Care Quality Commission

Greater Manchester Mental Health NHS Foundation Trust - HQ

Inspection report

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Date of inspection visit: 30 April - 2 May 2024; 3 May - 10 May 2024 (remote)
Date of publication: 21/06/2024

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Overall summary

We carried out an unannounced comprehensive inspection of mental health services provided by Greater Manchester Mental Health (GMMH) NHS Foundation Trust at HMP Styal. We visited the services between 30 April and 2 May 2024, and continued to inspect remotely until 10 May 2024.

The purpose of this comprehensive inspection was to determine if the mental health services provided by GMMH were meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008 and that patients were receiving safe care and treatment.

We do not currently rate services provided in prisons. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

At this inspection, we found:

- A well-resourced, fully integrated mental health team worked effectively to provide appropriate care to patients with complex needs and high levels of risk.
- The provider had a wide range of skilled and dedicated staff who were suitably qualified and experienced for their roles.
- Staff treated patients with dignity and respect. Staff completed timely assessments of patients' needs and risks and planned appropriate care and treatment.
- Examples of good practice included the wide range of psychological therapies available to patients, an established neurodevelopmental pathway, and the risk management of patients with acute mental illness.

However, we also found:

- Medicines were provided and administered by another service and provider. The team experienced challenges in ensuring their patients received their prescribed medicines and associated health checks on time.
- The service faced challenges in providing appropriate care and treatment to some acutely unwell patients who had been transferred to prison as a 'safe place', and/or who were awaiting transfer to hospital.
- At the time of our inspection, there was no mental health training offered to prison staff but there were plans to re-introduce it.

Our inspection team

Our inspection team was made up of 3 Health and Justice inspectors and a pharmacist specialist.

How we carried out this inspection

Before the inspection, we reviewed a range of information and data that we held about the service and information sent to us by the commissioner.

During the on-site inspection, we looked at the quality of the healthcare environment and facilities, and at systems and processes relating to the running the service. We looked at patients' care and treatment records. We spoke with a range of staff including managers, administrative staff, clinical leads, nurses, a psychiatrist and psychology staff.

During the remote part of our inspection, we spoke with healthcare staff and key partners, including commissioners. We collated further information about the service, reviewed care records and analysed performance data.

Background to Greater Manchester Mental Health NHS Foundation Trust - HQ

HMP Styal is operated by HM Prison Service. It is a women's prison in Cheshire for up to 450 women.

NHS England has commissioned Greater Manchester Mental Health (GMMH) NHS Foundation Trust to provide primary, secondary and specialist perinatal mental health services.

GMMH is registered with CQC to provide the regulated activities of diagnostic and screening procedures, and treatment of disease, disorder or injury.

Inspected but not rated

Are services safe?

Safe and clean environment

- The integrated mental health team was located in a separate building (Iris Centre) from the rest of healthcare.
- The building had several offices and clinic rooms that were visibly clean, and in reasonable condition. A cleaner attended the centre daily.

Safe staffing

- The integrated mental health service was made up of a clinical mental health team and a psychological therapies team. The team had safe staffing levels and was able to provide a comprehensive service. However, although the clinical nursing team had sufficient staffing levels to manage patients' needs safely and effectively, they experienced pressures due to vacancies for qualified staff and the number of complex, high-risk patients they supported.
- The clinical team had 2 vacancies for qualified mental health nurses, 1 vacancy for a health and wellbeing practitioner and 0.3 vacancy for psychiatry. One nursing post had been recruited to and was subject to vetting. The team had access to regular temporary staff to cover 1.5 of the vacant roles. Due to ongoing difficulties in recruiting staff, the provider had invited other professional groups such as social workers and occupational therapists to apply for the qualified practitioner roles.
- The psychological therapies service had expanded significantly in the past year and had no vacancies at the time of our inspection.
- The team had experienced challenges associated with tasks undertaken by the primary healthcare provider, including medicines administration and blood tests. To reduce the risks, nurses in the mental health team had offered to provide 'depots' (long-acting injections) and blood testing for patients on specific medicines. The team also planned to undertake health checks for their patients once they had recruited a health and wellbeing practitioner, thereby further reducing the need to rely on primary healthcare staff.
- The team had interim arrangements to cover the perinatal mental health service. This involved access to a community perinatal mental health nurse who visited the prison one day a week, and a perinatal psychiatrist who offered 2 sessions a month. Work was underway to develop a referral pathway and protocol. The provider acknowledged that the service offer was limited but had plans to develop the service further in line with perinatal pathways provided in other women's prisons.

Assessing and managing risk to patients

- Patients received timely assessment of their mental health needs following their initial reception screening process. The service offered a range of scheduled clinics, with emergency and duty systems in place to respond to immediate risks and urgent needs. Staff worked flexibly to ensure patients' needs were met.
- The team used the trust's clinical risk assessment tool to assess and manage clinical risks.
- Staff supported prison staff with prisoners subject to 'ACCT' (Assessment, Care in Custody and Teamwork). This is the care planning framework for prisoners identified as being at risk of suicide or self-harm. Staff attended the initial ACCT review, and continued to attend ACCT reviews for patients on their caseloads. They opened ACCTs for patients they had concerns about to ensure they received the appropriate welfare checks. The records we reviewed showed that patients on ACCTs were seen regularly including at weekends.
- Staff knew their patients well. They had good oversight of patients on the Care Programme Approach (CPA), those in receipt of specialist medicines, acutely unwell patients, and those at high risk of harm.
- The clinical team often had to support acutely unwell patients who had been sent to prison as a 'safe place'. Staff assessed these patients' needs and risks promptly and referred them to hospital if needed. However, the process took some time and patients accepted for transfer often had to wait for a bed to be available. Staff maintained good oversight of this process.

Inspected but not rated

Are services safe?

- Staff supported discharges for patients whose release date was approaching while they were waiting for transfer to a mental health hospital. Staff we spoke with gave examples of complex and high-risk situations they had managed involving a range of external agencies throughout the country.

Staff access to essential information

- The service used an electronic system for recording and managing patient information, scheduling clinics and appointments, and maintaining waiting lists.
- Patients' records were kept secure as the system could only be accessed by authorised staff using a 'smartcard'. Staff were aware of the need to maintain patient confidentiality when liaising with the wider prison staff.
- Staff kept patients' care records in good order and up to date. Patients' notes were comprehensive containing the appropriate assessments, care plans and reviews.
- Administrative staff had good oversight of the records to ensure quality and consistency. They supported staff with caseloads, appointment bookings, recalling patients, and waiting list management.

Medicines management

- The provider had responsibility for prescribing and reviewing psychiatric medicines but the primary care provider on site had the responsibility for the pharmacy, and medicines management and administration.
- Prescribers such as psychiatrists were fully aware of the safer prescribing in prison guidelines and had good awareness of medicines that were at risk of abuse.
- The mental health team had experienced some issues with medicines administration for their patients, including missed or delayed doses of long-acting injections ('depots'). Some patients received medicines that required close monitoring via blood tests but these were not always completed at the right time. In order to reduce the risks to patients, the mental health team had offered to administer depots and undertake essential blood tests. It also planned to oversee health checks for their patients in the future.
- Staff closely monitored those patients who received depots or medicines such as lithium and clozapine. They checked if they had received their medicines on time and followed up any errors or omissions.
- Staff also expressed concerns about the time of day their patients received sedative-type medicines. Psychiatrists and nurses were keen to see that patients received such medicines later in the evening but most of the time, they received it during the afternoon medicines administration clinic at 4pm.
- Staff ensured patients could access 'PRN' (pro re nata – as required) medicines should they need it by ensuring the prescription and guidance was available to medicines administration staff. However, they were not confident these would be issued appropriately by primary care staff.

Track record on safety

- The clinical service supported patients who were acutely unwell when they arrived at the prison, having been transferred there as a 'safe place'. Staff promptly commenced the referral process to specialist mental health hospitals but experienced significant delays to transfer due to bed shortages. As the patient neared release, and subject to the patient's risks, the service invoked a contingency plan involving 'gate assessments', that is, planning a Mental Health Act assessment immediately after release. Staff gave examples of highly complex and risky situations they had to manage as they tried to negotiate with external agencies and navigate through various systems and processes to ensure that patients or the public were not placed at risk.

Reporting incidents and learning from when things go wrong

Inspected but not rated

Are services safe?

- Staff recognised incidents and reported them appropriately on the trust's electronic incident reporting system. In the 12 months to 30 April 2024, staff had reported 52 incidents. These included several reports of incidents associated with MHA transfers delayed due to bed shortages and medicines errors or omissions.
- The provider had adopted the new Patient Safety Incident Response Framework (PSIRF) on 1 April 2024, and had modified its systems and processes for managing incidents accordingly. Local managers retained responsibility for locally reported incidents. The provider had a number of forums for oversight and discussion of incidents, including a dedicated health and justice patient safety group.
- The provider shared lessons learned with the whole team through a range of mechanisms including team meetings, briefings, lessons learned bulletins and patient safety news. These included updates from clinical reviews and death in custody recommendations.

Inspected but not rated

Are services effective?

Assessment of needs and planning of care

- The mental health team had systems and processes in place to support assessment of patients' needs and planning of care. They offered first night screening to all new patients, which helped identify their initial needs at an early stage. They ensured patients with urgent needs were identified and supported appropriately.
- The team triaged referrals based on urgency, completed initial assessments and then discussed them at weekly single point of access meetings to determine the appropriate care and treatment pathway. Once allocated to a pathway, staff completed further assessments to determine patients' individual needs, identify appropriate interventions and plan care.
- A specialist nurse assessed patients with learning disabilities, attention deficit hyperactivity disorder (ADHD) or autistic spectrum conditions (ASC) to identify any clinical needs. The nurse also undertook screening with patients who presented with possible neurodiverse conditions. She ensured patients received annual health checks and regular reviews of their needs.

Best practice in treatment and care

- The integrated mental health service operated a stepped model of care that matched the intensity of support to a patient's identified need.
- The service offered a comprehensive range of clinical and psychological treatments and therapies. Psychiatrists and mental health nurses oversaw the care and treatment of patients with severe mental illness. Nurses maintained a caseload of patients with complex needs including those subject to the Care Programme Approach. Clinical staff supported acutely unwell patients and responded to crises.
- The psychological therapies service had expanded significantly in the past year and offered a range of talking therapies at different levels of intensity depending entirely on the individual needs of patients. Psychological wellbeing practitioners offered low-intensity interventions mostly on a 1-1 basis such as behavioural activation, cognitive restructuring, sleep hygiene, anxiety management, and exposure therapy. Psychologists offered more intensive therapies such as Eye Movement Desensitisation and Reprocessing (EMDR), Dialectic Behaviour Therapy (DBT), Schema therapy, and Compassionate Focused Therapy. The art therapist adopted a psychodynamic approach to support patients with schizophrenia and personality issues.
- The provider commissioned skills-based programmes from specialist organisations. These included Big Life Group, Intuitive Thinking Skills and Odd Arts. Intuitive Thinking Skills offered recovery interventions and courses on anger management. Big Life Group offered groups on wellbeing, healthy choices and mindfulness. Odd Arts provided creative sessions. Some of these courses were accredited, and all were popular with patients and received very good feedback.
- The service had a well-developed learning disability and neurodiversity pathway supported by a dedicated lead nurse onsite and a regional neurodiversity hub. The nurse had received training in the positive behaviour support framework. She worked alongside the prison's neurodiversity officer to identify and support patients with learning disabilities and neurodiverse needs.
- Staff used recognised tools for their specialisms to assess needs and risk, plan care, monitor health, and complete observations. For example, the learning disability nurse had access to a range of screening and assessment tools including the Adaptive Behaviour Assessment System (ABAS-3) and the Autism Spectrum Quotient (AQ-10, AQ-50)). The nurse worked with psychologists to Wechsler Adult Intelligence Scale (WAIS), and the trust's LDSQ (LD screening questionnaire). The psychological therapies team used recognised outcome tools at the end of each session such as the GAD-7 (Generalised Anxiety Disorder questionnaire) and PHQ-9 (Patient Health Questionnaire).

Skilled staff to deliver care

Inspected but not rated

Are services effective?

- The service had a wide range of suitably qualified and experienced staff to support effective treatment and care for patients. The staff group included psychiatrists, nurses, psychologists, wellbeing practitioners and healthcare support workers. The service had a dedicated learning disability nurse and an art therapist. A small administrative team provided essential administrative support. There was a temporary gap for a speech and language therapist in the prison-wide neurodiversity hub, which was expected to be filled soon.
- The provider offered training and development opportunities that met the needs of the service, fill gaps and vacancies, enhance skills, and improve recruitment and retention. The service benefited from the additional resource and expertise that this provided. For example, at the time of our inspection, the service had 2 trainee forensic psychiatrists, 2 trainee psychologists, and 2 trainee psychological wellbeing practitioners. Staff welcomed the number of training and development opportunities available to them.
- Staff received an appropriate induction and completed a comprehensive mandatory training programme that included basic life support, clinical risk assessment, patient safety, safeguarding, incident reporting, mental capacity, and information governance. Team managers monitored compliance with training requirements and gave staff time to complete their training. At the time of our inspection, the compliance rate for mandatory training was 90%.
- Staff received regular and appropriate clinical and managerial supervision according to their specialism and role. Staff in training such as assistant and trainee psychologists received additional supervision. Some staff received supervision specific to their specialist approach, for example, EMDR. The learning disability nurse received supervision from the same discipline via the provider’s health and justice neurodiversity hub.
- Staff had access to team meetings and reflective practice sessions. The service held multi-disciplinary meetings where staff could discuss complex patients, and request advice and assistance. Psychologists attended senior clinicians meetings once a month to talk about complex cases. The learning disability nurse had the opportunity to meet with other nurses via the neurodiversity hub across prisons.
- Staff received annual appraisals. At the time of our inspection, the compliance rate for appraisals was 80% and the outstanding appraisals were scheduled.

Multidisciplinary and interagency teamwork

- The service had a range of effective multi-disciplinary team (MDT) meetings, for example, daily safety huddles, handovers, healthcare MDTs, complex cases meetings, and single point of access (SPOA) meetings. These were well attended with contributions from the relevant specialisms as required. We observed a complex cases meeting at which staff shared their concerns about patients and discussed the best way to meet their needs and manage their risks.
- The service worked closely with the other healthcare services in the prison including primary healthcare, substance misuse services, midwifery and social care. Staff conducted patient assessments and reviews of patients where appropriate.
- The team worked with partners to provide a full service. For example, the provider commissioned community-based organisations to provide groups and accredited courses. The provider had arranged perinatal mental health nursing and psychiatry support from a community-based service as an interim measure while it developed a new pathway.
- The service worked closely with the prison, for example, they maintained contact with the healthcare link governor, attended security and safer custody meetings, supported release planning, and attended ACCT reviews. Service managers attended the monthly local delivery board with key partners such as prison governors, NHS commissioners, and other healthcare providers.
- The service had started to make links with local authorities and other external agencies to manage the risks associated with the transfer or release of acutely unwell patients.

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

Inspected but not rated

Are services effective?

- Staff received training in the Mental Health Act (MHA). Staff had a good understanding of the relevant sections of the MHA that were applicable to their patients and the service had appropriate systems and processes in place to support the transfer of patients under the MHA pathway.
- Staff identified those patients requiring assessment and transfer under the Mental Health Act (MHA) and commenced the referral process immediately. In 2023, the service made 29 referrals for 26 unwell patients requiring hospital treatment. 23 patients were eventually transferred to hospital under the MHA during 2023. In 2024, the service had made 12 referrals for 11 patients, and 6 patients had been accepted by the time of our inspection.
- The service adhered to the national guidelines for referral and assessment, actively following up the requests they made to minimise delays. However, they regularly experienced delays in transferring patients to hospital due to factors outside their control such as the unavailability of beds. For example, the average waiting time for patients transferred to hospital in 2023 was around 79 days, which exceeded the national guideline of 28 days.
- The service had been experiencing several challenges that had increased the risks they had to manage, which placed additional pressure on the team. These included an increase in the acuity of patients in the prison and acutely unwell women being sent to prison as a 'safe place'. Staff expressed concern about caring for and treating mentally unwell patients in a prison environment. Also, staff did not have the power to compel treatment.
- The service had also experienced an increase in the number of patients nearing the end of their sentence while still awaiting transfer to hospital. In these circumstances, staff initiated a 'gate assessment', which involved liaising with local authorities to set up MHA assessments on release (at the gate). The service also had to initiate gate assessments for unwell patients who had very short 'stays' at the prison.
- There had been 7 gate assessments initiated since January 2024. In one case, a patient had been accepted for a medium secure unit (MSU) but there was still no bed available by the date of the patient's release from prison. Due to the risk to the patient and public, staff had initiated a local gate assessment for an out of area patient. However, there was still no bed available until very late in the day, and the incident was subsequently reported as a 'near miss'.
- The local authority expressed concern about the increasing number of gate assessments and associated risks to patients and the public. They were keen to establish closer links with the mental health team to share information, improve pathways and manage the risks.

Good practice in applying the Mental Capacity Act

- Staff demonstrated a good understanding of the Mental Capacity Act (MCA) and the principles that underpinned it.
- Staff supported patients to make their own decisions. Staff understood the need to seek consent from patients when providing care and treatment.
- Staff discussed any concerns they had about a patient's mental capacity and noted them in patients' care records. The service completed cognitive function tests if needed.
- Staff completed a mental capacity course as part of their mandatory training.

Inspected but not rated

Are services caring?

Kindness, privacy, dignity, respect, compassion and support

- We observed respectful interactions between staff and patients. Staff knew their patients well and were attentive to their needs.
- Staff followed up patients they had concerns about. Staff often had to support acutely unwell patients while they were waiting for transfer to hospital.
- Staff tailored their interventions to patients' individual needs and worked flexibly to support them. For example, they offered additional 1-1 therapy sessions if needed.
- The service often received positive feedback from patients about the care and compassion shown by staff.

Involvement in care

- The service invited feedback from patients, for example, through service user experience forms, and feedback at the end of therapy sessions and groups. They used the feedback to inform service delivery. For example, the service offered more therapies on a 1-1 basis as many patients had indicated they found it difficult to share personal experiences in group settings.
- Staff actively encouraged patients to engage with the appropriate pathway for their needs. They followed up patients who did not attend any clinic appointments or therapy groups to find out the reasons.

Inspected but not rated

Are services responsive to people's needs?

Access and discharge

- The service was accessible and responsive. It operated Monday to Sunday, 8am to 5pm. It had clear access criteria and received referrals from a range of sources.
- The team operated a duty system daily, which ensured timely responses to urgent needs, crises and new ACCTs. Staff triaged new referrals daily. Staff held a first night mental health clinic to screen all new arrivals.
- Waiting times were reasonable across the mental health service. The waiting time for a routine appointment with a psychiatrist was 3 weeks but urgent appointments could be offered within 7 days. The waiting time for an assessment by the clinical team was 12 weeks for a routine assessment and 4 weeks for an urgent appointment. The psychology service had a waiting time of 12 weeks for a routine appointment and 4 weeks for an urgent appointment.
- The service had reasonably good attendance rates. The psychological therapies team reported around 90% attendance rates with non-attendance only occurring for valid reasons. Staff followed up every patient who did not attend an appointment.
- Staff invoked the MHA referral protocol as soon as a need for transfer to hospital was recognised. However, this was often a lengthy process, with staff regularly chasing other services and agencies, while patients experienced delays to transfer.

Facilities that promote comfort, dignity and privacy

- Most of the mental health services were provided from the Iris Centre, a stand-alone building located nearby to the main healthcare building. The unit had its own reception and waiting area and several clinical and meeting rooms used to see patients. The rooms were pleasant and in good condition. However, there were not enough rooms available to meet demand.

Meeting the needs of all people who use the service

- The mental health team offered a range of clinical and psychological services. Some services were provided by the primary care provider, for example, depot injections, electrocardiograms (ECGs), blood tests and health checks.
- The service worked closely with other teams to ensure a holistic approach to patients' needs, for example, primary care, midwifery, perinatal mental health, substance misuse and social care.
- The dedicated learning disability nurse worked alongside the prison's neurodiversity officer to identify prisoners with learning disabilities, attention deficit hyperactivity disorder and autism. The nurse helped identify patients' communication needs and any reasonable adjustments they required such as the provision of ear defenders, or a move to a quieter cell. The nurse also ensured that patients received annual health checks, and drafted health action plans and hospital passports, if needed.
- Staff offered patients with ADHD a comprehensive self-help resource pack, which provided tools, tips, and information related to their condition.
- The therapies team offered patients 1-1 therapy in response to their needs and preferences; patients found these more effective than group-based therapy.
- Staff made referrals to specialist mental health hospitals when needed. The service used a spreadsheet to record and track referrals, assessments, and outcomes.

Listening to and learning from concerns and complaints

- The provider had a complaints policy and process. Patients knew how to complain, and could do so verbally or in writing.

Inspected but not rated

Are services responsive to people's needs?

- The service received very few complaints. For example, the service received no complaints between October and December 2023, and received 2 complaints between January and March 2024.
- Staff knew how to handle complaints in line with the provider's complaints policies and procedures. Staff tried to address patients' complaints informally, where appropriate. Staff dealt with complaints openly and transparently.
- Managers shared any learning from complaints with staff and made changes where required.

Inspected but not rated

Are services well-led?

Leadership

- The provider had a health and justice department with clear and robust structures setting out the leadership and management arrangements for prison healthcare services. These included dedicated clinical leadership for specialisms such as psychiatry, psychology and neurodiversity.
- Leaders and managers of the onsite service had the appropriate skills, knowledge and experience to perform their roles. They had a very good understanding of the services they managed. The staff we spoke with described their local managers as visible and approachable.
- Managers worked closely with the prison and the other healthcare services on site to ensure that care and treatment was coordinated and effective.

Vision and strategy

- The service had an integrated mental health team made up of a wide range of disciplines who worked collaboratively to deliver a stepped model of care.
- The service had benefited from a significant expansion in the past year, particularly in psychological therapies, which meant it was now able to offer a comprehensive range of mental health interventions to patients.
- The service had ambitions to develop further. This included further increasing the range of disciplines available in the team, undertaking a needs analysis, offering additional therapies, and developing skills-based groups.
- Staff and managers reported that the provider encouraged new ideas and developments and offered support and resources.

Culture

- Our observations and interactions during our inspection showed a strong and cohesive team. Staff morale was good; the staff we spoke with said they felt supported and valued. Staff told us, “It’s an amazing team,” “Very supportive,” and, “I can easily talk to someone in the team.”
- Staff welcomed the training and development opportunities available to them and said they received the time and support they needed to complete them.
- Staff felt comfortable in asking for help and raising concerns and could do so at any time. They said they were listened to and action was taken to address their concerns.
- Staff showed a strong commitment to their colleagues both within their service and across healthcare. For example, aware of the pressures in the primary healthcare service, they had offered to take on some clinical tasks to reduce their colleagues’ workload.
- Clinical staff were under pressure due to vacancies in the team and the high level of acuity and risk they were managing but nevertheless they worked diligently to support their patients. At times, this involved dealing with complex, high-risk situations such as managing imminent releases for unwell patients.

Governance

- The provider had an effective governance structure that ensured good oversight of the mental health service at the prison, mainly via their health and justice network.
- Managers participated in various meetings established to manage and monitor patient safety and service quality, for example, monthly clinical governance meetings, local delivery boards, and NHS contract meetings.
- Prescribers attended medicines management and governance meetings at which they discussed incidents, shared learning, reviewed policies, and developed new guidance as required. A new joint meeting between Spectrum and GMMH’s prescribers was due to start that would focus on their patients in common and their treatment plans.

Inspected but not rated

Are services well-led?

- The trust had policies and procedures to cover the full range of functions. In addition, the service at the prison had local operating protocols where needed.
- The service had an audit schedule for annual and quarterly audits that included infection prevention and control, record-keeping, safeguarding and mental capacity. Staff completed audits and identified any actions required, which were then followed up.

Management of risk, issues and performance

- The service maintained a risk register, which included the main risks the service faced. These included problems with the IT system, the absence of a shared care prescribing agreement between providers, and the delay in transfers of patients to hospital under the MHA.
- The service had experienced difficulties with the IT platform they used. This meant that electronic records that staff relied on were not always available when needed. The trust has registered this as a risk and work was underway to install a virtual platform that would allow full access to the trust's own system.
- The service collated a wide range of performance and activity data, for example, complaints and incidents, attendance rates, waiting lists, and treatment outcomes. This was used to assess and monitor service delivery, identify risks and issues, and plan improvements.
- Recruitment of staff was a challenge but the provider was committed to improving this with a renewed focus and ideas, for example, encouraging applications from other disciplines, such as occupational therapy and social work; offering training placements to doctors and psychologists, and developing their own staff's potential, for example, offering staff training to become psychological wellbeing practitioners.
- The service experienced risks to their patients due to issues with the quality of medicines administration and health checks provided by another provider. These included delays to or missed depot injections, unreliable records, and critical blood tests not being completed appropriately. As such, the service had plans to take on some healthcare tasks from the other provider. At the time of our inspection, the providers had developed a shared care protocol for the administration of depot administration, and already had an agreement in place to undertake critical blood tests.

Engagement

- The service had a wide range of interdependencies, which necessitated good and effective communication and engagement.
- Staff described working relationships across healthcare and the prison as good, especially, the joint work they did with the substance misuse service, and their input into the prison's young adults project.
- Staff worked closely with the prison, other onsite healthcare services and community services to help ensure coordinated care and treatment for patients. The service often had to liaise with commissioners, local authorities and other external agencies when planning transfers and discharges.
- The provider subcontracted other providers to help deliver a comprehensive mental health service. They commissioned Big Life Group, Intuitive Thinking Skills, and Odd Arts to provide specific activities and accredited programmes.
- The team promoted their services in the 'first night pack' that was offered to all new prisoners.
- The service encouraged feedback from patients. There were blank service user experience forms placed around the Iris Centre. The service reviewed their complaints and compliments. The service collated feedback from their subcontracted partners.

Learning, continuous improvement and innovation

Inspected but not rated

Are services well-led?

- The service had made links with the local authority to discuss the increasing number of risky 'gate MHA assessments'. They had also started to develop relationships with commissioners in other areas.
- The provider had approached the primary care provider to make changes to some care and treatment activities that would improve care and reduce risks.
- Psychologists had started to develop tools that would enable more robust treatment plans. They had also started data collection and analysis to identify needs and demands and developy a strategy.
- The service supported patients' preferences for 1-1 therapy sessions but aimed to offer groups for less intensive skills-based activities.
- The service had provided mental health training to prison officers in the past and planned to re-introduce it. This had ceased as the prison officer induction was undergoing review.