West NHS Foundation Trust has been inspected 18 times at seven locations since registration. We issued one compliance action against the trust at Trust Headquarters in October 2013 for staffing. The trust took steps to address this at the time.

What people who use the provider's services say

Before the inspection took place we met with **seven** different groups of patients from the specialist services network, Meadowbrook, Rivington and Moorside and community service users from Bolton, Salford and Trafford.

Through these groups we heard from 22 patients and carers. We also received feedback from two independent meant health advocacy services and one Healthwatch.

During the inspection the teams spoke to **198** people using services or their relatives and carers, either in person or by phone.

We received **390** completed comment cards of which **220** were positive, **86** negative and **10** mixed. A further **10** were blank and on **10** the comments were unclear. We also received individual comments from people through our website or by phone.

Much of the feedback we received was very positive as follows:

- Staff – kind, caring, professional, efficient, polite, approachable, compassionate, attentive, empathetic, supportive, listened to patient, non-judgemental, treated patients with dignity and respect, good communication with patients.
- Environment/food – environment was safe, clean, and hygienic and food was tasty and good.
- Service – excellent, efficient, exemplary quality of care, nothing needs improving, would recommend to friends and family.
- Treatment – brilliant care, treatment explained in full, needs responded to, groups have been helpful for recovery.

Some of the challenges that we were told about were as follows:

- Service - could be nearer home, changes to reception had reduced service levels, delay in follow up appointment, waiting times a bit long.
- Food – could be better, more variety, not appetizing.
- Communication – no communication about discharge.
- Staff –not listening to patients/service users, not keeping things private, not enough staff/lack of staff, cold, busy and unwelcoming staff, lack of respect, only care about their goals, staff spend too much time in staff room messing.
- Environment – car parking, toilets are constantly blocked, one shower for 21/22 beds, ward is dirty, some wards dark and depressing with no bright lights.

Good practice

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

Across all wards we found evidence of excellent interagency working. For example at Medlock ward pregnant patients and new mothers were often supported by midwives and specialists such as breast feeding specialists.

The psychology input across the three wards based within Bolton Royal Hospital had a particularly robust provision for psychological interventions. We observed and reviewed ward based psychological groups that were provided to patients on a daily basis, (except weekends). We found that these were well attended by patients and that the psychological ethos was embedded in the ward culture.

We also found that despite a high bed occupancy rate on each ward, there was an effective bed management system in place which ensured patient flow was not hampered by external or internal obstacles. We observed the daily board round meetings where patient's needs were discussed and

barriers for potential progress and discharge were delegated for action. This enabled patients to be discharged in a timely way with the correct support in place.

In wards for older people with mental health problems:

At both sites there was a room to provide end of life care for patients. The wards had good links with the local hospice and Macmillan nurses to ensure that patients were looked after in the best possible way in the final weeks of their life. There was an end of life care lead who provided staff with training in relation to end of life and any issues surrounding this. This person was available on site whenever a patient was nursed to end of life and on the ward each shift to see if they needed any extra advice or assistance.

The older adult wards were heavily involved in the trust research and development programme. There was a dementia research event at the trust headquarters in November 2015. This was in order to raise awareness of current dementia research available both within the trust and outside the trust. The trust had an opt out policy for research in order to boost research participants within the trust. On all the wards there was information about this on noticeboards and in welcome packs for patients and their families to read about.

The wards were all taking part in the Advancing Quality (AQ) dementia measures programme. These quality standards covered care provided by health and social care staff in direct contact with people with dementia in hospitals, community, home-based, group care, residential or specialist care settings. AQ aims to give patients a better experience of the NHS by making sure every patient admitted to a north west hospital is given the same high standard of care no matter which hospital you attend. This standard was recommended by the National Institute for Health and Care Excellence.

In forensic inpatient/secure wards:

The trust had a recovery academy that provided training and courses for staff and patients. The Edenfield Centre had its own branch of the recovery academy specifically for patients on the forensic inpatient wards. The recovery academy provided groups and sessions for patients. Patients were involved in the creation and provision of some of the groups. They included living with a personality disorder, peer mentoring (where patients supported other patients), and a pre-discharge course. This was for patients who may have been in hospital for a long time, and addressed practical issues such as how to register with a GP.

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

The care plans at Bramley Street were of a very high standard with evidence of carer involvement. All patients stated that they had been involved in the care plans and contributed to the content, reflecting their needs and wishes.

Community-based mental health services for adults of working age:

Each team we visited had a physical health lead. The physical health leads were assertive in approach, and would visit people in their own home to complete physical health screening and tests.

Teams were involved in enabling people with experience of mental health services to be involved in research; the psychosis research unit led the research.

The nurse led clinic at Salford provided a step down provision to people who had previously been accessing support from the community mental health teams and were ready for gradual discharge from the service.

Community-based mental health services for older people:

There was a multidisciplinary group (MDG) attended by staff from the team. This was a group of professionals from both mental health and physical health backgrounds. The focus of the MDG was to review and problem solve complex cases, provide plans and anticipate care needs for those using health and social care services. Potential referrals for the community mental health team were discussed at this group and brought back to the team to promote timely intervention and treatment.

The service was involved in enabling patients to take part in research projects and had close links with the local university. Research undertaken was used to further advance knowledge of functional and organic disorders. Current research projects included young onset dementia, combined treatments in adults with psychosis and the influence of expressed emotion on dementia sufferer's adjustment.

Summary of findings

Mental health crisis services and health-based places of safety:

There was very good clinical leadership into the health based places of safety with team manager, senior manager and consultant psychiatrist oversight. This was especially the case at the services at Salford.

There was an alcohol worker integrated into the Trafford rapid assessment, interface and discharge service to support intoxicated patients.

There was a pilot service with mental health nurses working in police stations at some localities to support the police to better signpost and manage people who regularly contacted the police.

The multi-agency form for recording section 136 episodes was colour coded which provided a simple but effective way of ensuring that different professionals completed the sections of the forms relevant to them which helped to enable them to discharge fully their responsibilities when placing or assessing someone on section 136.

Areas for improvement

Action the provider MUST take to improve

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

- The trust must ensure that all relevant staff have the necessary training in order to safely perform their roles and protect patient safety.
- The trust must ensure that equipment and medical supplies are replaced when necessary in order for safe care and treatment to be delivered to patients in an emergency situation.
- The trust must ensure that environmental checks are completed in a consistent way and that improvements are made in a timely manner.
- The trust must ensure that staff do not seclude patients without the correct checks and safeguards being in place in respect of the Mental Health Act code of practice and trust policy.

In wards for older people with mental health problems:

- The trust must ensure that arrangements for single sex accommodation are adhered to in order to ensure the safety, privacy and dignity of patients. Clear signage should be in place at the entrance to each gender area informing patients who can enter. There must be a dedicated female only lounge on each mixed sex ward and bathrooms should be available for members of each sex to use without passing the bedroom of a member of the opposite sex.
- The trust must ensure all staff understand the application of the Mental Capacity Act in practice. Documentation should contain evidence of recording of any decisions made about a patient's capacity.
- The trust must ensure that older adult wards comply with both national guidance and trust policy on rapid tranquilisation. Physical observations should be monitored following rapid tranquilisation on the trust approved form and within the correct timescales. All incidents of rapid tranquilisation should be recorded as an incident as per trust policy.
- The trust must ensure that patients detained under the Mental Health Act 1983 are read their rights at key points during their detention, in particular when progressing from one section to another.

In forensic inpatient/secure wards:

- The trust must ensure that staff monitor patient's physical healthcare after medication has been given for rapid tranquilisation, so that any side effects are identified.
- The trust must ensure that staff have the skills and experience to provide care to patients in the event of a medical emergency.

In child and adolescent mental health wards

- The trust must ensure there are sufficient number of staff who are adequately trained to provide safe care.
- The trust must ensure that mandatory training is completed by all staff to achieve the trust standard of 80%.
- The trust must ensure there is a plan in place to evaluate and minimise the use of blanket restrictions.
- The trust must ensure care and treatment is planned and delivered in line with the MHA code of practice.

Summary of findings

- The trust must ensure that there are effective governance structures in place that address concerns in a timely manner to improve care standards.
- The trust must ensure that staff maintain accurate, complete and contemporaneous records.

Action the provider SHOULD take to improve

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

- The trust should continue to ensure that staffing levels reflect the acuity of patients and that there is an appropriate skill mix within all wards.
- The trust should ensure that patients who are detained under the Mental Health Act can clearly understand their Section 17 leave entitlement.

In wards for older people with mental health problems:

- The trust should ensure all older adult wards display notices both on the inside and the outside of locked entrance doors to inform informal patients of the reason for the ward being locked and their right to leave at any time
- The trust should ensure all staff have an annual performance appraisal
- The trust should ensure that leaflets provided to patients detailing their rights under the MHA include the most up to date contact details for the Care Quality Commission

  The trust should ensure that mandatory training is completed for all staff to achieve the trust target of 85%.

In forensic inpatient/secure wards:

- The trust should keep under review its environmental risks.
- The trust should ensure its auditing of medication procedures, and competency training are effective.
- The trust should continue to improve the usability of the electronic record system.
- The trust should ensure that consent to treatment forms (T2s and T3) are completed correctly.
- The trust should ensure that where patients have their rights under the Mental Health Act, this is recorded in individual patient care records.
- The trust should continue to improve the usability of the electronic record system.
- The trust should ensure that staff have appropriate knowledge and understanding of the Mental Health Act and the Mental Capacity Act.
- The trust should ensure that all risk assessments and care plans are up to date, person centred, recovery focused and reflect the care needs of each patient.

In child and adolescent mental health wards:

- The trust should ensure that staff record all complaints appropriately
- The trust should ensure that staff consider patients' competency and capacity when planning and delivering care through appropriate assessments
- The trust should ensure that staff are trained in the Mental Health Act, including the changes to the Code of Practice and the Mental Capacity Act
- The trust should ensure that there is appropriate accessible information available for patients.

Greater Manchester West Mental Health NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

The trust's systems supported the appropriate implementation of the Mental Health Act (MHA) and its Code of Practice. The application of the Act was overseen by the Mental Health Act and Mental Capacity Act compliance committee. This committee met two monthly and received activity reports covering the number of uses of the Act, uses of seclusion, breaches of the Act, data on patients who were absent without leave and matters raised by the CQC in Mental Health Act reviews. Administration of the Mental Health Act took place at offices at trust headquarters, Woodlands and Recovery First. The trust had a number of sites without on site MHA administrators which was identified as a challenge by staff. The trust was reviewing the model for delivering MHA administration.

Training on the Mental Health Act was made mandatory at the trust in January 2016 with an e learning course available for staff. Training rates for staff were low with only 19% staff trained at 19 January 2016. We found that staff generally had a good understanding of the Act, and were able to explain their role in relation to it. In older people's wards staff told us that they had not been updated on changes in the Code of Practice.

We carried out formal Mental Health Act monitoring visits on four wards as part of the comprehensive inspection of the trust, and checked adherence to the Mental Health Act and Code of Practice in a range of other settings. In most of the case records reviewed, relating to the detention, care and treatment of detained patients, we found that the principles of the Act had been followed and the Code of Practice adhered to. However, we did determine a number of lapses as outlined below.

We found that where the Mental Health Act was used, most patients were detained with a full set of corresponding papers. However, in one instance some statutory documentation could not be located and in two other cases documentation was not fully in order. We looked for evidence that a copy of the approved mental health practitioner (AMHP) report was available to staff and found this to be very inconsistent. We also found evidence of a patient who should have been automatically referred to a mental health review tribunal, but this had been missed.

Patients usually had had their rights explained to them. However, sometimes this was happening late and further attempts were not always undertaken at appropriate times. On one case file no evidence of an explanation about rights was present. For patients on community treatment orders, we found very low levels of recording about attempts to explain to patients what their rights were.

There was an independent mental health advocacy service available for patients.

Records did not always show how risk assessments had been used to assess and inform the use of section 17 leave. Staff were not always recording the outcome of leave, particularly the views of patients as to how their leave had gone.

Recording of section 17 leave on the PARIS electronic patient record was confusing, as all previously agreed leave was shown at the same time as current leave. The copy of authorised leave given to patients also outlined all previously agreed leave arrangements. Not all patients were given a copy of the leave that had been agreed.

(Note: If someone is detained in hospital under the Mental Health Act, it is against the law for them to leave without specific permission granted by the responsible clinician. Permission to leave the hospital grounds, to visit their family for example, or for a trial visit home prior to discharge can be given under section 17.)

We found with few exceptions, prescribed medication was authorised by a form T2 (patient's consent) or T3 (doctor's authorisation). However there were four instances where this was not the case, one relating to a form T2 that was overdue, two to incorrectly completed forms authorising emergency treatment under section 62, and one where a patient was deemed to have consented to electroconvulsive therapy (ECT) when, the previous day they had been determined to be lacking capacity to consent. The recording of patients' capacity to consent was very inconsistent, and not always undertaken when medication was first administered or when a form T2 or T3 had become necessary.

(Note: Section 58 of the Mental Health Act sets out the circumstances in which medication or treatment can be given to patients without their consent. Form T2 is a certificate of consent to treatment completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a certificate of second opinion completed by a doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent.)

Records did not contain evidence that a patient's wishes or desires in relation to treatment were routinely captured, either through the use of advance statements or other means.

The introduction of a new electronic record system had taken place some months before our visit and we found that the level of awareness amongst staff as to how to locate important statutory documentation was very inconsistent, with many staff unable to find documents when asked to do so.

Mental Capacity Act and Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards are rules on how someone's freedom may be restricted in their best interests to enable essential care or treatment to be provided to them. The safeguards ensure that the least restrictive option that can be identified to meet a specific need is applied.

The trust had made 18 Deprivations of Liberty Safeguards (DoLS) applications between 8 December 2014 and 16 September 2015. These occurred across four wards: Chapman Barker Unit, Delamere, Holly and John Denmark unit.

In July 2015, the trust had completed an audit to check staff awareness of the Mental Capacity Act (MCA) and the Code of Practice and to ascertain what training staff had and would like to receive.

The results were that 115/176 (65%) of staff were aware of the process of undertaking mental capacity assessments. Staff wanted more training on the MCA with 132/176 staff requesting additional training. The trust had taken action and since January 2016, there was e learning available for staff which was now included as part of mandatory training.

Staff we spoke with understood the principles of the MCA and were able to give us examples of how they had appropriately assessed patient's capacity. Staff understood the process to follow should they have to make a decision about or on behalf of a patient lacking mental capacity to consent to a proposed decision.

In older people's wards there were examples around do not attempt resuscitation and best interest decisions around

future care settings. We spoke with patients' relatives who told us how they had been involved in these meetings and what their understanding was of the decisions being made. However, records did not always reflect this.

In older people's, adult community services and long stay service, MCA assessments completed by the team were appropriate and there was evidence of the consideration of mental capacity in daily notes.

In crisis services, staff routinely checked if patients' consent to the assessment and treatment when receiving care from the home treatment teams, including whether there were any doubts about patients' capacity to consent.

On the child and adolescent wards we found that not all staff were confident in describing the application of the MCA. However, there were recorded assessments of capacity about decisions on patients' case files.

Recording of discussions and assessments of capacity was generally good except in forensic services and older people's wards.

Requires improvement

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

The summary can be located on page 6

Our findings

Safe and clean care environments

The trust provided services from 60 sites, which included eight hospital sites and community clinics. There was an estate strategy in place which provided a structure for the service development plans and improvements in estate condition, environments and locations necessary to support the service delivery strategy. There were planned improvements for the Gardener unit, where medium secure mental health services were provided to children and young people. The trust had recently opened The Curve, a new build which housed the executive team alongside training and meeting rooms for staff, patients and carers. It was also the base for the recovery academy.

Of the eight core services we inspected, all except one were providing care for patients that met the Department of Health guidance for same sex accommodation. The exception was wards for older people at Bollin and Greenway wards on the Moorside unit. On Greenway ward, male patients had to pass female bedrooms to access the one available bath. Also, the female designated lounge was used for a group activity which men and women attended. On Bollin ward, the female and male bedrooms were all along one side of the corridor. Although females took up the first part and males the second, there was no signage to identify that the area was specifically for either sex or that members of the opposite sex should not enter. The male toilet and shower room was in the female part of the corridor, which meant males would have to pass female bedrooms to use it. The female bathroom was in the middle of the corridor so this meant that depending on how many males were on the ward, females would have to pass by male bedrooms to get to the bathroom. We raised

this with the trust at the time of our visit. The trust took immediate action and put a protocol in place to make sure that the Department of Health guidance was being followed.

Seclusion rooms were clean and well maintained and met Code of Practice requirements.

The trust had an infection prevention and control policy which outlined the roles and duties of the executive team, senior managers, clinical and non-clinical staff. Their policy set out staff responsibilities in relation to the reduction of healthcare associated infections and identified yearly training and updates for staff in infection control including:

- standard (universal) infection prevention precautions
- hand hygiene
- aseptic technique
- major outbreak of a communicable infection
- isolation of patients
- safe handling and disposal of sharps

There was a clear governance structure in place to monitor the implementation of infection prevention and control policies. There was an annual infection prevention audit, monthly patient environment assessment team assessments and three monthly hand hygiene audits.

We saw staff washed their hands when necessary and wore personal protective clothing when carrying out tasks that required it.

Throughout the trust, the standard of cleanliness and maintenance was very good. The trust engaged in monthly patient led assessments of the care environment (PLACE) on all wards. The outcome of PLACE visits were reported to, and monitored by the infection prevention and control committee. In 2015, the trust was above the England average for all four criteria. The trust scored 100% (England average 98%) for cleanliness for all sites: for condition, appearance and maintenance the trust scored 99% (England average 91%); for food the trust scored 94% (England average 90%) and for a dementia friendly environment the trust score was 93% (England average 86%).

Between 13 November 2014 and 12 November 2015, Mental Health Act reviewer visits highlighted issues on 17 occasions with the environment being unsafe and unsupportive. Issues regarding noise and temperature control were also noted.

The trust had a programme for assessing and managing environmental risks which included a ligature audit. The trust directorate risk register contained a risk with a risk rating of 15 concerning window frame ligature risks.

In six of the eight services we visited, environmental risks were well managed with effective actions in place to reduce risks. However, in acute wards for adults of working age and psychiatric intensive care units and wards and older peoples wards there were not clear lines of sight for staff to observe patients. In some acute wards, this was being managed by increasing the observation level of patients which was keeping patients safe however this meant they were not being cared for in the least restrictive manner.

The trust had effective systems in place to keep staff safe. Where required, staff had alarms and rooms had emergency call bells. In community services, staff followed the trust's lone worker policy.

The directorate risk register contained identified risks in the environment which showed that risks were monitored at board level.

Safe staffing

There was a workforce strategy in place, which was monitored via directorate performance reports. Where services had been redesigned, such as the acute care pathway, workforce plans had been implemented and monitored by the board.

Performance reports which included vacancies and sickness were monitored at monthly board meetings. The trust had been managing sickness more actively which had led to a reduction in sickness levels. The September 2015 board assurance framework highlighted three high risks related to safe staffing, sickness absence rates and mandatory training compliance.

The board had acknowledged that the change in the acute care pathway had led to a higher degree of dependency of inpatients and the board had agreed to increase staffing levels on the acute wards. The board had also agreed to

over recruit to vacancies to ensure that there were sufficient staff. Board minutes showed that this was being monitored closely and the trust was proactive in trying to recruit staff.

In October 2015, the overall trust vacancy rate was 12%. Risks associated with vacancies were monitored via the directorate risk register. The trust employed bank and agency staff to ensure that there were sufficient staff to provide safe care. The trust had a staff health and wellbeing strategy to help support staff and had recently changed their human resource partner to enhance the service.

We found that staffing levels were not always sufficient to meet the needs of patients on the child and adolescent mental health wards. This was because when patients were put on higher levels of observations which required more staff, staffing levels were not being increased.

Between 1 November 2014 and 30 October 2015, the overall trust sickness rate was 5% although there were variations between services. Salford older people's services had the highest sickness rate with 13% followed by Bolton older people's community mental health team with 10% and Bolton adult in patient with 9%. The percentage of staff suffering work-related stress in last 12 months was similar to the national average.

Between July 2015 and September 2015, 2169 shifts were filled by bank or agency staff to cover sickness, absence or vacancies. For the same period there were 458 shifts not filled by bank or agency staff where there was sickness, absence or vacancies. Borrowdale ward at Prestwich had the most shifts not filled with 55.

The trust was not meeting its target for mandatory training. The trust had set itself a target of 85% staff completing mandatory training. There were 15 mandatory training courses. The trust overall mandatory training compliance rate in December 2015 was 60%. Immediate life support had the lowest compliance rate at 46%, followed by control of infection level 3 compliance rate at 58% and basic life support at 61%.

However, we found discrepancies in training rates with records in local teams showing higher rates of compliance than records held centrally. A number of life support training sessions had been cancelled by the training provider and the trust was in the process of re-procuring training provision.

Staff told us that they were confident in responding to emergency situations. There were arrangements in place for medical cover out of hours.

Assessing and managing risk to patients and staff

The trust was implementing Safewards. The Safewards project encourages the use of ten interventions to minimise conflict on wards and enhance safety and recovery. This had been piloted at Meadowbrook and was rolled out across Bolton, Trafford and forensic services.

In the quality account 2015, the trust had identified two areas which would improve risk management. These were;

- to improve the assessment and treatment of physical health conditions in order to reduce the risks associated with this for our service users and
- to reduce conflict in inpatient settings.

The trust used a physical health monitoring tool and employed staff who were responsible for reviewing patient's physical health in the forensic service. However, we found that in wards for older people, forensic services and CAMHS services staff were not always monitoring patient's physical observations after the use of rapid tranquilisation. This meant there was a risk of unwanted effects of medication not being identified quickly. The trust had a form for recording observations but they were not always being used by staff.

Risk assessments were used to assess patients' risks but these were sometimes difficult to find in the electronic system. We found that risk assessments were comprehensive, current and regularly reviewed and updated except in community services for adults of working age and the forensic service. Staff could describe what individual risks were and how they worked with the patients individually to manage them.

There were effective systems in place for managing safeguarding incidents. Each directorate had an identified safeguarding lead and there was a named doctor and nurse for both adults and children's safeguarding. The trust attended local adult safeguarding boards and stakeholders reported good partnership working. Between 1 April 2015 and 3 February 2016, the trust had made 184 adult safeguarding referrals and 12 child safeguarding referrals. Referrals were made across all localities and services.

Detailed findings

Safeguarding adults and safeguarding children level 1 training courses were mandatory and were undertaken every 3 years. In December 201, 90% of staff had completed safeguarding training. However, staff working in child and adolescent wards had not received level 3 training in safeguarding children as required.

The trust was implementing changes in line with the Department of Health's 'Positive and proactive care: reducing the need for restrictive practices.' The trust was auditing the use of restrictive practices with an aim to ensure the least restrictive practice was used. Across adult services we found that patients were cared for with minimal restrictions. Risks were managed individually. However, on Junction 17, we found that there were blanket restrictions in place. Young people were not allowed access to their bedrooms during the day; they were allowed mobile phones only when on leave and were searched on return from leave. When we returned for an unannounced inspection of Junction 17, the trust had already taken action to address these issues.

In child and adolescent and mental wards and acute wards for adults of working age, we found that patients were being cared for in de stimulation areas and were not being allowed to leave. Staff were not recognising this as seclusion and were not ensuring that the checks and safeguards for seclusion described in the Code of Practice were being followed.

Between 1 July 2015 and 31 December 2015, there had been 1105 incidents of restraint involving 325 patients. Eighty five of these restraints had been in the prone position with 24 leading to the use of rapid tranquilisation.

In the same six month period, there were 247 episodes of seclusion. Chaucer ward, a psychiatric intensive care unit, had the highest number with 46 episodes. There was one episode of long term segregation which we reviewed during this inspection. The trust was managing this well and working with the patient, their family and commissioners to identify a more suitable placement.

Ward staff told us that the pharmacist team were a good support if they had any medicines queries. Pharmacists were also involved in delivering a comprehensive medicines related education programme throughout the trust. We saw that training was updated with learning from audits. For example, learning from the National Audit of Schizophrenia had been included in doctors' education on induction, explaining the need for documentation of the rational for prescribing antipsychotics to patients with schizophrenia.

The trust was drafting a strategy for medicines optimisation. A business case for bringing medicines supply 'in-house' had been agreed and was being implemented at the time of our visit. Clinical pharmacy staffing was included on the trust risk register but a skill mix review and business care had yet to be developed to address trust identified gaps in the provision of pharmacy clinical services.

We found that the trust policy for rapid tranquilisation was not consistently followed. This had been identified by trust audits in child and adolescent mental health services and forensic services completed in 2015. The trust policy had been reviewed in accordance with National Institute for Care and Health Excellence guidance in February 2016, and there were plans for re-audit. This is important to ensure the safe prescribing, administration and monitoring of medication used for rapid tranquillisation.

Systems were in place for reporting and assessing medicines incidents and errors through the medicines safety group. A medication error booklet was used to support reflective practice and to identify any individual learning needs, following medicines incidents. Medicines management newsletters were used to raise staff awareness of current medication themes from audits, incidents and national guidelines.

To support the NHS drive towards paper light systems, plans were in place for sending discharge notifications and summaries electronically to GP practices. Additionally, a project board had been established in February 2016 to support the safe implementation of electronic prescribing and medicines administration across the trust.

Track record on safety

We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning system (NRLS) and to the Strategic Executive Information System (STEIS) and serious incidents reported by staff to the trust's own incident reporting system. These three sources are not directly comparable

because they use different definitions of severity and type and not all incidents are reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.

Providers are encouraged to report all patient safety incidents of any severity to the NRLS at least once a month. The average time taken for the trust to report incidents to NRLS was 16 days which means that the trust was considered a consistent reporter.

The trust reported a total 5,887 incidents to the NRLS between 1 November 2014 and 31 October 2015. When benchmarked with other trusts, the trust was about the same as other trusts. Of incidents reported to NRLS, 66% resulted in no harm, 29% in low harm, 4% in moderate harm, 0.1% in severe harm and 0.5% in death. The percentage of all patient safety incidents that resulted in severe harm or death fell by 1.5% to 0.8% in 2014/15 when compared to 2013/14. The NRLS considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture.

The incident category which was most frequently reported was 'self-harming behaviour' which accounted for 40% of the incidents reported, followed by 'disruptive, aggressive behaviour (including patient-to-patient)' with 17%, followed by followed by 'patient accident' with 11%.

Trusts are required to report serious incidents (SI) to STEIS. These include 'never events' (serious patient safety incidents that are wholly preventable and should never occur). The trust reported 68 serious incidents between 1 November 2014 and 31 October 2015. None of these were never events. Of the incidents reported to the STEIS 2 (historic) system, 35% were 'unexpected death of community patient (in receipt)', 17% were incidents related to 'suicide by outpatient (receiving care)' and 14% were 'suspected suicide'. Of the incidents reported to the STEIS 3 system, 62% related to 'apparent/actual/suspected self-inflicted harm meeting SI criteria', 8% were incidents related to 'treatment delay meeting SI criteria' and 8% were 'abuse/alleged abuse of adult patient by staff'.

Between 10 March 2014 and 23 August 2015, trust staff reported 64 serious incidents. The commonest type of serious incidents were categorised as 'death / suicide' at 38% and 'suspected suicide' at 34%.

The number of the most severe incidents recorded by the trust incident reporting system is broadly comparable with that reported to STEIS. This demonstrates that the trust was reporting SIs to STEIS as required.

In the NHS Staff Survey 2015, the trust was in the worst 20% of all mental health/learning disability trusts for questions related to staff witnessing potentially harmful errors, near misses or incidents in last month.

The number of clinical negligence claims via the NHS Litigation Authority related to the trust was similar to other trusts.

Commissioners highlighted areas for improvement related to the Safety Thermometer which showed a higher than national average incidence of violence in inpatients wards. The trust had identified this as a priority in the 2015 quality account. Commissioners raised concerns about trends and 'hot spots' for suicide and the trust was working collaboratively to address these.

The Courts and Tribunals judiciary publish 'Reports to Prevent Future Death', which contain recommendations which have been made by coroners with the intention of learning lessons from the cause and prevention of deaths. The trust had received one report in February 2016 which related to access to psychological therapy in the community. The trust had to submit information to the coroner as instructed under Regulation 28, to identify action it intended to take to address the recommendation made by the coroner. Regulation 28 can be issued to providers of services by a coroner in relation to the death of a patient in receipt of mental health services.

Reporting incidents and learning when things go wrong

The trust used an electronic system for reporting incidents and staff recognised what needed reporting as an incident and knew how to report them. The trust was investigating and closing serious incidents in a timely manner with no outstanding cases on STEIS as at 8 January 2016.

The trust monitored the numbers of incidents reported on a monthly basis. This included the number of new serious incidents and physical assaults against staff and patients. This data was provided to the board as part of the quality and performance dashboard and trends were identified.

Detailed findings

Where particular issues were identified thematic reviews looking in more detail were taking place. The trust also monitored national reports to identify any lessons to be learned that applied to their services.

Incident reporting and investigation was managed well in the organisation. Incidents were investigated in a timely manner and learning was shared across teams.

Nine root cause analyses were randomly chosen and reviewed by the inspection team and these had been completed comprehensively. The trust had a number of methods of sharing lessons learned which included newsletters, splash screens, staff meetings and learning events. Prior to the inspection, stakeholders had raised support for staff following serious incidents as a concern. However; staff told us they felt supported following incidents.

Duty of Candour

The statutory duty of candour was introduced for NHS bodies in England from 27 November 2014. The obligations associated with the statutory duty of candour are contained in regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The key principles are that NHS trusts have a general duty to act in an open and transparent way in relation to care provided to patients. This means that an open and honest culture must exist throughout the organisation. Appropriate support and information must be provided to patients who have suffered (or could suffer) unintended harm whilst receiving care or treatment.

The majority of staff we spoke with understood the underlying principles of the duty of candour requirements and the relevance of this within their work.

Incident reports included a section to monitor whether duty of candour duties had been considered and acted upon. Complaints and incidents reviewed contained evidence that the trust apologised when things went wrong and were open and transparent. Stakeholders reported that the trust worked collaboratively in an open and transparent manner.

Anticipation and planning of risk

The trust had a current comprehensive emergency preparedness, resilience and response policy. There was an easy to use action card system within the policy for staff to follow in an emergency situation. The risk management strategy group reviewed and oversaw the policy and process.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

The summary can be located on page 6

Our findings

Assessment of needs and planning of care

In all of the services we visited, patients had their needs assessed within the timelines set out in trust procedures. Generally. the assessments were comprehensive, holistic and person centred. In Bramley Street, in the rehabilitation service, the care plans were of a very high standard with all the patients involved in the development of the plans. However, in acute wards and forensic wards, records did not always show how patients or carers had been involved in the development of care plans. Patients' views were not always recorded and not all patients knew they had care plans. In some areas, staff struggled to find documents on the electronic system. The trust had changed their electronic information system in September 2015. We spoke with staff during the inspection who described varying degrees of satisfaction with the system. Some staff felt that it was an improvement on the previous system and were able to easily navigate the system. However, other staff were very unhappy and struggled to locate information on the system. In order to further support staff, the trust had extended the support systems in response to staff feedback. Support included system champions, individual training, written guidance and a helpline.

There were a total of 117 readmissions within 90 days reported by the trust between 27 July 2015 and 25 January 2016. The wards with the highest number of readmissions within 90 days were Brook ward with 22 and Eagleton ward with 20.

Between 27 July 2015 and 25 January 2016 there were nine delayed discharges from inpatient facilities. The ward with the highest number of delayed discharges was Medlock ward with four.

The trust proportion of admissions to acute wards kept by the crisis resolution home treatment team had been above the England average for all seven quarters reported.

We found that patients were receiving good physical health care. For example in the forensic inpatient services there was an on-site health centre offering input from a GP, dentist and optician. In acute services, all wards were supported by a team of physical health practitioners who led on patients' physical health needs. They undertook health checks and physical health care planning.

The physical health improvement tool was used to record physical health issues which was located in the electronic records system. Staff used the modified early warning system chart to record patient's vital signs and easily identify if there were changes to their observations that needed to be reviewed.

Previous MHA reviewer visits had highlighted a lack of activities on eight occasions. On our inspection we found that there was a variety of activities provided. However, in acute wards and PICU, we found that activities and leave were sometimes cancelled due to lack of staff.

The trust was identified as an elevated risk by CQC for the proportion of records that showed evidence of discharge planning. In previous MHA monitoring visits, 19 of the 87 records checked by Mental Health Act reviewers had a discharge plan in place. During this inspection we found good discharge planning on the acute wards and on older people's wards.

Best practice in treatment and care

The trust ensured it maintained the care it provided in line with the latest guidance. Assurance around the monitoring of National Institute for Health and Care Excellence (NICE) guidance, national guidance and quality standards was monitored by the trust NICE implementation and audit group subcommittee. The sub committee was multi-disciplinary and included representatives from all divisions. The sub committee had the following responsibilities in relation to NICE:

- consulting on and reviewing of all national guidance

Good

Are services effective?

- NICE guidelines and quality standards
- approving all relevant policies and procedures
- reviewing new interventions and treatments
- producing a bi-monthly report to the quality governance committee which included agenda items and any actions that may be required
- ratifying decisions about appropriate clinical leads for each specific NICE guidance
- ensuring an organisational gap analysis took place when relevant NICE guidance was issued
- reviewing and agreeing the dissemination and implementation of plans, and considering if the identified action was adequate and appropriate
- reviewing and agreeing plans to monitor uptake/audit of implementation of NICE guidance monitoring progress against agreed dissemination and the implementation and audit plans.

We saw that the trust policy for physical health and wellbeing was being referred to when developing local protocols and strategies. However, the trust policy had not been reviewed to take into account the recommendations in NICE CG178: Psychosis and schizophrenia in adults: prevention and management, 2014 amendments.

Pharmacist resource meant that attendance at ward multidisciplinary team meetings or consultant ward rounds meetings was not always possible. The trust was unable to comply with the recommendation that a specialist pharmacist was part of the multidisciplinary team when developing individualised pharmacological strategies for patients at risk of violence and aggression, (NICE NG10 2015: Violence and aggression: short-term management in mental health, health and community settings) and in supporting medicines reconciliation within 24 hours of admission (NICE NG5 2015: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes).

Between March 2015 and September 2015, the trust had completed 15 audits against NICE guidelines, including smoking cessation, and use of anti-depressants in community patients.

A trust audit programme was in place to assess medicines handling in accordance with the trust's medicines policies and national guidance, with the outcome of these audits beings shared at the medicines management committee and relevant directorate level clinical governance meetings. The trust subscribed to POMH UK (Prescribing Observatory for Mental Health) to enable audit of prescribing practice against national standards and to benchmark their performance against other similar trusts. The trust was also monitoring a CQUIN for reducing omitted doses through the use of the Mental Health Safety Thermometer.

The trust had participated in three national audits including the Prescribing Observatory for Mental Health Use of Antipsychotic Medication in CAMHS (topic 10C) report issued May 2014, the Second English National Audit of Memory Clinics and the National Audit of Schizophrenia.

The trust participated in the National Audit of Schizophrenia in 2014 which assessed the quality of prescribing antipsychotic medicines for patients with schizophrenia in the community and the monitoring of patient's physical health. (Note: antipsychotic medications are a group of medicines used to treat illnesses such as schizophrenia or bipolar disorder. They can also be used to treat severe depression.)

The trust scored better than the England average in eight indicators in the audit. However, it scored worse than the England average for 10 indicators. These were related to the proportion of;

- patients offered family interventions
- the proportion of patients reporting they knew how to get help from mental health services in a crisis
- the overall monitoring of five risk factors
- monitoring of body mass index
- monitoring of glucose control, lipids and blood pressure, frequency of polypharmacy (cases not on clozapine)
- frequency of high dose prescribing above the British National Formulary guidelines
- patients not in remission and not on clozapine without a reason normally considered as appropriate.

We found the trust was implementing the actions identified following the audit.

The trust recognised that clinical audit was an essential part of improving quality. From March 2015 to September

Good

Are services effective?

2015, the trust carried out 39 clinical audits across a range of services. Some of these were to check compliance with targets set by commissioners. Examples included audits of compliance with discharge plans in acute wards, use of the MHA, care plans, in-reach psychology referrals and use of medications. During the inspection we saw audits being completed and the results being used to make improvements to services. However, an audit in 2015 had identified that staff were not always monitoring patient's physical observations following use of rapid tranquilisation and we found that this was still not happening during our inspection.

To measure outcomes for individuals, the trust was using the Health of the Nation Outcome Scales to measure the health and social functioning of patients with a severe mental illness and over times the patient outcomes. Services also used a wide range of other outcome measures and assessment tools dependent on the needs of the individual to see how patients were progressing.

The trust had a wide range of measures in place agreed with commissioners, including NHS England with the aim of improving the outcomes of patients who use their services.

The commissioning for quality and innovation (CQUIN) framework had financially incentivised the trust to deliver improvement. The North of England Specialised Commissioning Team confirmed that the trust has completed this year's CQUIN targets.

The trust's Quality Account highlights that the trust had made significant progress against all eight of their 2014/15 priorities for improvement. During this period the trust had implemented a new acute patient pathway.

The trust had set eight priorities for 2015/16 which included;

- psychological therapies – improving access and outcomes
- listening to/learning from feedback
- involvement & engagement of carers
- recovery, improving identification
- enhancing the quality of life for people with dementia and older people with functional Illness
- physical health
- promoting individualised support plans
- dual diagnosis.

The trust had achieved all the targets set by Monitor.

Skilled staff to deliver care

All staff; permanent, temporary, staff seconded into the trust, volunteers and bank workers, received a three day corporate induction. After corporate induction, staff received a local induction and completed an induction workbook. The local induction included time spent shadowing more experienced members of the team. For locum and agency staff, there was a local induction checklist which had to be completed before the start of duties. We saw that these were used across the services. Staff described the induction process as helpful.

Staff were very positive about the training opportunities available to them. The trust provided access to appropriate development and training via a training services department. Courses available included;

- leadership and management
- personality disorder
- National KUF (Knowledge and Understanding Framework) Programme
- alcohol and substance misuse specialist training
- British Sign Language training
- assistant practitioner and mentorship training
- cognitive behaviour therapy training
- family therapy training.

The trust had educational partnerships with Salford University and a research and development department.

The trust offered two apprenticeship frameworks for existing members of staff in business administration and health and social care. This allowed staff in Bands 1-4 to have the opportunity to gain a nationally recognised qualification whilst continuing in their existing roles.

A new joint education centre, the recovery academy, had also been built for use by staff and patients. The recovery academy provided a range of free educational courses and resources for patients with mental health and substance

misuse problems, their families and carers as well as health care professionals. The courses focussed on supporting patients with their recovery and promoting good health and wellbeing.

The trust had identified the need to improve the number of staff receiving regular supervision and appraisal and had taken steps to improve performance.

The NHS Staff Survey 2014 showed the trust were in the worst 20% of all mental health/learning disability trusts for questions relating to staff being appraised and having a well-structured appraisal. In the 2015 survey, the trust performance had improved with 82% of staff reporting they had received an appraisal. As at 25 January 2016, the percentage of non-medical staff that had an appraisal in the last 12 months was 82%. Community based mental health services for older people had the lowest appraisal rate with 68%, followed by acute wards for adults of working age and PICU with 75%. The trust had recently improved the accuracy of recording at corporate level and implemented action plans for services with lower levels of compliance.

The trust expected staff to receive clinical supervision six times a year. Between February 2015 and January 2016, the supervision rate for the trust was 63**%**. We found that there were variations across services. All staff working in community teams in Bolton were receiving clinical supervision six times a year, as were staff on 11 of the 18 forensic wards. The wards with the lowest rates were Holly ward for older adults where 22% of staff had received regular supervision and Irwell ward, an acute ward, with a figure of 37%. Group supervision was also available in some services: for example, in Bolton community staff could attend a group for supporting patients on the personality disorder pathway.

The 2015 General Medical Council training scheme survey showed that the trust was above average for induction. However they were below average for clinical supervision at Meadowbrook.

Health Education North West advised the trust had two or more areas of notable practice for management of education and training and equality, diversity and opportunity.

We saw that teams were also having regular team meetings.

The trust complied with the medical revalidation statutory requirements. At 26 January 2015, 93% of the trust doctors had completed their appraisal.

We reviewed a sample of files which showed that the trust addressed staff performance issues. The files showed that policies and procedures were followed. Within the last 12 months, 26 staff had been suspended.

Multi-disciplinary and inter-agency team work

In the 2015 NHS Staff Survey, the trust was performing the same as other trust's relating to effective team working. There were a number of different meetings in place across services to ensure effective team working.

Staff spoke positively about multi-disciplinary work. We observed a number of meetings including multi-disciplinary meetings and staff handovers. These reflected some good practice and we saw staff working well together in a respectful manner. We found these were effective in sharing information about a patient's care needs and advice was sought from different professionals across the service dependent on individual need.

We also saw how different teams worked together to support patients as they moved along care pathways. We observed staff from community teams and care coordinators attending wards as part of the patients' admission and discharge planning.

The trust worked with three local areas to provide services: Bolton, Salford and Trafford. The trust also provided specialist services which were commissioned by NHS England. Stakeholders spoke positively about the partnership working and described effective working relationships within district services. Examples of working together to drive improvements included the redesign of the acute care pathway and strengthening of home treatment teams which meant that patients spent a shorter time in hospital. Stakeholders also gave examples where they had raised questions about differing performance against targets across the areas and the trust had responded to improve quality. Stakeholders described a mature effective organisation that was open to challenge and willing to listen.

The trust also had a joint agreement with a private provider to provide rehabilitation services in Widnes. Feedback again was that the trust had worked collaboratively to address the challenges when setting up the service.

Good

Are services effective?

We found examples of good inter-agency work. The trust was contributing to the development and implementation of an integrated primary and acute care system to meet all health and social care needs in Salford, working with commissioners, the local authority and the acute trust.

The trust worked in partnership with third sector colleagues. Examples included working to support patients into training and employment.

The trust worked with acute trusts to provide support to patients attending A&E with alcohol problems. The rapid access to alcohol detoxification acute referral (RADAR) team supported adults with alcohol problems by working with them as soon as they were admitted to hospital A&E wards. The team took referrals from 11 acute hospitals across Greater Manchester and had a 97% successful detoxification rate for patients admitted to the eight bed ward. RADAR was named non-age Specific Psychiatric Team of the Year 2014 by the Royal College of Psychiatrists.

Collaboration between police officers and mental health professionals had led to quicker assessments and reduced the number of mentally ill people held in police cells.

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

The trust's systems supported the appropriate implementation of the Mental Health Act and its Code of Practice. The application of the Act was overseen by the Mental Health Act and Mental Capacity Act compliance committee. This committee met two monthly and received activity reports covering the number of uses of the Act, uses of seclusion, breaches of the Act, data on patients who were absent without leave and matters raised by the CQC in Mental Health Act reviews. Administration of the Mental Health Act took place at offices at trust headquarters, Woodlands and Recovery First. The trust had a number of sites without on site MHA administrators which was identified as a challenge by staff. The trust was reviewing the model for delivering MHA administration.

Training on the Mental Health Act was had recently been made mandatory with an e learning course available for staff. Training rates for staff were low with a 19% staff trained at 19 January 2016. We found that staff generally had a good understanding of the Act, and were able to explain their role in relation to it.. We found that staff in the child and adolescent mental health wards and acute wards were not always recognising when they were secluding patients. We found that on occasion patients were being cared for in destimulation rooms and not allowed to leave.

In most of the case records reviewed, relating to the detention, care and treatment of detained patients, we found that the principles of the Act had been followed and the Code of Practice adhered to.

We found that where the Mental Health Act was used, most patients were detained with a full set of corresponding papers. However, in one instance some statutory documentation could not be located and in two other cases documentation was not fully in order. We looked for evidence that a copy of the approved mental health practitioner (AMHP) report was available to staff and found this to be very inconsistent. We also found evidence of a patient who should have been automatically referred to a mental health review tribunal, but this had been missed.

Patients usually had had their rights explained to them. However, this was not always consistently recorded. Sometimes explaining rights was happening late and further attempts were not always undertaken at appropriate times. For patients on community treatment orders, we found very low levels of recording about attempts to explain to patients what their rights were. In wards for older people, we found that not all wards had information displayed by locked entrance doors to tell informal patients of their rights to leave.

There was an independent mental health advocacy service available for patients. We saw that patients were actively encouraged to use the service.

The recording of section 17 leave was not always completed thoroughly. Records did not always show a clear link between risk assessments and the facilitation of section 17 leave. Staff were not always recording the outcome of leave, particularly the views of patients as to how their leave had gone.

The recording of section 17 leave on the electronic patient record was confusing, as all previously agreed leave was shown at the same time as current leave. The copy of authorised leave given to patients also outlined all previously agreed leave arrangements. Not all patients were given a copy of the leave that had been agreed.

Good

Are services effective?

(Note: If someone is detained in hospital under the Mental Health Act, it is against the law for them to leave without specific permission granted by the responsible clinician. Permission to leave the hospital grounds, to visit their family for example, or for a trial visit home prior to discharge can be given under section 17.)

With regard to consent to treatment we found that the vast majority of patients had an appropriately completed form T2 or T3 in place, authorising medication that was being administered. We also found that the recording of patients' capacity to consent was very inconsistent, and not always undertaken when medication was first administered or when a form T2 or T3 had become necessary.

(Note: Section 58 of the Mental Health Act sets out the circumstances in which medication or treatment can be given to patients without their consent. Form T2 is a certificate of consent to treatment completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a Certificate of second opinion completed by a doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent.)

Records did not contain evidence that a patient's wishes or desires in relation to treatment were routinely captured, either through the use of advance statements or other means.

The introduction of a new electronic record system had taken place some months before our visit and we found that the level of awareness amongst staff as to how to locate important statutory documentation was very inconsistent, with many staff unable to find documents when asked to do so.

Good practice in applying the Mental Capacity Act

The trust's systems supported the appropriate implementation of the Mental Capacity Act and its Code of Practice. The application of the Act was overseen by the Mental Health Act and Mental Capacity Act compliance committee. This committee was responsible for monitoring Deprivation of Liberty arrangements and review of the MCA policy.

The trust had made 18 Deprivations of Liberty Safeguards (DoLS) applications between 8 December 2014 and 16 September 2015. These occurred across four wards: Chapman Barker Unit, Delamere, Holly and John Denmark unit.

In July 2015, the trust had completed an audit to check staff awareness of the MCA and the Code of Practice and to ascertain what training staff had and would like to receive. The results were that 115/176 (65%) of staff were aware of the process of undertaking mental capacity assessments. Staff wanted more training on the MCA with 132/176 staff requesting additional training. The trust had taken action and since January 2016, there was e learning available for staff which was to be included as part of mandatory training, which it had not been previously.

Training rates for staff were low across services with 24% of staff having received training as at January 2016. However, mostly staff we spoke with understood the principles of the MCA and were able to give us examples of how they had appropriately assessed patients' capacity. Staff understood the process to follow should they have to make a decision about or on behalf of a patient lacking mental capacity to consent to a proposed decision.

In older people's wards there were examples around do not attempt resuscitation and best interest decisions around future care settings. We spoke with patients' relatives who told us how they had been involved in these meetings and what their understanding was of the decisions being made. However, records did not reflect this.

In older people's, adult community services and long stay service, MCA assessments completed by the team were appropriate and there was evidence of the consideration of mental capacity in daily notes.

In crisis services, staff routinely checked if patients' consent to the assessment and treatment when receiving care from the home treatment teams, including whether there were any doubts about patients' capacity to consent.

On the child and adolescent wards we found that not all staff were confident in describing the application of the MCA. However, there were recorded assessments of capacity about decisions on patients' files.

Recording of discussions and assessments of capacity was generally good except in forensic services and older people's wards.

Good

Are services caring?

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

Summary of findings

The summary can be located on page 6

Our findings

Kindness, dignity, respect and support

During our inspection we saw interactions between staff, patients and carers. We saw that patients were treated with dignity, respect and compassion. Patients and carers told us that staff were caring and approachable. We saw staff taking time to be with patients and attend to their needs.

Staff knew their patients well and were able to describe their individual needs and how they liked to be cared for.

On acute wards and PICU, we observed staff interactions with patients on the ward and in review meetings which were conducted in a caring and compassionate way. Patients who appeared distressed were responded to in a calm and respectful manner. We witnessed situations on the wards being de-escalated well. Staff remained calm and made every effort to engage patients in regulating their own behaviours whilst ensuring other patients were safe and supported.

In community services for adults of working age, staff were reassuring and encouraging to individuals to be open and honest and share how they were currently feeling. Staff explored topics with patients in a respectful and nurturing manner. Within the sessions, staff shared the progress made in their recovery and offered additional support to individuals if their mental state was deteriorating. Staff advised individuals to phone them if they needed support between their visits. Feedback from comments card included staff were caring, they listen to you and do not judge you. Staff were understanding and patients felt able to talk to staff as they knew the information they shared was confidential and staff respected their confidentiality.

In long stay and rehabilitation services we saw interaction between staff and patients that was respectful, thoughtful, considerate, timely, and professional.

However, on Junction 17, one of the child and adolescent units, we found language used by a small number of staff to describe behaviours that was not respectful of patients. We raised this with the trust who took immediate action to address this. On this ward, patients told us that they felt staff did not always have the time to respond to their needs when they were distressed.

The trust's overall score for privacy, dignity and wellbeing in the patient-led assessments of the care environment 2014 was 95% which was above the England average of 89%. At each of the locations within the trust, scores were also above the England average with scores ranging from 95% to 98% at Bramley Street.

In the patient friends and family test data 89% of respondents were either 'likely' or 'extremely likely' to recommend the trust as a place to receive care, which was better than the England average of 86%. There had been 107 responses to this survey.

In the staff friends and family test data for April to June 2015, 76% of respondents were either 'likely' or 'extremely likely' to recommend the trust as a place to receive care, which was worse than the England average of 79%. There was a response rate of 36%.

For the three questions relating to care in the NHS staff survey 2015, the trust scored better than the England average for mental health trusts.

The percentage of staff feeling satisfied with the quality of work and patient care they delivered from the NHS Staff survey 2015 was better than the England average.

For the question: "Care of patients / service users is my organisation's

top priority", 74% of staff agreed compared to an England average of 70% for mental health trusts.

For the question: "My organisation acts on concerns raised by patients / service users",

77% of staff agreed compared to an average of 72%.

For the question: "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation", 65% agreed compared to an average of 59%.

Good

Are services caring?

In the CQC Community Mental Health Patient Experience Survey 2015, the trust performed about the same as other trusts for all questions including 'Overall in the last 12 months, did you feel that you were treated with respect?' The only exceptions were for 'Have you been told who is in charge of organising your care and services?' and 'Do the people you see through NHS mental health services help you with what is important to you?' where the trust was among the best performing trusts.

Involvement of people in the care they receive

The trust had a number of systems of involving patients and carers. Patients and carers were invited to public board meetings. Minutes from patient meetings were fed back through the trust governance system. Patients were involved in training staff and the development of information resources as part of the recovery academy. The trust ran courses at the recovery academy for patients and their families and carers. Patients and carers also contributed to delivering training for staff. The trust had a C.A.R.E (Compassion And Recovery-focussed Everytime) Hub which worked in partnership with carers, service users, volunteers, staff and external organisations to develop the care provided. The Hub proactively sought feedback to improve people's experiences of the services. In some services, patients were involved in the recruitment of staff. We saw 'you said we did' posters on the wards in response to feedback from patients. There was an annual carer's event where carers could share their experiences and a quarterly carer's newsletter.

The trust had received a second star for the 'triangle of care' initiative. This was developed nationally to improve carer engagement in mental health acute inpatient and home treatment services.

On John Denmark unit, information was provided in an appropriate format for patients with the use of deaf syntax. Staff were trained to communicate with deaf patients and there were also British Sign Language translators available. All about me files were used and we saw copies of advanced statements within those files. At Bramley Street, the care plans were excellent with person centred and up to date information which demonstrated that patients were totally involved in their development.

In acute wards and PICU, there was a mixed experience for patient involvement with approximately half of the patients having detailed involvement and awareness of care plans.

The service had good initiatives to involve patients. Patients were invited to public board meetings and shared their experiences of care. Regular community meetings were held on the wards where notes were taken and fed back into the trust's governance structure. Patients were involved in training staff and the development of information resources as part of the recovery academy.

In the CQC Community Mental Health Patient Experience Survey 2015 – the trust performed about the same as other trusts for questions relating to 'involving service users and their carers in care planning'. We found that the majority of working age adults receiving care in the community had meaningful involvement in their care plans.

Good

Are services responsive to people's needs?

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

Summary of findings

The summary can be located on page 6

Our findings

Service planning

The trust worked with clinical commissioning groups, local authorities, patients, GPs and other local providers to understand the needs of the people where local mental health services were provided. The trust also worked jointly with an independent health care provider to provide rehabilitation services in Wigan and Salford. The trust provided specialist services where patients came from across the country to receive care.

The trust had redesigned the acute care pathway in order to improve the service it delivered. This had been done in partnership with commissioners with the aim of reducing the length of stay for patients in hospital. Patients and carers had been invited to comment on the proposals and attend meetings to discuss them. The change had led to an increase of the levels of illness of patients being admitted to the ward. The trust had recognised this and was recruiting extra staff to ensure that care could be delivered safely in the inpatient setting.

Other examples of good partnership working to provide services which met the needs of the community were seen in the crisis and health based places of safety service. There was an alcohol worker integrated into the Trafford RAID service to support intoxicated patients. There was a pilot service with mental health nurses working in police stations at some localities to support the police to better signpost and manage people who regularly contacted the police.

External stakeholders were very positive about the trust's provision of rehabilitation services at Bramley Street. The trust had agreed to provide this service for Manchester. Patients had been expected to stay months and over 50% had been discharged within six months without readmission. The trust was looking to replicate this model.

Access and discharge

A bed occupancy rate of below 85% is considered ideal by The Royal College of Psychiatrists to ensure the orderly running of the ward and hospital. This is because patients can be admitted to a local bed in a timely fashion, and keep links with their social support network. It also reduces the risk of the bed being used for another patient if they go on leave and patients being moved wards for non-clinical reasons.

Between 27 July 2015 and 25 January 2016, the average bed occupancy rate was 91%. Of the 41 wards, 37 were above the 85% bed occupancy benchmark. All the inpatient core services were above the 85% occupancy rate.

Acute wards for adults of working age and psychiatric intensive care units 99%

Child and adolescent mental health wards 102%

Forensic inpatient/secure wards 97%

Long stay/rehabilitation mental health wards 88%

Wards for older people with mental health problems 95%

Eight wards had a bed occupancy of over 100% for the six month period, this included Bollin ward 105%, Brook ward 106%, Copeland ward 101%, Derwent ward 122%, Eagleton ward 102%, Maple House 102%, Rockley House 114% and Phoenix ward the highest with 125%.

There had been 11 out of area placements in the last six months. Nine were for patients requiring care in a psychiatric intensive care unit.

The acute care pathway redesign that had taken place meant that waiting times from referral to treatment were minimal as every referral was treated as an emergency and either allocated an inpatient bed or opened to home based treatment teams. The trust was consistently performing better than the England average for the proportion of admissions gate kept by crisis resolution home treatment teams in all seven quarters reported. The lowest number reported was 99% with the ideal being 100% of patients being assessed.

Good

Are services responsive to people's needs?

There were a total of 117 readmissions within 90 days reported by the trust between 27 July 2015 to 25 January 2016. The wards with the highest number of readmissions within 90 days were Brook ward with 22 and Eagleton ward with 20.

The trust performed well in ensuring that patients were able to return to the community when they were well. Between 27 July 2015 to 25 January 2016 there had been nine delayed discharges from inpatient facilities which was better than the England average. The ward with the highest number of delayed discharges was Medlock ward with four. The most common reason for delay was waiting for availability of a placement in an adult social care setting.

The trust performed above the England average for the proportion of patients on the Care Programme Approach followed up within seven days of being discharged from a psychiatric inpatient unit for all of the quarters between January 2014 and September 2015.

The trust met all of their targets regarding the number of days from initial referral to initial assessment during the period. The trust also met all of their targets regarding the number of days from initial assessment to onset of treatment during the period.

Salford CCG expressed concerns with improving access to psychological therapies programme waiting times, which had been longer in Salford than in Trafford. The trust had worked with the commissioner and adopted the same approach as Trafford in Salford which had led to a reduction in waiting times.

The facilities to promote recovery, comfort, dignity and confidentiality

Most of the places where patients were cared for were clean and comfortable. The trust had plans in place to improve settings where accommodation was older and less suitable such as the Gardener unit. Where patients stayed for longer periods, they were encouraged and supported to personalise their rooms and wards. However, the environments in the health based place of safety had a clinical appearance with bare walls.

Patients had access to quiet rooms, rooms for activities and to outside space.

In the community service for adults, staff ensured that there was always an interview room kept free so that patients could be seen in an emergency. Staff saw patients in places that were convenient to them such as in their homes, in GP practices and community centres. In community services for older people, patients were normally seen in their homes. However in response to requests from patients and carers, a clinic had been set up in a local unit so that patients could be seen outside their home if they wanted.

Meeting the needs of all people who use the service

Equality and diversity within the trust was monitored via the Equality, Inclusion, Recovery Steering Group which then escalated issues and learning to the Quality Governance Committee. The group

produced an annual report which set out priorities and reported on progress against targets.

The trust's priorities were:

- to strengthen data collection of the protected characteristics of patients and workforce
- to collate and monitor data on the protected characteristics of patients who make complaints
- to set local equality objectives in business development plans and to undertake equality impact assessments on policies and business development
- plans to ensure they met the needs of, and do not disadvantage, patients of any protected characteristics.

The trust demonstrated a real commitment in terms of meeting patients' equality, diversity and human rights. Staff received mandatory training in equality and diversity on induction and this was updated. At December 2015, 88% of staff had attended this training. There were equality champions.

The trust website was accessible and easy to use for everyone, no matter what browser visitors to the website chose to use, and whether or not they had any disabilities. The website's layout took in to account users who were blind or visually impaired. It was fully compatible with popular screen reading software.

The trust had monthly equality and diversity splash screens. The splash screens appeared on all trust desktops for three days at the beginning of the calendar month and contained information about religious days, festivals and

Good

Are services responsive to people's needs?

observances for the coming month and special days which related to protected characteristics. Splash screens have included information about age, ethnicity, faith, disability and sexual orientation.

The trust was developing a deaf recovery package called 'All about me'. NHS booklets on the individual patient's recovery process were inaccessible to deaf patients due to the language format in which they were presented. Deaf professionals and patients from the John Denmark Unit had been fully involved in creating this package.

The John Denmark Unit hosted the only deaf readers' group for people with mental health problems in the country. The initiative was introduced in 2015 and was fully subscribed.

Staff were able to access interpreters and signers when required. We saw examples of this service being used. All Mental Health Act Information had been translated into the main languages used by black, Asian and minority ethnic communities in Greater Manchester.

The trust had a service which provided specialist mental health assessment, management and prescribing advice and consultation to Salford GPs who referred patients who were asylum-seekers and refugees. The service had organised a conference about caring for asylum-seekers and refugees for multiple stakeholders in the north west region in 2015.

There was a very active chaplaincy team, which included people from Christian and Muslim faiths. The imam had delivered sessions on 'Awareness of Islam'. Patients of any religion and none were visited by the chaplaincy team both in the hospital and the community. Visits by representatives of other faiths were facilitated when requested and where possible. The chaplaincy team also supported patients with links into the community and had an extensive knowledge of support groups for patients following discharge. A staff development session on spiritual care was being delivered by chaplains, initially at The Woodlands. A 'Focus on Faith' blog was being set up on the staff internet.

The trust provided halal, caribbean and kosher meal choices every day. The trust's catering service also employed a catering liaison officer who met patients to consider their individual dietary requirements and agree meal plans which met their specific religious, cultural or ethical needs and clinical dietary needs.

The Woodlands Unit had been refurbished to improve the patient experience for patients living with dementia. The work included a remodelled reception area, new reception counter, and new contemporary furniture of differing style that improved access for all patients.

Listening to and learning from concerns and complaints

Information about how to complain was displayed on posters, leaflets and on the trust website.

Complaints could be raised directly to staff within services, service managers and the customer care team. If a complaint raised safeguarding concerns, an automatic alert was sent to lead staff for safeguarding adults or safeguarding children. Patients felt generally well informed about how to make a complaint. Staff we spoke with were aware of the process for local resolution and we saw some examples where local resolutions had taken place.

Between January 2015 and January 2016, 304 individual complaints were received and of these, 10% were fully upheld and 23% were partially upheld. Four complaints were referred to the Ombudsman and one was upheld by the Ombudsman. Complaints are referred to the Ombudsman when the complainant is not satisfied with the investigation of their complaint or its outcome.

The most common theme for complaints in 2014 – 2015 was 'all aspects of clinical treatment' and 'attitude of staff'. The service with the most complaints were the community based mental health services for adults of working age with 98 of which 17 were fully upheld and 35 partially upheld.

Complaints were discussed within the governance framework and reported to the trust board. Actions arising from complaints were logged on datix and monitored. Staff told us that they received feedback on complaints through emails, team meetings and supervision sessions. Complaints were a standard agenda item on team meetings in several of the services that we visited.

We reviewed a selection of complaints and found that the trust followed their policy. We saw that the trust was open and transparent and offered apologies when people complained. We also saw that where safeguarding issues were identified they were escalated appropriately.

The trust also monitored compliments that were received. The most common themes for compliments were care and attitudes of staff.

Good

Are services well-led?

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

Summary of findings

The summary can be located on page 6

Our findings

Vision, values and strategy

The trust's vision was 'Improved lives and optimistic futures for people affected by mental health and substance misuse problems'.

The trust's objectives were:

- Promote recovery by providing high quality care and delivering excellent outcomes
- Work with service users and carers to achieve their goals
- Engage in effective partnership working
- Invest in our environments
- Enable staff to reach their potential and innovate
- Achieve sustainable financial strength and be well-governed

The trust's five values were:

- We are caring and kind
- We go the extra mile
- We value and respect
- We are welcoming and friendly
- We work together

The trust had identified eight priorities within their quality account for 2015/2016 which included;

- improving access to psychological therapies, both as in patient and in the community
- improving services by listening to and acting on feedback from service users
- delivering recovery focussed services
- delivery of the carer's strategy to improve engagement with carers
- enhancing the quality of life for older people with dementia and functional illness
- improving assessment and treatment of physical health
- promoting individualised support plans to reduce conflict in inpatient settings by delivering the 'positive and safe strategy'
- improving response to patients with a dual diagnosis.

The trust's values were evident throughout the operational plans and strategies. The strategies in place were delivering quality care within budget. The trust had a recurrent surplus of £3 500 000. The trust was meeting their values and objectives and this was reflected in the delivery of high quality care with excellent partnership working.

The financial director described an example of where a cost improvement programme (CIP) would not be agreed if it did not align with the business strategies. For example, if a service had proposed a vacant staff position was removed from their service structure to contribute towards a CIP, this would not be approved as it would have a negative impact on the proposed recruitment drive and increasing of staffing levels.

Stakeholders reported that the trust was disciplined and innovative and were responsive to the needs of commissioners and patients. They described the trust as managing relationships with commissioners well and adapting to the needs and approaches of different groups. Stakeholders told us that the trust always put forward options for the delivery of services for good patient outcomes.

Good governance

At the start of the inspection, the trust gave a presentation which described what the trust did well and what the challenges were and where improvements were needed.

Good

Are services well-led?

This was comprehensive and reflected almost all of the findings of our inspection. The exception to this was the issues we found in the child and adolescent mental health service (CAMHS).

The trust had an effective board assurance framework (BAF) in place. This identified the key areas of risk and the measures of progress for assurance. The framework included operational and strategic risk. This was supported by a performance report which was clear and provided assurance to the board on progress against a range of key performance indicators. The key performance indicators included both national and locally agreed priorities. The trust had recently developed directorate and ward level dashboards to further embed quality monitoring. This was still embedding when we inspected. Some local figures for training did not correlate with centrally held data.

There were four committees which were subcommittees of the board;

- the quality governance committee
- the audit committee
- the charitable funds committee and the remuneration
- terms of service committee.

The quality governance committee developed and defined the trust quality framework/strategy on behalf of the board of directors which identified the trust key quality priorities, safety issues, goals and standards. It was responsible for monitoring performance against the quality framework including quality account priorities and taking action on substandard performance. It received reports from a number of sub committees which included;

- the operational implementation of safeguarding
- the Mental Health Act and Mental Capacity Act
- medicines management
- incidents, complaints and patient experience
- equality inclusion recovery steering group
- National Institute for Health and Care Excellence implementation and audit group.

We found that risks were identified and managed well within the trust. Services and districts had local risk registers which identified risks, rated them, and these were agreed at the risk management meeting. If the risk score, following mitigation was 12 or above, then the risk would be added to the BAF. In December 2015 there were 10 risks on the BAF. Risks included;

- safe staffing
- implementation of the acute care pathway
- implementation of PARIS clinical information system
- sickness absence rates
- mandatory training compliance.

There were 13 risks highlighted in the December 2015 directorate risk register, all of which were rated as 'high risk ratings'. The two risks scoring a 15 concerned window frame ligature risks and the appointment grid system not being available on the Paris system. The eleven risks scoring a 12 concerned;

- qualified vacancies on inpatient wards
- clinical record availability in primary care psychology
- community team access to electronic record systems
- CPA systems
- inpatient unit violence and aggression
- functionality of PARIS staff diary
- measuring and reporting service delivery/targets
- failure to achieve performance and quality targets
- low staffing levels within MHA admin team
- qualified nursing vacancies
- PARIS System Implementation Project
- inadequate pharmacy staffing.

The trust had divided services into a specialist services network which included forensic, CAMHS and criminal justice, substance misuse and community psychology, mental health and deafness and district services network which covered Bolton, Salford and Trafford. There were matrons in both networks however; the roles were not aligned and this was being reviewed. There was a ward manager and matron's network which monitored performance and shared good practice across the districts.

Good

Are services well-led?

Monitor had no concerns about the trust governance systems and had rated it as green, with a financial sustainability risk rating of 4 which indicates the least risk.

A recruitment and retention paper was prepared in October 2015. Actions from that had been a recruitment and retention drive within the trust. The trust had held open days for recruitment and was looking at analysis of leaver information and exit interviews were taking place. The paper also considered the length of time taken to recruit and the length of service for leavers.

There was a clinical and internal audit programme in place. There was evidence that findings from audits were used to drive improvements. For example, the audit of Mental Health Act and Mental Capacity had led to a paper to propose the inclusion of training in these areas into the mandatory training programme and the monitoring of physical health. However, we found that areas for improvement identified in audit had not always been acted upon. For example, lack of physical health monitoring following rapid tranquilisation and out of date oxygen on two wards.

The newly introduced electronic patient information system had streamlined the reporting of incidents with an interface between the patient record and datix. This enabled individual patient incidents to be available within patient records.

The trust was rated as 'satisfactory' in the 2014/15 Information Governance Toolkit. For 2014/2015 the trust achieved level three, which meant there were effective systems in place to keep information safely.

Fit and proper persons test

The Fit and Proper Person Requirement (FPPR) is a regulation that applied to all NHS trusts, NHS foundation trusts and special health authorities from 27 November 2014. Regulation 5 says that individuals, who have authority in organisations that deliver care, including providers' board directors or equivalents, are responsible for the overall quality and safety of that care. This regulation is about ensuring that those individuals are fit and proper to carry out this important role and providers must take proper steps to ensure that their directors (both executive and non-executive), or equivalent, are fit and proper for the role.

Directors, or equivalent, must be of good character, physically and mentally fit, have the necessary qualifications, skills and experience for the role, and be able to supply certain information (including a Disclosure and Barring Service check and a full employment history).

The trust had a Fit and Proper Person Test policy to meet the Fit and Proper Persons requirements. The measures were approved by the trust board on 27th October 2014. The policy established a process to monitor that the trust was meeting its duty. We reviewed the files of 12 executive and non-executive directors and all contained the required information**.** There was a system in place to ensure that this was reviewed annually.

In the NHS Staff Survey 2015, the trust compared favourably to the national average and scored above the national average in nine questions.

- staff recommendation of the organisation as a place to work
- staff motivation at work
- recognition and value of staff by managers and the organisation
- working extra hours
- support from immediate managers
- staff satisfaction with resourcing and support
- % experiencing harassment, bullying or abuse from staff in the last 12 months
- % believing the organisation provides equal opportunities for career progression/promotion
- staff confidence and security in reporting unsafe practice.

The trust performed worse than the national average and in the worst 20% of all MH/LD trusts for five out of the 32 questions. These five questions related to;

- % feeling pressure in last 3 months to attend work when feeling unwell
- % experiencing physical violence from patients, relatives or the public in last 12 months
- % experiencing physical violence from staff in last 12 months

Good

Are services well-led?

- % reporting most recent experience of harassment, bullying or abuse
- staff witnessing potentially harmful errors, near misses or incidents in last month.

In five of the 32 questions, the trust had an improved performance on the 2014 survey.

The trust was identified by the Health Service Journal and Nursing Times as one of the best places to work in the NHS. The trust had signed up to a number of initiatives designed to improve the work environment, including being a Mindful Employer andan Improving Working Lives Practice Plus Employer. The trust was also signed up to pay a living wage.

The trust was monitoring staff sickness and a paper was presented to the board in January 2016 with an update on the sickness rates. This noted an improvement in the rate of long term sickness however there had been a slight increase of short term sickness.

The trust had recently procured a new human resource partner for occupational health to support staff. There was a health and wellbeing strategy and the trust was in the process of appointing a member of staff as the lead for staff wellbeing.

The trust had an overarching strategy to promote equality amongst staff and patients. To implement this, there was a set of local equality objectives which were incorporated into the quality account, annual business plans and local management work streams. There was trust equality inclusion recovery steering group which included equality champions representing disability, pregnancy and maternity, race, religion and belief and sexual orientation.

The trust had completed an annual public grading for the Equality Delivery System 2 and overall was rated as developing in Bolton and Salford and achieved in Trafford against three criteria which were;

- the trust assesses and meets peoples' mental health needs in the best and most suitable ways, considering all protected characteristics.
- people are given the information and receive support to be involved in decisions about their care
- fair NHS recruitment and selection processes lead to a more representative workforce at all levels.

The trust had introduced Equality into Action workshops in 2014. The purpose of the workshops was to bring together people with an interest in equality and diversity and mental health. Members of the public, representatives from councils and the voluntary sector and members of staff were able to attend. The trust scored better than other mental health trusts in the NHS staff survey in the percentage of staff who believed the organisation provided equal opportunities for career progression.

The trust had a policy which set out staff's responsibility to being open when things went wrong. Incident reports included a form to monitor whether Duty of Candour was engaged. There was a whistleblowing policy in place which was being reviewed. There had been a review of how comfortable staff felt about raising concerns and in response the trust was appointing a 'speak up' champion to support staff to raise issues. There were 11 whistleblowing enquiries raised with the CQC between 1 November 2014 and 31 October 2015. There were no common themes.

The trust scored higher than average in the staff survey question relating to good communication between senior management and staff.

In the staff Friends and Family Test, the trust had a response rate of 36%: of which 66% of the respondents were either 'likely' or 'extremely likely' to recommend the trust as a place to work which was above the England average of 62%.

There were policies in place to address all aspects of staff performance. Staff side representatives reported good working relationships with the trust.

We reviewed 25 recruitment files, five referrals to professional bodies, four grievances, five files of people being managed under the sickness policy, five being managed under the performance policy and five disciplinary cases. The review showed that policy was followed and issues were dealt with promptly.

In the past three years, the trust had referred eight staff to the General Medical Council: five cases were closed, two were referred to panel and one resulted in undertakings.

Engagement with the public and with people who use services

Good

Are services well-led?

The trust had a families and carers strategy 2015-2019 which provided a framework for the trust and local organisations to work together to improve delivery of service for patients, carers and their families.

The trust created a care hub in 2014 to develop and coordinate approach to patient and carer engagement and feedback in order to develop and improve services. There were quarterly reports from the care hub which monitored of the implementation of the trust engagement policy. It included a report on the patient and carer feedback from the Friends and Family test and patient and carer questionnaires, themes and recommendations from feedbacks, compliments and complaints under the trust's five core values and patient and carer engagement activity.

The trust used a number of ways to gather feedback from carers and patients which included kiosks around the hospital, patients sharing their journey at board meetings and also at staff training, discharge surveys and an annual carer's event. External stakeholders and third party organisations reported good engagement with patients. The involvement of patients and their families in the recent move of older people's ward from Bolton was cited as a good example. They also acknowledged the success of the recovery academy in helping to build relationships between patients and carers.

There were carer's champions to offer practical and emotional support, a regular newsletter for carers, carer awareness training for staff and free courses for carers aimed at health and wellbeing.

Patients were involved in the recruitment of staff at all grades. The trust was working with patients and carers to form a group of representatives to join interview panels, events held at the recovery academy, induction training and support training, participate in PLACE inspections and contribute to the development of policies and review information. The trust offered payment for participating as well as expenses.

In the 2014 NHS Staff Survey, the trust performed better than the national average for patient feedback being used to make informed decisions in directorates/departments.

Quality improvement, innovation and sustainability

The trust had three services which had received national accreditations:

- electroconvulsive therapy accreditation service
- memory services national accreditation programme: Bolton memory assessment service and the Salford memory assessment service which was accredited as excellent.

The trust had a dragon's den initiative where £100 000 was available annually to support ideas and innovations from services up to the value of £10 000. Staff presented to a panel that would award money. Ideas which had been successful included: a DVD for carers on how to gain support through the trust and the Recovery Academy started from the dragon's den before being supported via capital investment. Service users were producing a DVD for staff training about their experiences of being held in restraint and how this had felt for them.

The trust had two services which had been shortlisted for national awards:

- The dementia crisis team for a Health Service Journal award
- Rapid Access to Detoxification Acute Referral project for a Nursing Times award.

'The Curve' education facility had recently opened, providing courses for 2000 patients and their families to help them in their recovery.

Salford Council had commissioned the trust to train 30 ex-prisoners and addicts to help families to tackle drug and alcohol abuse.

All patients were included in research programmes unless they actively opted out.

The trust clearly understood the need to deliver better care in a challenging economic environment. In order to achieve this they were working with commissioners and other partners to continue redesigning the local services. Examples included the Salford vanguard integrated care model and the trust was the lead on the commissioning for quality and innovation payment aligned to the crisis concordat.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Dignity and respect Service users must be treated with dignity and respect **How the regulation was not being met** In wards for older adults with mental health problems Both Bollin and Greenway wards did not comply with the Department of Health's guidance on eliminating mixed sex accommodation. On Bollin ward there was no clear signage to indicate where members of the opposite sex should not enter. On Greenway ward there was only one bath which was at the end of the female corridor. This meant that males using the bath would have to pass by female bedrooms to get to it. There was a designated female only lounge but on the day of our inspection this was used for a singing group which was attended by both males and females. In child and adolescent mental health wards On Junction 17, there were a number of blanket restrictions in place including restricted access to mobile phones and routine searches following periods of leave. **This was a breach of regulation 10(1)(2)(a)(b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment

This section is primarily information for the provider

Requirement notices

Care and treatment must be provided in a safe way for service users

How the regulation was not being met

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

We found that staff were secluding patients in the de-escalation room without following the Mental Health Act code of practice guidance and the trust's own policy.

Patients were not permitted to leave the de-escalation room and were restrained and prevented from leaving by staff.

Staff lacked awareness of the MHA and the safeguards that should be followed if patients are secluded in this way.

Patients were not aware of their rights or protections that the MHA provides to patients who are secluded.

Staff did not document or report that an incident of seclusion had occurred.

This meant that patients were secluded and that their rights and safeguards under the Mental Health Act were not followed.

We found that two of the wards we visited had out of date oxygen which had not been replaced despite regular audits which identified it needed to be replaced.

Staff had checked the oxygen on a regular basis but had not acted on the findings of the checks.

In an emergency patients would not have access to equipment that was suitable for use.

This meant that equipment and medical supplies needed in an emergency situation were not kept up to date and safe for patient use.

In wards for older adults with mental health problems

This section is primarily information for the provider

Requirement notices

On all of the wards we found evidence that National Institute for Health and Care Excellence (NICE) guidance was not being followed in relation to rapid tranquilisation. Staff were not monitoring and recording physical observations after the use of rapid tranquilisation.

On Bollin and Greenway wards, staff we spoke to were not aware of the trust policy in relation to physical health monitoring following rapid tranquilisation.

On Holly ward, we found one incident had not been logged on the trust incident reporting system. This is a requirement in the trust policy for rapid tranquilisation.

Records did not show that leave was routinely risk assessed prior to authorisation or that the outcome of any specific period of leave was reviewed consistently.

The layout of the wards did not allow staff clear lines of sight. This risk was not mitigated on any of the wards by the use of mirrors, risk assessments or staff observations.

In forensic wards

Rapid tranquilisation was not carried out in accordance with NICE guidance, as patients did not always have physical healthcare checks carried out afterwards, which may put them at risk.

In child and adolescent mental health wards

Patients were being nursed in the intensive nursing suite and were prevented from entering the main ward area.

Records showed that staff did not carry out physical observations following administration of rapid tranquilisation medication on three separate occasions. This meant patients were at risk of physical health complications not being recognised

This was a breach of regulation 12(2)(a)(b)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Good governance

Systems and processes must enable the registered person to maintain securely and accurate, complete and contemporaneous record in respect of each service user, including decisions taken in relation to the care and treatment provided.

How the regulation was not being met;

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

We found that environmental checks were not completed in a consistent way and that inappropriate fixtures and fittings were not replaced in a timely way.

•Ligature point audits were not completed in a consistent way on each ward.

•The findings of the ligature point audits were not acted upon without delay.

This meant that in order to mitigate the environmental risk factors, staff were required to increase patient observations and complete regular environmental checks**.**

In wards for older adults with mental health problems

At both Greenway and Holly wards, discussions around capacity and best interest were not being documented in patients care records. This meant that it was difficult for staff to identify when these decisions would need to be reviewed and show evidence of this being done, as a baseline discussion was not recorded.

The recording and reviewing of patients' rights was inconsistent across all five wards for people detained under the Mental Health Act

This section is primarily information for the provider

Requirement notices

On Holly ward there was one example of a patient who had a do not attempt resuscitation form in place but no capacity assessment and best interest decision were recorded.

In child and adolescent mental health wards

Monitoring systems in place had failed to identify that care was not being delivered safely or effectively due to insufficient staffing numbers and lack of suitably trained staff.

On Junction 17, we saw 15 missing entries on patient observation records.

On Junction 17, we saw 19 missing entries on fridge temperature monitoring records.

This was a breach of regulation

17 (2)(a)(b)(c)(d)(ii)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform **How the regulation was not being met** In forensic wards

This section is primarily information for the provider

Requirement notices

On 14 wards less than 75% of staff had completed basic life support training and on 10 wards less than 75% had completed immediate life support training. This may put patients at risk should they require life support in an emergency.

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

We found that staff were not adequately trained in important elements of nursing care.

A high proportion of staff were not up to date with training in immediate life support and basic life support.

A high proportion of staff were not up to date with training in the Mental Health Act and Mental Capacity Act.

Staff demonstrated a lack of understanding regarding the Mental Health Act and Mental Capacity Act.

This meant that staff were not aware of the latest guidance and best practice in relation to safe patient care and treatment.

In child and adolescent mental health wards

There were not always enough staff on duty to deliver safe care. We found insufficient staffing on duty to cover enhanced observations and to manage incidents effectively.

Staff had not received service specific training, including the need to alter the approach when manging violence and aggression with children and adolescents.

This was a breach of regulation 18(1)(2)(a)