Greater Manchester Mental Health NHS Foundation Trust

Inspection report

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Date of inspection visit: 04 June to 10 July 2019
Date of publication: 09/01/2020

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

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

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

Ratings

Overall rating for this trust	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

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

Summary of findings

Background to the trust

Greater Manchester Mental Health NHS Foundation Trust was formed on 1 January 2017, following Greater Manchester West NHS Foundation Trust's acquisition of Manchester Mental Health Social Care Trust. Greater Manchester Mental Health NHS Foundation Trust provides community-based and inpatient mental health care and treatment to a population of 1.2 million people living in Salford, Bolton and Trafford and the City of Manchester. The trust employs over 5400 staff. The trust provides a wide range of more specialised mental health and substance misuse services across Greater Manchester and the North West of England. The trust also provides in reach services to prisons across the north of England. The trust has one of three national sites providing care for people who are deaf and an inpatient mother and baby unit which provides care to mothers and their babies in the North West.

Greater Manchester Mental Health NHS Foundation Trust has a total of 13 registered locations serving mental health needs. There are 875 beds across the trust in 59 wards. The trust provides 662 community mental health clinics per week. Over a year the trust expects to provide care to 53000 people.

The trust is commissioned to provide services by several organisations: NHS England for specialist commissioning of forensic and children and young people's services. The local clinical commissioning groups which the trust works with are in Bolton, Salford, Trafford and Manchester.

We last inspected the trust in September 2017. At that inspection, we rated the trust as good overall with the well led domain rated as outstanding. The safe domain was rated as requires improvement. We found that the trust did not comply with regulation 9 – person centred care, regulation 11 – need for consent, regulation 12 - safe care and treatment and regulation 18 - staffing.

Since the last inspection report the trust has acquired additional services. Specialist community mental health services for children and young people was added as a core service following the acquisition of services in Bolton in April 2018. The trusts provision of community based mental health services for adults of working age also increased to cover the city of Manchester since the core service was last inspected in February 2016.

Overall summary

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

What this trust does

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

Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

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

Summary of findings

What we inspected and why

What this trust does

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

What we inspected and why

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

We inspected four of the trust's mental health services as part of our continual checks on the safety and quality of healthcare services were:

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

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

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

The services which were not inspected have an overall rating of good except for substance misuse services which has an overall rating of outstanding. Where services were not complying with regulations, and we have not inspected, we have monitored the trust's actions and are assured of progress.

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

Summary of findings

What we found

Overall trust

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

- We rated effective, caring and well-led as good, and safe as requires improvement. We rated seven of the trust's ten core services as good, two as requires improvement and one as outstanding. In rating the trust, we considered the current ratings of the six services not inspected this time.
- We rated well-led for the trust overall as good.
- Patients received a range of care and treatment based on national guidance and best practice from staff who had the range of skills needed to provide high quality care. Teams included or had access to the full range of specialists to meet the needs of patients.
- Staff understood their responsibilities under the Mental Health Act 1983 and Mental Health Act Code of Practice.
- Staff treated patients with compassion and kindness. Staff respected the privacy and dignity of patients and in most services involved patients in their care planning.
- Services did not have referral criteria which excluded patients who may benefit from care and met the needs of patients, including those with a protected characteristic.
- The trust investigated incidents and treated complaints seriously. The trust learned from the outcome of investigations and complaints, sharing learning across the organisation to improve services.
- The trust had an experienced and senior leadership team who provided leadership to create a culture which supported high quality care. The trust engaged with patients, staff and communities to develop services which met the needs of local people and sought feedback to allow services to be improved.
- Senior leaders understood the current and future risks to the trust and acted to mitigate these. Strategies were in place which supported the vision of the trust and its role within the wider health and social care system within the Greater Manchester area.

However:

- The trust did not have effective processes in place to monitor the provision and compliance with supervision across its services.
- Dormitory accommodation was being provided for patients admitted to acute wards for people of working age.
- Not all patients within community services for working age adults had current risk assessments in place.
- Patients waited too long for to access treatment in specialist community mental health teams for children and young people and community mental health services for working age adults.
- Processes were not in place to ensure emergency equipment was safe to use in specialist community mental health teams for children and young people.

Are services safe?

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

- We rated four of the ten core services as requires improvement and six as good.

Summary of findings

- In forensic inpatient wards systems and processes to safely prescribe, administer and record medicines were not always followed.
- In community based mental health services for adults of working age not all patients had a current risk assessment in place.
- In specialist community mental health services for children and young people emergency equipment had not been serviced to ensure it was safe to use.
- In two core services staff had not received the required level of training in safeguarding children.
- In specialist community mental health services for children and young people staff had not made an incident report when safeguarding referrals had been made.

However:

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- The service had a good track record on safety.

Are services effective?

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

- We rated one of the ten core services as requires improvement and nine as good.
- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

However:

- In acute wards for adults of working age and community based mental health services for adults of working age records did not show that supervision of staff in the service was effective. This was identified as a breach of regulation in acute wards for adults of working age in the 2017 inspection.

Are services caring?

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

- We rated nine of the ten core services as good and one as outstanding.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Summary of findings

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

Are services responsive?

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

- We rated seven of the ten core services as good, two as requires improvement and one as outstanding.
- Services were easy to access. Referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly.
- Services met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The design, layout, and furnishings of most wards supported patients' treatment, privacy and dignity.
- The trust treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with teams and across the wider service.

However:

- In specialist community mental health services for children and young people and community mental health services for adults of working age, patients who did not require urgent care waited too long for treatment.
- Dormitory accommodation was still being provided at Park House an acute ward for people of working age.

Are services well-led?

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

- The trust had an experienced and stable board with a range of experiences that brought effective challenge and collective leadership. Leaders understood the challenges for the trust and recognised the positive progress that the trust had made. Leaders were able to identify where further improvement was required and worked together to ensure delivery of services.
- Leadership, governance and culture supported the delivery of high-quality care. Leaders were visible and approachable.
- Strategies and plans in place were aligned to the wider health and social care system. Plans were monitored and consistently implemented and there was evidence of improvement in the quality of services. The trust had completed a two-year programme to improve mental health services in the City of Manchester and was now developing its strategy and priorities for the next five years.
- The trust identified, monitored and responded to current and future risks. There were effective audit processes in place and actions were taken when issues were identified.
- An open and transparent culture was promoted by the senior leadership team. Staff were encouraged to raise concerns and felt able to do so. When things went wrong the trust adhered to Duty of Candour, investigated what happened and acted to improve services.
- The trust engaged constructively with staff and people who use services working proactively to gather people's views and developed services with their full participation. The trust showed a commitment to act on feedback received regarding their services.

Summary of findings

- The trust continued to maintain strong financial management. The trusts financial position was closely monitored and understood by the board. Financial decisions were considered against their impact on the quality or service delivery and patient safety.
- There were systems in place to support improvement and innovation. The trust played an active and lead role in supporting the development and delivery of mental health services across Greater Manchester. The trust worked collaboratively with others, including Greater Manchester Health and Social Care Partnership to share learning and develop innovative services to meet the needs of the population it serves.
- The trust had a strong research strategy and high level of research activity taking place throughout the organisation. The trust aims for its services to be academically informed and that research and innovation are embedded in its services and policies.

However:

- The trust did not have effective processes in place to monitor the provision and compliance with supervision across its services. This was identified as a breach of regulation in acute wards for adults of working age during the September 2017 inspection.

See guidance note 7 then replace this text with your report content. (if required)…

Ratings tables

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

Outstanding practice

We found examples of outstanding practice in two services.

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

Areas for improvement

We found areas for improvement including breaches of four regulations that the trust must put right. For more information, see the Areas for improvement section of this report.

Action we have taken

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

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

What happens next

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

Outstanding practice

On this inspection we found the following examples of outstanding practice:

Summary of findings

- In acute wards for working age adults the trust had made the decision to provide a dedicated ward for women aged 18-25 years after completing a piece of research to identify a patient group with a high level of unmet need. Griffin ward's function to support the transition to adult mental health services was in line with priorities set out in the NHS long term plan.
- "Safewards" had been implemented on all acute wards for adults of working age. This is an evidence-based initiative that promotes recovery, and aims to reduce violence and aggression, and the use of restrictive interventions.
- The trust was working with the local university to provide targeted services to improve mental health provision for all students.
- The trust was working with a housing provider to support patients into appropriate housing and promote and maintain recovery. Housing support staff worked on wards directly with patients to support them in securing accommodation.

Areas for improvement

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

Action the trust MUST take to improve

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

Trustwide

- The trust must ensure that a robust system for the monitoring and delivery of supervision in line with trust policy is in place across all services. (Regulation 18: Staffing).

In forensic inpatient wards:

- Medicine reviews must align with patients' care and treatment plans and pathways and be completed and reviewed regularly by clinical, medical and pharmacy staff. Staff must adhere to policies and procedures about managing medicines. (Regulation 12: Safe care and treatment).

In specialist community mental health services for children and young people:

- The trust must ensure that patients wait no longer than 18 weeks from the point of referral to start treatment (Regulation 9: Person Centred Care).
- The trust must ensure that all equipment is properly maintained (Regulation 15: Premises and equipment).
- The trust must ensure that all staff are trained to level 3 safeguarding children (Regulation 18: Staffing).

In community based mental health services for working age adults:

- The trust must ensure that risk assessments are completed for each new patient admitted to the service (Regulation 12: safe care and treatment).
- The trust must ensure that waiting times for referral to assessment and referral to treatment do not impact on the care and treatment of patients (Regulation 9: Person-centred care)

Action the trust SHOULD take to improve

Summary of findings

Trustwide:

- The trust should continue to address the provision of dormitory accommodation in the trust and deliver on its plan to replace this as soon as possible.

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

- The trust should ensure that all staff receive supervision and that a robust recording and monitoring process is introduced across all services.
- The trust should ensure that plans are in place to replace all dormitory accommodation with single bedrooms.
- The trust should ensure that all medication is stored, managed, recorded and disposed of correctly.
- The trust should ensure that all staff receive appropriate safeguarding children training.
- The trust should ensure that small windows in bedroom doors are not visible to people passing by (inbuilt lockable blinds are fitted in many but not all doors), to ensure each patient's privacy and dignity is maintained.
- The trust should ensure that all paper patient records are scanned into the electronic system as soon as possible, so that patient information is accessible when required.
- The trust should consider psychology provision on all inpatient wards, so that patients receive the necessary support and treatment in accordance with national guidance.
- The trust should review access to toilet and shower facilities from the seclusion room on Irwell ward.
- The trust should continue to review the recruitment and retention of staff, particularly staff nurses.
- The trust should that information in care records is person centred, and consistently recorded so it is easy for staff to find.
- The trust should consider how considerations of sexual safety are documented, including when decisions are made about admitting a patient to a single sex or mixed sex ward.

In forensic inpatient wards:

- Decisions to deploy staff to cover duties on different wards should be agreed through the on-call management system in place and in take account of those staff who have disability passports and are not meant to be moved to cover other ward areas.
- Patient care plans should be person centred, reflect the patient voice and use the patient's own words.
- Staff should record patients' physical healthcare following rapid tranquilisation in one place within the patient record system so these are easily accessible by the staff team.
- Patients' one to one sessions with their named nurse should take place as per the trust policy and records should reflect the details of what was discussed between the patient and their named nurse concerning their care and treatment.
- When patients are offered a copy of their care plan, staff should record whether the patient accepts or declines the offer.
- The trust should ensure that all staff receive supervision and that a robust recording and monitoring process is introduced across all services.

In specialist community mental health services for children and young people

Summary of findings

- The trust should ensure that all care plans are personalised, holistic and recovery-oriented, and that patients and/or carers are offered a copy.
- The trust should ensure that all patients, carers and referrers are given advice to contact the service if the child or young person's mental health deteriorates while they are waiting for an appointment.

In community based mental health services for working age adults

- The trust should ensure that mandatory training with regards to safeguarding children level three and the Mental Health Act are improved across the service.

Is this organisation well-led?

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

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

- The trust had not ensured that all staff received supervision and that this was recorded and monitored effectively. This was identified as a breach of regulation in the September 2017 inspection.
- The trust had four core services rated as requires improvement for the safe domain. Community services for working age adults went down one rating from good to requires improvement.

However:

- The trust had an experienced and stable board with a range of experiences that brought effective challenge and collective leadership. Leaders understood the challenges for the trust and recognised the positive progress that the trust had made. Leaders were able to identify where further improvement was required and worked together to ensure delivery of services.
- Leadership, governance and culture supported the delivery of high-quality care. Leaders were visible and approachable.
- Strategies and plans in place were aligned to the wider health and social care system. Plans were monitored and consistently implemented and there was evidence of improvement in the quality of services. The trust had completed a two-year programme to improve mental health services in the City of Manchester and was now developing its strategy and priorities for the next five years.
- The trust identified, monitored and responded to current and future risks. There were effective audit processes in place and actions were taken when issues were identified.
- An open and transparent culture was promoted by the senior leadership team. Staff were encouraged to raise concerns and felt able to do so. When things went wrong the trust adhered to Duty of Candour, investigated what happened and acted to improve services.
- The trust engaged constructively with staff and people who use services working proactively to gather people's views and developed services with their full participation. The trust showed a commitment to act on feedback received regarding their services.

Summary of findings

- The trust continued to maintain strong financial management. The trusts financial position was closely monitored and understood by the board. Financial decisions were considered against their impact on the quality or service delivery and patient safety.
- There were systems in place to support improvement and innovation. The trust played an active and lead role in supporting the development and delivery of mental health services across Greater Manchester. The trust worked collaboratively with others, including Greater Manchester Health and Social Care Partnership to share learning and develop innovative services to meet the needs of the population it serves.
- The trust had a strong research strategy and high level of research activity taking place throughout the organisation. The trust aims for its services to be academically informed and that research and innovation are embedded in its services and policies.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↓ Oct 2019	Good →← Oct 2019

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

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good ↑ Oct 2019	Good ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↑ Oct 2019
Long-stay or rehabilitation mental health wards for working age adults	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Forensic inpatient or secure wards	Requires improvement →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019
Child and adolescent mental health wards	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Wards for older people with mental health problems	Good Feb 2018	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Community-based mental health services for adults of working age	Requires improvement ↓ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Requires improvement ↓ Oct 2019	Good →← Oct 2019	Requires improvement ↓ Oct 2019
Mental health crisis services and health-based places of safety	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Specialist community mental health services for children and young people	Requires improvement Oct 2019	Good Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019
Community-based mental health services for older people	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Substance misuse services	Good Feb 2018	Good Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018
Overall	Requires improvement →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good ↓ Oct 2019

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

Forensic inpatient or secure wards

Good

See guidance note ICS 1 – then delete this text when you have finished with it.

Key facts and figures

The forensic inpatient/secure wards provided by Greater Manchester Mental Health NHS Foundation Trust are part of the trust's specialist services network.

There are 18 wards. Sixteen of the wards are on the Prestwich Hospital site,

- Twelve wards are in the Edenfield Centre (Rydal, Dovedale, Eskdale, Borrowdale, Silverdale, Coniston, Ullswater, Keswick, Ferndale, Buttermere, Derwent, and Hayeswater).
- Two wards are in the Lowry Unit (Isherwood and Delaney).
- Loweswater and Newlands are standalone units.

Rockley House (closed for refurbishment) is in a residential area of Prestwich, and Wentworth House is in Eccles.

Medium secure services for men are provided at:

- Assessment: Rydal ward (15 beds), Dovedale ward (15 beds), Eskdale ward (13 beds)
- Ongoing treatment: Borrowdale ward (currently closed for refurbishment), Silverdale ward (16 beds), Coniston ward (15 beds)
- Pre-discharge: Ullswater ward (18 beds), Keswick ward (18 beds)
- Long term: Ferndale ward (15 beds)

Medium secure services for women are provided at:

- Assessment: Buttermere ward (9 beds)
- Pre-discharge: Derwent ward (5 beds)
- Enhanced support: Hayeswater ward (4 beds)

Secure open rehabilitation or step down from medium secure services are provided at:

- Newlands (8 female beds)
- Rockley House (Reopening Autumn 2019 as a 6 bedded step-down facility for men)
- Wentworth House (10 female beds)

Low secure services are provided at:

- Isherwood ward (15 male beds)
- Delaney ward (15 male beds)
- Kingsley (12 female beds).

During this inspection we looked at all five key questions: was the service safe, effective, caring, responsive and well led? The inspection was announced at short notice on the day of inspection, so staff did not know we were coming until the day of the inspection.

Forensic inpatient or secure wards

We visited the low and secure services based on the Edenfield site and Wentworth House based in the community. We visited 12 of the 18 wards. We chose the wards we visited based on our intelligent monitoring.

Before this inspection, we reviewed information that we held about the service. During the inspection we:

- spoke with 24 patients
- spoke with 33 staff who had clinical or administrative roles
- spoke with 12 ward managers
- spoke with an independent Mental Health Act advocate
- reviewed 30 care records
- reviewed all 21 prescription charts
- carried out a tour of 12 wards and visited the onsite recovery academy and physical health centre
- observed a multidisciplinary team meeting and a handover
- looked at a range of policies, procedures and other documents relating to the running of the service.

The twelve wards visited were:

- Buttermere
- Coniston
- Delaney
- Derwent
- Dovedale
- Eskdale
- Ferndale
- Isherwood
- Loweswater
- Newland
- Silverdale
- Wentworth House

A comprehensive inspection of forensic inpatient or secure wards was last carried out by the Care Quality Commission in February 2016. Forensic inpatient or secure wards were rated as good in effective, caring, responsive and well led, and requires improvement in the safe domain. The service was rated as good overall.

Summary of this service

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

Forensic inpatient or secure wards

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

However:

- Staff did not always make requests for cover through the on-call management system.
- Staff did not always review the prescription of high dose antipsychotic medicine.
- Medicines were not always administered safely. Staff oversight of the administration of medicine was inconsistent and patients were at risk because drug interactions were not recognised, or medicine administration reviewed, so medicine was not administered appropriately.
- Staff did not always record information about patients' care and treatment in a way that was comprehensive and easy to find.
- Not all care plans were person centred and did not reflect the patient voice. Care plans used a medical language rather than the patient's own words.
- Recording of physical healthcare following rapid tranquilisation was recorded in patients' electronic records but not all in the same place. Staff were recording monitoring either in daily notes or on medical early warning scores.
- Patients' one to one sessions with their named nurse were taking place, but not as two to three times a week as per the trust policy. One to one sessions were recorded but did not reflect the details of what was discussed and if this related to patients' care, treatment and recovery.
- Patients were offered a copy of their care plan, but this was not consistently recorded as to whether the patient had accepted or declined the offer.

Is the service safe?

Requires improvement 

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

- The trust did not have a robust mechanism for assuring staff reviewed the prescription of high dose antipsychotic medicine.

Forensic inpatient or secure wards

- Staff oversight of the administration of medicine was inconsistent and patients were at risk because drug interactions were not recognised, or medicine administration reviewed, so medicine was not administered appropriately.
- Staff did not always make requests for cover through the on-call management system.

However:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good 

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Forensic inpatient or secure wards

- The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- There was not a robust system in place to ensure staff supervision was being completed in line with trust policy.

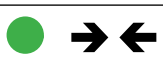
Is the service caring?

Good 

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good 

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

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom, most with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.

Forensic inpatient or secure wards

- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Is the service well-led?

Good  

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes were generally operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However:

- Staff did not always record information about patients' care and treatment in a way that was comprehensive and easy to find.
- Not all care plans were person centred and did not reflect the patient voice. Care plans used a medical language rather than the patient's own words.
- Recording of physical healthcare following rapid tranquilisation was recorded in patients' electronic records but not all in the same place. Staff were recording monitoring either in daily notes or on medical early warning scores.
- Patients' one to one sessions with their named nurse were taking place, but not as two to three times a week as per the trust policy. One to one sessions were recorded but did not reflect the details of what was discussed and if this related to patients' care, treatment and recovery.
- Patients were offered a copy of their care plan, but this was not consistently recorded as to whether the patient had accepted or declined the offer.

Areas for improvement

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

Must improve

Forensic inpatient or secure wards

- Medicine reviews must align with patients' care and treatment plans and pathways and be completed and reviewed regularly by clinical, medical and pharmacy staff. Staff must adhere to policies and procedures about managing medicines. Regulation 12(2)(b)(g).

Should improve

- Decisions to deploy staff to cover duties on different wards should be agreed through the on-call management system in place and in take account of those staff who have disability passports and are not meant to be moved to cover other ward areas.
- Patient care plans should be person centred, reflect the patient voice and use the patient's own words.
- Staff should record patients' physical healthcare following rapid tranquilisation in one place within the patient record system so these are easily accessible by the staff team.
- Patients' one to one sessions with their named nurse should take place as per the trust policy and records should reflect the details of what was discussed between the patient and their named nurse concerning their care and treatment.
- When patients are offered a copy of their care plan, staff should record whether the patient accepts or declines the offer.
- The trust should ensure that all staff receive supervision and that a robust recording and monitoring process is introduced across all services.

Community-based mental health services of adults of working age

Requires improvement 

Key facts and figures

Greater Manchester Mental Health NHS Foundation Trust provides community mental health services to adults of a working age for people resident in Bolton, Salford, Trafford and the City of Manchester who suffered from mental illness, typically those suffering from schizophrenia, severe affective disorder or a complex personality disorder. This could include people with Autism Spectrum Conditions, whose needs could resemble those of a complex personality disorder.

They provided a service for people with a substantial disability as a result of their illness, such as an inability to care for themselves independently, sustain relationships or gain and maintain employment. The aim was to provide a high quality and comprehensive level of care to support the recovery of patients in the community.

The service comprised of 37 teams, each team with a specific area of coverage and of expertise. The teams included early intervention teams, community mental health teams, engagement and recovery teams, specialist service for affective disorders, and psychotherapy services.

We inspected six of the 12 community mental health teams:

Bolton Functional North community mental health team, Bentley House (RXVF2)

Central Manchester East community mental health team, Rawnsley Building (RXVON)

South Mersey community mental health team, Brian Hore Unit (RXVL2)

Ramsgate House community mental health team, Ramsgate House (RXV44), Salford

Trafford South and Central community mental health team, Brook Heys (RXV07)

Trafford North and West community mental health team, Crossgate House (RXV84)

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

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We visited the service on 18-20 June 2019, with two inspectors and four specialist advisors.

During the inspection we:

- toured six services
- interviewed eight managers, including service managers
- spoke with 25 nursing staff and managers
- attended two visits to patient's homes
- interviewed seven carers and 17 patients
- looked at 38 care records
- looked at 83 depot cards
- attended two zoning meetings

Community-based mental health services of adults of working age

- spoke with two psychiatrists
- attended one multidisciplinary team meeting
- viewed one carer assessment
- spoke with three psychologists.

This is the first time we have inspected this service since the acquisition of Manchester Mental Health and Social Care NHS Trust in 2017. Community-based mental health services for adults of working age in Manchester were last inspected in March 2015 and rated as requires improvement. The former Greater Manchester West Mental Health NHS Foundation Trust achieved a good rating for this service in its 2016 inspection.

Summary of this service

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

- In four out of six care records reviewed at the Central Manchester community mental health team, patients allocated a care coordinator in April 2019 had not been risk assessed, a situation confirmed with team management at the time of the inspection
- Data provided about referral to initial assessment and referral to treatment times indicated very long waiting times within the service
- Mandatory training data for safeguarding children level three was well below the trust target.

However,

- environmental risk assessments had been completed, including ligature assessments, and actions taken to remove or reduce risks. Staff monitored patients waiting for assessment, with a duty officer system that allowed patients to contact the service during and after assessment
- patient notes were recorded electronically and were found to be comprehensive and entered onto the system in a timely manner
- Assessments of patients were comprehensive and holistic, and physical health monitoring was taking place, where required
- Staff provided a range of treatments and access to treatment across the service, and care was delivered in line with national guidance
- Staff were taking part in clinical audits and using results to drive improvement. Staff employed in the service had the right skills and experience to ensure informed treatment for patients
- Staff were seen to be responsive and respectful when dealing with patients. Patients were involved in decisions about the service, where appropriate
- There was a strategy to maintain and renew engagement with patients in the service, ensuring patients had every opportunity to receive the treatment they were prescribed.
- The service used key performance indicators to take the service forward.

Community-based mental health services of adults of working age

Is the service safe?

Requires improvement 

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

- Four of six care records checked at the Central Manchester community health team allocated in April 2019 showed no evidence of any risk assessment having been completed, with a further record showing no activity or contact with the patient in progress notes; this situation was confirmed with management at the time of the inspection.
- Mandatory training for safeguarding children level three was well below the trust target.

However,

- The service had enough nursing staff of all grades to keep patients safe
- Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.
- Where completed, staff regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified.
- Staff monitored patients on waiting lists for changes in their level of risk and responded when risk increased.
- Patient notes were comprehensive, and all staff could access them easily.
- Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Is the service effective?

Good 

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

- Staff completed a comprehensive mental health assessment of each patient. Staff made sure that patients had a full physical health assessment and knew about any physical health problems.
- Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff reviewed and updated care plans when patient's needs changed. Care plans were personalised, holistic and recovery-orientated.
- Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance (from relevant bodies such as NICE).
- Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice.
- Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements.
- Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work.

Community-based mental health services of adults of working age

- Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff knew where to get accurate advice on Mental Capacity Act.

However,

- Supervision records provided by the trust showed that supervision of staff in the service was not effective, with little or no monitoring and auditing of staff supervision. This has been addressed as a trust wide issue in this inspection.

Is the service caring?

Good 

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

- Staff were discreet, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it.
- Staff supported patients to understand and manage their own care treatment or condition. Staff understood and respected the individual needs of each patient.
- Staff involved patients and gave them access to their care plans. Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff supported patients to make advanced decisions on their care.
- Patients could give feedback on the service and their treatment and staff supported them to do this.
- Staff made sure patients could access advocacy services.
- Staff involved patients in decisions about the service, when appropriate.
- Staff supported, informed and involved families or carers. Staff helped families to give feedback on the service. Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Requires improvement 

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

- Data provided about referral to initial assessment and referral to treatment times indicated very long waiting times within the service.

However,

- The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists.
- Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff tried to contact people who did not attend appointments and offer support.
- Patients had some flexibility and choice in the appointment times available. Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Appointments ran on time and staff informed patients when they did not.

- The service had a full range of rooms and equipment to support treatment and care. Interview rooms in the service had sound proofing to protect privacy and confidentiality.
- The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Managers made sure staff and patients could get hold of interpreters or signers when needed.
- The service received a low number of complaints reflecting that patients were satisfied with their care.

Is the service well-led?

Good  

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

- Managers had opportunities for leadership training and development, not just within the trust, but completing external courses as well.
- The values of the trust were launched in September 2017 after engagement with patients, carers, staff and governors. The trust strategic objectives were evident at the service, and the teams worked toward those objectives.
- The service used key performance indicators to gauge and drive performance.
- Staff at the service could submit items to the provider risk register by approaching the team manager.
- The trust had a quality improvement initiative called Dragon's Den, a quality innovation fund designed to support delivery of quality improvement at service level.
- The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services.

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure that risk assessments are completed for each new patient admitted to the service (Regulation 12: safe care and treatment).
- The trust must ensure that waiting times for referral to assessment and referral to treatment do not impact on the care and treatment of patients (Regulation 9: Person-centred care)

Action the trust SHOULD take to improve:

- The trust should ensure that mandatory training with regards to safeguarding children level three are improved across the service.

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

Good ↑

Key facts and figures

The trust provides 14 acute wards for adults of working age and five psychiatric intensive care units across six sites. These are:

Griffin Ward (Prestwich)

- Griffin Ward (eight beds for women aged 18-25, in transition from child and adolescent mental health services)

Laureate House (Wythenshawe)

- Bronte Ward (31 beds for men and women)
- Blake Ward – psychiatric intensive care unit (eight beds for women)

Meadowbrook Unit (Salford)

- Eagleton Ward (23 beds for men)
- Keats Ward (22 beds for women)
- MacColl Ward (14 beds for men)
- Chaucer Ward – psychiatric intensive care unit (eight beds for men and women)

Moorside Unit (Trafford)

- Brook Ward (22 beds for men)
- Irwell Ward - psychiatric intensive care unit (six beds for men and women)
- Medlock Ward (21 beds for women)

Park House (Crumpsall)

- Elm Ward (24 beds for women)
- Juniper Ward – psychiatric intensive care unit (10 beds for men)
- Laurel Ward (23 beds for men)
- Mulberry Ward (20 beds for men)
- Poplar Ward (20 beds for women)
- Redwood Ward (20 beds for men)

Rivington Unit (Bolton)

- Beech Ward (22 beds for men)
- Maple House – psychiatric intensive care unit (six beds for men and women)
- Oak Ward (20 beds for women).

During this inspection we looked at all five key questions: was the service safe, effective, caring, responsive and well led? Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

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

Before this inspection, we reviewed information that we held about the service. During the inspection we did a tour and talked with at least one member of staff, usually the ward manager or their deputy, on all 19 wards. We spoke with at least one other member of staff and at least one patient on 13 of the wards. We looked at a sample of care records on 14 of the wards. We reviewed medication charts and looked in detail at the clinic room and medication processes on nine of the wards. We left comment cards and boxes on 18 of the wards; two were damaged, but the remaining 16 were collected (four were empty).

In total, during the inspection we:

- spoke with 33 patients
- spoke with two carers or relatives of patients
- reviewed 49 comment cards from across 12 wards
- spoke with 51 staff including activity workers, doctors, nurses, occupational therapists, pharmacists, psychologists, support workers, and trainee assistant practitioners and student nurses
- spoke with six ward managers or their deputies in detail, carried out ten shorter interviews with ward managers or their deputies, and spoke with six senior managers
- reviewed 29 care records
- reviewed 45 prescription charts
- looked in detail at the clinic room and medication processes on nine wards, and observed two medication rounds
- carried out a tour of all 19 wards
- observed four patient or staff meetings, and staff responses to incidents that occurred during our inspection
- looked at a range of policies, procedures and other documents relating to the running of the service.

A core service inspection of acute wards for adults of working age and psychiatric intensive care units was last carried out by the Care Quality Commission in October 2017. Acute wards for adults of working age and psychiatric intensive care units were rated as requires improvement in the safe and effective domains and good in the caring, responsive and well led domains. The overall rating was requires improvement.

Summary of this service

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.

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

- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was usually available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- The design, layout, and furnishings of the wards did not always support patients' treatment, privacy and dignity. Each patient did not have their own bedroom, as five of the wards at Park House had dormitories.
- The trust did not have a robust mechanism for assuring itself that all staff received appropriate supervision. This was identified as a breach of regulation at the last inspection in 2017 and has been addressed as a trustwide issue at this inspection.

Is the service safe?

Good 

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

- Overall, the wards were safe, clean, well equipped, adequately furnished and maintained, and broadly fit for purpose.
- The service had nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. However, the trust had vacancies, particularly for staff nurses, and used bank and agency staff to fill these gaps. The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

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

Is the service effective?

Good ↑

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

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- The trust did not have a robust mechanism for assuring itself that all staff received appropriate supervision. This was also identified as a breach of regulation at the last inspection of this core service in 2017. This is addressed as a trustwide issue in this inspection report.

Is the service caring?

Good →←

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

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

Is the service responsive?

Good 

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

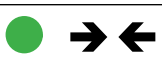
- Staff managed beds well. A bed was usually available when needed and patients were not usually moved between wards unless this was for their benefit.
- There were quiet areas on the wards for privacy.
- The food was of adequate quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

The design, layout, and furnishings of the wards did not always support patients' treatment, privacy and dignity. Five of the wards at Park House had dormitories. Each patient did not have their own bedroom and could not always keep their personal belongings safe. Five of the wards at Park House had dormitories.

- Discharge was sometimes delayed for other than clinical reasons.

Is the service well-led?

Good 

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

- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied to the work of their team.
- Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Outstanding practice

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

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

The trust had made the decision to provide a dedicated ward for women aged 18-25 years after completing a piece of research to identify a patient group with a high level of unmet need. Griffin ward's function to support the transition to adult mental health services was in line with priorities set out in the NHS long term plan.

The seclusion room on Griffin ward had an interactive touchscreen wall that patients could use to play games or music.

Several psychology-based or psychosocial initiatives were being implemented or piloted on individual wards to improve the support, experience and outcomes for patients. This included positive behavioural support plans, compassion focused therapy and managing difficult emotions as part of a personality disorder pathway.

"Safewards" had been implemented on all the wards. This is an evidence-based initiative that promotes recovery, and aims to reduce violence and aggression, and the use of restrictive interventions.

Areas for improvement

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

SHOULD

The trust should ensure that all staff receive supervision and that a robust recording and monitoring process is introduced across all services.

The trust should ensure that plans are in place to replace all dormitory accommodation with single bedrooms.

The trust should ensure that all medication is stored, managed, recorded and disposed of correctly.

The trust should ensure that all staff receive appropriate safeguarding children training.

The trust should ensure that all windows in bedroom doors are not visible to people passing by (inbuilt lockable blinds are fitted in many but not all doors), to ensure each patient's privacy and dignity is maintained.

The trust should ensure that all paper patient records are scanned into the electronic system as soon as possible, so that patient information is accessible when required.

The trust should consider psychology provision on all inpatient wards, so that patients receive the necessary support and treatment in accordance with national guidance.

The trust should review access to toilet and shower facilities from the seclusion room on Irwell ward.

The trust should continue to review the recruitment and retention of staff, particularly staff nurses.

The trust should that information in care records is person centred, and consistently recorded so it is easy for staff to find.

The trust should consider how considerations of sexual safety are documented, including when decisions are made about admitting a patient to a single sex or mixed sex ward.

Specialist community mental health services for children and young people

Requires improvement

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Key facts and figures

Bolton child and adolescent mental health service is a community mental health service for children and young people aged 5-18 registered with a GP who is part of the Bolton Clinical Commissioning Group. The service comprises:

- a single point of access team who screen referrals, undertake initial assessments and coordinate diagnostic assessments for children who may meet criteria for autism spectrum disorder or attention deficit hyperactivity disorder
- a core child and adolescent mental health service team who offer further assessment and intervention to children, young people and families experiencing significant emotional difficulties
- a learning disabilities team who offer consultation and intervention to children and young people with a learning disability and/or autism.

Bolton child and adolescent mental health service does not provide an out-of-hours crisis service. Children and young people presenting to the acute hospital with risks relating to mental health difficulties are assessed by the trust's all-age mental health liaison team. Bolton child and adolescent mental health service do however provide follow-up for these children and young people in the community.

Bolton child and adolescent mental health service also do not provide a service for children and young people who present with an eating disorder or children and young people aged 14 years or over who are experiencing psychosis. These children and young people are supported by other services.

Bolton child and adolescent mental health service is located on the grounds of the Royal Bolton Hospital. The service has been provided by Greater Manchester Mental Health NHS Foundation Trust in partnership with North West Boroughs Healthcare NHS Foundation Trust since April 2018. Greater Manchester Mental Health NHS Foundation Trust is the lead provider and maintains operational oversight and responsibility. All staff work to this trust's clinical and operational policies.

Greater Manchester Mental Health NHS Foundation Trust employs all staff at band 8 and above. North West Boroughs Healthcare NHS Foundation Trust employs staff at band 7 and below. Employees are managed in accordance with the human resources policies of their employing organisation.

Our inspection focused on the aspects of the service that were provided by Greater Manchester Mental Health NHS Foundation Trust. We did not formally interview staff employed by North West Boroughs Healthcare NHS Foundation Trust, although we did speak with the two team managers to get an understanding of the service. We reviewed care records, observed care and spoke with patients and/or carers where Greater Manchester Mental Health NHS Foundation Trust staff were the lead workers.

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

We visited the service on 18 and 19 June 2019. Our inspection team comprised a CQC inspection manager and a specialist advisor.

During the inspection we:

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- toured the premises where staff saw patients
- spoke with the service manager, the two operational managers and the two team managers
- spoke with six staff including the clinical lead, two clinical psychologists, the social worker and the family therapist
- spoke with five patients and four carers
- attended and observed four clinical appointments
- reviewed 14 patients' care records
- looked at a range of policies, procedures and other documents relating to the running of the service.

This is the first time we have inspected Bolton child and adolescent mental health service since it was acquired by the current providers in April 2018.

Summary of this service

We have not previously inspected this service under the current provider. We rated it as requires improvement because:

- Children who did not require urgent care waited too long to start treatment.
- Emergency equipment kept on the premises had not been serviced, meaning that it was not safe to use. None of the partner trust's staff had completed level 3 training in safeguarding children. Between April 2018 and February 2019, staff only reported two safeguarding referrals as incidents.
- Governance structures were not always effective. Routine checks had not identified that emergency equipment was overdue for a service. Managers could not be assured that staff were discharging their responsibilities in relation to safeguarding.

However:

- Clinical premises where patients were seen were safe and clean. Patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood the principles underpinning capacity, competence and consent as they apply to children and young people and managed and recorded decisions relating to these well.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The criteria for referral to the service did not exclude children and young people who would have benefitted from care.
- Managers promoted a positive culture. They worked with partners to meet local needs.

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Is the service safe?

Requires improvement

We have not previously inspected this service under the current provider. We rated safe as requires improvement because:

- Emergency equipment kept on the premises had not been serviced, meaning that it was not safe to use. None of the partner trust's staff had completed level 3 training in safeguarding children. Between April 2018 and February 2019, staff only reported two safeguarding referrals as incidents.
- Initial letters sent to patients and referrers did not make it clear that they could contact the service if the patient's mental health deteriorated while they were waiting for an appointment.

However:

- All clinical premises where patients received care were clean, well equipped, well furnished, and fit for purpose.
- The service had enough staff to keep patients safe from avoidable harm. Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.
- Staff we spoke with understood how to protect patients from abuse and the service worked well with other agencies to do so. The service had a designated safeguarding officer.
- Staff kept detailed records of patients' care and treatment. Records were reasonably clear, up to date and easily available to all staff providing care.
- Staff regularly reviewed the effects of medications on each patient's physical and mental health. Staff followed a safe and secure process for storing and recording forms used for prescriptions.
- The teams had a good track record on safety. The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good

We have not previously inspected this service under the current provider. We rated effective as good because:

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

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- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

However:

- Only one of the 14 care plans we viewed was fully personalised, holistic and recovery-oriented.
- The service did not offer evidence-based interventions for children presenting with emotional dysregulation, risky/self-destructive behaviours, feelings of emptiness and anger, and unstable relationships.

Is the service caring?

Good

We have not previously inspected this service under the current provider. We rated caring as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.
- When appropriate, staff involved families and carers in assessment, treatment and care planning.
- Patients and parents and carers were involved in the design and delivery of the service.

However:

- There was no evidence that patients and carers were offered copies of care plans at the start of treatment.

Is the service responsive?

Requires improvement

We have not previously inspected this service under the current provider. We rated responsive as requires improvement because:

- Patients who did not require urgent care waited too long for treatment. Some children were waiting for over 40 weeks.

However:

- Referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly. Staff followed up patients who missed appointments.

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- The service ensured that patients who would benefit from care from another agency made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the patient's care.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Requires improvement

We have not previously inspected this service under the current provider. We rated well led as requires improvement because:

- Governance structures were not always effective. Routine checks had not identified that emergency equipment was overdue for a service. Managers could not be assured that staff were discharging their responsibilities in relation to safeguarding.

However:

- Leaders understood the issues, priorities and challenges the service faced. They were visible in the service and supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and was developing a strategy to turn it into action. The service's priorities were aligned to local plans and the wider health economy.
- Staff we spoke with felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance.
- Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

Outstanding practice

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure that patients wait no longer than 18 weeks from the point of referral to start treatment (Regulation 9: Person Centred Care).

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- The trust must ensure that all equipment is properly maintained (Regulation 15: Premises and equipment)
- The trust must ensure that all staff are trained to level 3 safeguarding children (Regulation 18: Staffing)

Action the trust SHOULD take to improve:

- The trust should ensure that all care plans are personalised, holistic and recovery-oriented, and that patients and/or carers are offered a copy.
- The trust should ensure that all patients, carers and referrers are given advice to contact the service if the child or young person's mental health deteriorates while they are waiting for an appointment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

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

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

Our inspection team

A Head of Hospital Inspection, led this inspection. Four specialist advisers - a deputy director of nursing, a safeguarding adviser, and two board level advisers - supported the well led review.

The inspection team across the four core services and well led review included: two inspection managers, 12 inspectors, a Mental Health Act reviewer, a pharmacist, 12 specialist advisers, a data analyst, and two experts by experience.

Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services

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