healthwatch
Wigan & Leigh

Mental Health Project Report 2023-2024

Walking in their shoes

Mental Health Project Report 2023-2024
Executive Summary

A comprehensive project was undertaken to better understand those using mental health services provided by Greater Manchester Mental Health Trust (GMMH) for residents of the Wigan Borough. This was in response to concerns raised by national media regarding negative experiences of patients accessing mental health services across Edenfield Hospital, Prestwich by the same mental health trust.

The project aimed to understand residents' experiences with mental health services under the relatively newly appointed provider, GMMH which replaced Northwest Boroughs in April 2021.

We spoke to a significant amount of people during this project and 130 of those agreed to share their stories and for us to record them.

We used focus groups and interviews allowing everyone to share their journey, experiences, and thoughts in a way that they felt comfortable with.

People said that there were some challenging and distressing experiences within the mental health services, particularly at Atherleigh Park. It's clear from their account that there are several issues, including issues with the quality of care, staff responsiveness, involvement and delivery of care plans, illicit substances on the wards, poor communication, and concerns about not being able to give their experiences of the care they have received in an easily accessible way.

Greater Manchester Mental Health Trust have been given the opportunity to comment on the findings outlined in this report.

"Please tell the staff to get to know who we are, not just our diagnosis".

Mental Health Project Report 2023-2024

Walking in their shoes

Introduction

People that use mental health services are often extremely vulnerable and it can be difficult for them to have their voice heard. In addition, those that are detained within a secure unit have less opportunity to speak to someone independent of the environment that they are in.

There has been a lot of publicity in the media recently around patients having negative experiences whilst using mental health services. This has been highlighted by the airing of the Panorama programme showing the poor care experienced by inpatients at Edenfield Hospital, Prestwich.

As a result of this Greater Manchester Mental Health Trust (GMMH) have been placed in special measures by the CQC and are being support by NHSE/I on an improvement plan.

In April 2021 GMMH replaced Northwest Boroughs NHS Foundation Trust as the provider of mental health services in the borough. Therefore, is a relatively new provider locally.

This work gives the opportunity for patients to have their views heard by an independent organisation working specifically on behalf of the residents of the Wigan borough.

From the point of view of the patient, we want to hear what is going well and what, if anything, could be made better. We want to ensure that any person receiving care from mental health services in Wigan is treated with dignity and respect.

Key objectives were to:

- Enable local people to monitor and scrutinise the standard of provision of local mental health services.
- Obtain the views of users of services regarding their needs for and experiences of local mental health services and importantly to make these views known.
- Formulate views on the standard of provision and make recommendations on whether the local services could and ought to be improved.
- Share these views with Greater Manchester Mental Health Trust, CQC, Wigan system leaders and Healthwatch England.

Approach

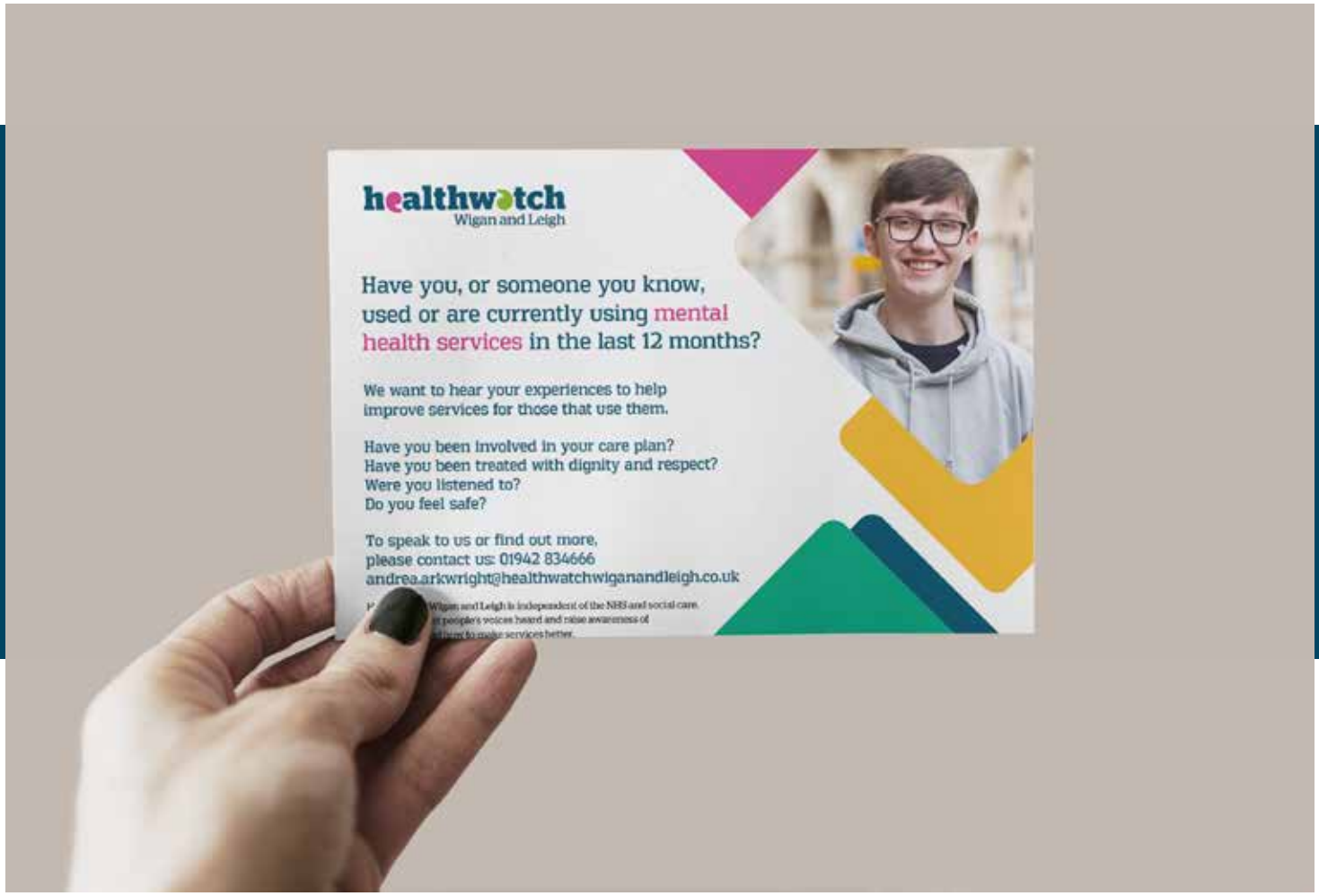
It was felt that we needed to take a different approach to this project. Initially we met with all the GMMH Wigan staff across the services. We also arranged to meet our partners to share our project proposal with them, so everyone had an understanding why we were undertaking the work. By approaching the project in this way, it gave us a real opportunity to have all the staff working with us.

The Senior Leadership Team of GMMH requested monthly meetings with Healthwatch. This was to provide real time feedback on the information we were receiving from the residents.

Senior Managers	Services	Other
Head of Operations	ADHD Team	ICS Quality Team
Senior Manager –Inpatients & Urgent Care	Early Intervention Team(EIT)	Wigan Safeguarding Operational Manager and Service Manager
Senior Manager- Community	Recovery North and South Team (Community Mental Health Team)	Wigan Safeguarding Board
Operational Manager –Community mental Health Team	Early Detection Intervention Team (EDIT)	Wigan Social Work Lead- Approved Mental Health Practitioner
Operational Manager –LL&MS	Later Life & Memory Service(LL&MS)	Mental Health Subgroup VCSE Sector
Operational Manager- Early Intervention Team	Homebase Treatment Team	Family Welfare
Operational Manager Living Well/Link Workers/PCN	Psychological Services	Brookfield
Operational Manager- Inpatients	Ward Managers Meeting	Hardybutts
Matron- Clinical Leads for Inpatients	Community Therapies	Ashwood Court
Operational Manager –Urgent Care	Specialist Psychological Therapies	Rose Bridge Court
Lead for Service User and Carer Engagement	Consultant Clinics	Fir Trees Independent Hospital
	Makerfield Streaming Area Team	GMMH Liaison meeting
		Discharge Support Homeless

Who we listened to

To promote the project, we developed a postcard with all the information on about the project and some key subjects that we wanted to hear peoples experience about.



We undertook the following engagement sessions

61

Engagement Sessions Attended

Ward Focus Groups
10 visits

Community Services
14 visits

Atherleigh Park Reception
31 visits

Supported Accommodation
3 visits

Independent Hospitals
3 visits

Conclusion

During this piece of work we gained feedback from over 130 residents' carers or relatives who chose to share their experiences with us from across a wide selection of services.

Healthwatch Wigan and Leigh established a positive working relationship with the leadership team within Wigan Services. We felt welcomed by everyone, and staff took the project seriously. We had monthly escalation meetings which offered a platform to address urgent concerns promptly, with swift responses from the team.

The project had impact across Wigan Borough and Greater Manchester. Information from the project influenced Wigan Council tendering / contract development for supported living. The contribution of patient, relative, and carer experiences as "I" statements were put into the tender documents, ensuring a patient centred approach.

The Mental Health project received recognition from, Greater Manchester Adult Social Care Transformation as a piece of good practice, highlighting its effectiveness and adherence to high standards.

Information from the mental health project, has contributed to the development of digital initiatives surrounding Approved Mental Health Professionals Service (AMHPS) within the Digital Mental Health (Adult Social Care) Greater Manchester

These accomplishments highlight the significant impact and recognition of Healthwatch Wigan and Leigh's mental health project, locally and regionally, in enhancing services and advocating for patient centred care.

Patients said that there were some challenging and distressing experiences within the mental health services, particularly at Atherleigh Park. It's clear from their account that there were several issues, including issues with the quality of care, staff responsiveness, involvement and delivery of care plans, drugs on the wards, communication, and concerns about not being able to give their experiences of the care they have received in an easily accessible way.

A common recurring concern across all the mental health services was the inconsistency in involving patients in their care plans or even receiving a care plan at all. Patients reported significant delays, with some waiting months before receiving a care plan. This lack of involvement in care planning can have detrimental effects on patient engagement, treatment outcomes, and overall patient centred care and ownership of recovery.

During the 72-hour review, patients expressed concerns about inconsistencies in their involvement in discharge planning, noting that some were only notified of their discharge on the day itself. Additionally, many patients reported not seeing a social worker during their review or being asked about ongoing support at home, such as access to a complex dependency worker, tenancy officer, or homecare provider.

These issues highlight gaps in the discharge process and the need for improved communication and coordination between healthcare/social work providers and patients/carers regarding discharge planning and ongoing support services. Patients, carers should be actively involved in the planning process and provided with necessary information and support to ensure a smooth transition from hospital to home or other care settings.

Patients didn't know about referrals to the Independent Mental Health Advocate (IMHA). Some patients expressed dissatisfaction from staff, noting that there was a delay in the referral process or no referral at all. This delay resulted in frustration and a sense of being overlooked or unsupported by the healthcare team. Access to advocacy services such as the IMHA is crucial for patients to have their voices heard and to ensure that their rights are upheld within the mental health system. The feedback highlights the need for improved awareness among staff and patients about the availability and importance of advocacy services.

Patients expressed concerns about feeling safe on the wards due to incidents of patient conflicts and fighting. These incidents created a sense of fear and unease among patients, impacting their overall sense of safety and well-being during their stay.

Patients expressed significant concern about the presence of drugs being brought onto the ward and patients illegally selling drugs while on the premises. This issue was particularly highlighted at Atherleigh Park, with patients describing the drug selling as blatant. The presence of drugs and drug dealing not only poses serious safety risks but also undermines the therapeutic environment of the ward and can exacerbate existing mental health issues for patients.

Patients have requested changes in the review process, advocating for smaller review panels. They find it intimidating to face up to six people during reviews and suggest that smaller panels would be more comfortable and conducive to open communication. It also identified the lack of advocacy support which also exacerbates the issue.

Patients expressed significant concerns regarding agency staff assigned to the wards, particularly related to their behaviour and communication. Many patients noted that agency staff were frequently speaking in their first language, which made patients feel paranoid and frightened to approach them. This behaviour contributed to a lack of trust and increased anxiety among patients, as they felt as though the staff were talking about them behind their backs.

Additionally, patients reported observing agency staff spending excessive time on their phones, engaging in activities such as gambling, rather than attending to their duties. Patients frequently asked agency staff questions but often received unresponsive or dismissive responses, further exacerbating feelings of frustration and isolation. These concerns highlight the need for better oversight and training of agency staff to ensure they adhere to professional standards and provide appropriate care and support to patients.

Patients expressed concerns about staff members who were perceived as inattentive, with many noting that staff often remained in their offices rather than engaging with patients.

“Please tell the staff to get to know who we are not just our diagnosis”.

Patients felt that there was an overall lack of communication and that their voices were not being heard by staff members. This feedback emphasises the need for improved staff-patient interactions, including increased presence and engagement from staff, efforts to build rapport with patients, and active listening to patient concerns and feedback. Building a culture of open communication and mutual respect between staff and patients is essential for enhancing the quality of care and patient experience within mental health services.

The patients frequently informed about the lack of activities on the ward. Not all wards had had activity coordinators this due to sickness levels and people leaving, so their days and especially weekends become so long. Some patients wanted to have a wider variety of activities on the ward.

The patients who spoke to us gave constant feedback about the lack of or no visits at all from the Recovery Team when they had been pre-arranged or planned. In some cases, causing stress and anxiety for the patients.

Patients expressed that they were rarely asked to provide feedback on their experiences or their stay as inpatients or in community services. They noted that they hadn't seen QR codes to scan for feedback, and even if they had, some patients mentioned that their phones were not compatible with QR code technology. Additionally, patients reported not being given printed copies of patient or carer questionnaires to complete. This lack of opportunity for patients to share their perspectives and experiences highlights the need for improved methods of seeking feedback and ensuring accessibility for all patients, regardless of their technology or literacy levels. Providing multiple avenues for feedback, such as printed questionnaires and face-to-face interactions, can help ensure that patients' voices are heard and valued in shaping the quality of mental health services.

Patients spoke to us around privacy and dignity whilst using the showers on the ward commenting that people can see you whilst you're in the shower as the door is hooked back. Also, patients expressed their concern in the 136 suite and how degrading it is not to have a toilet door on the toilet. They did offer a suggestion of a diagonal door to offer some privacy to the patient.

The patients recognised and acknowledged the potential pressure on staff due to the high number of patient requests highlights the challenges faced by healthcare professionals in these settings. Recognising their efforts and understanding the constraints they may be under is essential for fostering a positive and collaborative atmosphere.

Patients and carers consistently praised the staff within the mental health services, highlighting their kindness, attentiveness, and willingness to listen to concerns. Specifically, doctors and consultants were commended for their dedication, with some going above and beyond by staying late to address patient concerns even outside of regular hours. Most community services received positive feedback, indicating satisfaction with the care and support provided. Patients attending specialized clinics, such as the Clozapine and Depo clinics, expressed gratitude for the caring and compassionate treatment they received from staff. Additionally, services such as the Community Therapies Service, Home Based Treatment Team, ADHD Service, and Later Life and Memory Service were praised for their effectiveness and consideration of patient needs. Overall, the positive feedback reflects the commitment of healthcare professionals to providing high-quality care and support to patients and their families within the mental health services.

Patients expressed appreciation for the activities provided on the ward and offered alternative suggestions for additional variety. Additionally, they commended the quality of the food but noted that baked potatoes were frequently repetitive during lunchtime. They appreciated the patient/staff meetings that took place on the wards.

Recommendations

Healthwatch Wigan and Leigh recommend:

1. Reviewing the existing process and tools used to gather feedback from patients, carers, and relatives about their experiences. It's crucial to ensure that these feedback channels are user-friendly, readily accessible, and inclusive, enabling the effective sharing of valuable insights. Providing multiple avenues for feedback, such as printed questionnaires and face-to-face interactions, can help ensure that patients' voices are heard and valued in shaping the quality of mental health services.

2. Staff to undergo thorough training emphasising the significance of engaging patients and the public in all aspects of their work, as well as recognising the crucial role of patient feedback in enhancing services.

3. That the current care plan process is reviewed. We recommend that the patient/carer is actively involved in the care plan process and a copy of the care plan is given to the patient in a timely manner.

4. Regular audits carried out by the leadership team to monitor care plans.

5. Improved communication and coordination between health and social care providers and patients/carers regarding discharge planning and ongoing support services. Patients/carers should be actively involved in the planning process and provided with necessary information and support to ensure a smooth transition from hospital to home or other care settings.

6 That patients are offered a referral to the Independent Mental Health Advocate in an appropriate timely manner. This will enable patients to get the right support, have their views and wishes heard in decisions about their care or treatment and raise anything they are unhappy with relating to their care or treatment.

7 Improved awareness among staff about the availability and importance of advocacy services.

8 The review the safety of patients on the ward particularly around the following.

- Patient conflicts and fighting on the ward.
- The presence of drugs and the illegal selling of drugs on the ward.

9 To consider the redesign of the patient reviews and how many people are on the review.

- Involve the patients, carers, and relatives in the redesign of the review meetings.
- Support from the advocate.

10 A better oversight and training of agency staff to ensure they adhere to professional standards and provide safe good quality of care and support to patients.

11 The need for improved staff-patient interactions, including increased presence and engagement from staff, efforts to build rapport with patients, and active listening to patient concerns and feedback. Build a culture of open communication and mutual respect between staff and patients.

12 To audit the recovery teams organised /planned visits to patients to establish how many visits do/do not take place for the patient.

13 To co-produce with patients the coordinated schedule of activities for the wards.

14 Privacy and Dignity. Staff to explain to individuals how they might be observed when.

- Taking showers on the ward
- Being taken to the 136 suite and what the suite is like explaining the facilities.

15 To work with the providers to establish patient champions to ensure that patients, carers, and the public voices are heard and can continue to give feedback from all mental health services across Wigan Borough.

Responses

Wigan Greater Manchester Mental Health (GMMH) Services would like to thank Healthwatch for completing the independent review project 'Walking in their Shoes' which took place over a 12-month period between January 2023 – January 2024. The views of Wigan residents accessing mental health services is very important to us.
Throughout the project, Wigan GMMH maintained regular contact with Healthwatch on a monthly basis to discuss and address any immediate concerns raised. Wigan GMMH will continue to work in collaboration with Healthwatch and would like to take this opportunity to share what we have been doing over the last 12 months to improve peoples experiences of mental health services and how this links to the Trust Strategic Priorities and Our Improvement plan.
Below is an update of progress against each of the recommendations made within the Healthwatch report:
Recommendation 1:
Reviewing the existing process and tools used to gather feedback from patients, carers and relatives about their experiences. It's crucial to ensure that these feedback channels are user-friendly, readily accessible, and inclusive, enabling the effective sharing of valuable insights. Proving multiple avenues for feedback, such as printed questionnaires and face to face interactions, can help ensure that patients voices are heard and valued in shaping the quality of mental health services.
Progress to Date:

- Over the last 12months, Wigan GMMH senior leadership team has introduced a new Service User and Carer Engagement lead for Wigan and Leigh who has been working with the GMMH Service User and Carer Experience and Engagement leads to develop a local action plan in Wigan in line with the GMMH Together Strategy. The local action plan focuses on the four pillars of collaborative care, service user and carer feedback, service user and carer engagement and service user and carer involvement in service delivery to ensure that we are working together to recognise everyone's experiences. This includes the development of our of Carer's Champion role.

- We now have 34 identified Carer's Champions who work across our inpatient, urgent care and community teams to support staff to recognise the vital role of carers and support carers to access the support they need when their loved one is accessing our services.

- We have also introduced our Service User and Carer Forum to provide service users and carers with the opportunity to share their views about accessing our services, including what we are doing well and what we could be doing better. This forum also gives us the opportunity to share what is happening across our services with services users, carers and other services and provide an opportunity to ask questions and seek feedback. The first meeting will take place on Thursday 20th June 2024 at Atherleigh Park Hospital from 5pm to 7pm.

- It is acknowledged however, from time to time, services users or their carers may have concerns. We are therefore committed to ensuring that any individual who wishes to seek advice or information, raise concerns, or make a complaint about the services we provide, is listened to and supported. As a result, we have successfully recruited a

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Patient Advice Liaison Service (PALs) officer working across Wigan and Bolton GMMH services. Our PALs officer works across our inpatient services attending ward community meetings to listen, advise and support service users and carers with any concerns they may have and works closely with ward staff sharing feedback on what is working well and what would be even better.

Recommendation 2:
Staff undergo thorough training emphasing the significance of engaging patients and public in all aspects of theory work, as well as recognising the crucial role of patient feedback in enhancing services.
Progress to Date:

- All of our staff complete Mandatory and Essential training, which is essential to ensure as a Trust we deliver safe and effective services. This training provides our staff with the right knowledge and skills to carry out their duties and to provide the right care and support to people accessing mental health services.

- As part of our Working Together Strategic plan, we now meet quarterly with the Service User and Carer Engagement leads across the Trust and facilitate Carer Engagement Training every quarter for all of our staff.

- We are working to increase our volunteer network and looking at different ways to provide opportunity for feedback from service users and carers to help shape our services. This includes triangulating themes from our compliments and complaints to make changes to services based on feedback.

- We continue to learn a lot through engagement, collaboration and listening to peoples lived experiences which is helping us shape and develop our services across Wigan. This is evident in the Living Well model for Wigan which focuses on working together with Wigan residents to co-design and co-produce what services mean to them whilst improving accessibility to mental health services in the area where they live.

- We acknowledge there is more work to be done across Atherleigh Park hospital and are working closely with our Wigan Service User and Engagement lead, our PALs officer, our patients, carers and staff to look at how we capture feedback in different ways to improve our inpatient services.

- Our Trust is developing a new Clinical and Care Strategy which will focus on meeting the needs of our population, delivering high quality care and co-production and involvement.

Responses

Recommendation 3 and 4:
That the current care plan process is reviewed. We recommend that the patient/carer is actively involved in the care plan process and a copy of the care plan is given to the patient in a timely manner. Regular audits carried out by the leadership team to monitor care plans
Progress to Date:

- As part of Our Improvement Plan, our care planning process and templates are being reviewed. We acknowledge we need to improve the collaborative approach to care planning across our services. Therefore, we are working with our staff across all of our teams involved in care planning to ensure that service users and carers are involved in care planning and that it is shared with them regularly.

- We monitor care plans as part of our Best Care Every Day standards in our monthly Governance meeting and look at what actions are needed to improve our compliance across all of our Wigan services. Our clinical leads complete qualitative audits into a number of important care interventions each month, with care plans being one of the domains. These audits have identified some quality issues that require improvement which we are working on with our staff.

- We have recently reviewed our quality assurance framework which highlights where we have improved and areas that requiring further work to ensure people and their carers have opportunities to be involved in their care planning and receive this in line with our Best Care Every Day standards.

Recommendation 5:
Improved communication and coordination between health and social care providers and patients/carers regarding discharge planning and ongoing support services. Patients/carers should be actively involved in the planning process and provided with necessary information and support to ensure a smooth transition from hospital to home or other care settings.
Progress to Date:

- We have a positive partnership approach across the Wigan locality to support safe discharges from Atherleigh Park hospital. This involves GMMH, NHS Greater Manchester Integrated Care, Adult Social Care, Housing and Homeless Services and Mental Health Providers. We recently facilitated a full day multiagency discharge event (MADE) to look at how can improve working together to support safe discharges from hospital. As a result, we have agreed to develop a 'home first' approach, based on work already happening at Royal Albert Edward Infirmary.

- We already have three designated social workers based at Atherleigh Park who regular attend our ward meetings to offer support for any patient that may have ongoing care and support needs on discharge. We are looking to strengthen this process with partnership working involving them in the home first approach model which will be led by our Adult Social Care colleagues. By working closer together, we will involve

relevant community services in the discharge planning process, which includes complex dependency workers, tenancy officers and home care providers.

- This work is due to commence from June 2024 onwards and there will be opportunities service users and carers in developing this new approach.

- To support discharge planning, we offer regular care reviews where discharge planning is discussed, however some people feel disconnected from their discharge planning. As a result, we are working with our patients to develop a care review prompt sheet that staff and patients will complete together prior to the care review, that will enable them to discuss important issues such as discharge dates when they are in the stressful situation of care reviews. We do need to acknowledge that it is not always possible to get full consensus regarding the best possible time for a person to be discharged some people feeling like they can go sooner and others feeling like they need to stay longer. The MDT need to take all views and clinical expertise into account when making this decision. .

Recommendations 6 and 7:
That patients are offered a referral to the Independent Mental Health Advocate in an appropriate timely manner. This will enable patients to get the right support, have their views and wishes heard in decisions about their care or Treatment and raise anything they are unhappy with relating to their care or treatment. Improved awareness among staff about the availability and importance of advocacy services.
Progress to Date:

- We recognise there is a lot of information given to people when they are admitted to hospital therefore, we have improved our patient notice information boards and our admission packs to include information on the role of Independent Mental Health Advocate and to access an advocate.

- We have also reviewed our multidisciplinary team (MDT) prompt sheet to include the offer of an Independent Mental Health Advocate. This creates further opportunity to discuss the offer and role of advocate and as a result, we have seen an improvement in referral rates for an Independent Mental Health Advocate.

Recommendation 8:
Review the safety of patients on the ward particularly around the following:

- Patients conflicts and fighting on the ward
- The presence of drugs and illegal selling of drugs on the ward

Progress to Date:

- Patient safety is paramount to us. Our staff are trained to appropriately respond to violent and aggressive incidents to deescalate situations when they arise in saying that we know how distressing these incidents are for other patients and providing support to these patients is also a priority. All violent and aggressive behaviours towards other patients and our staff are reported on our incident management platform InPhase.

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These are reviewed daily by managers and leaders and appropriate action is taken when these incidents take place to ensure the safety of our patients and our staff.

- Any patient involved in aggressive behaviours will have an updated risk assessment and a care review at the earliest opportunity.

- Illicit substances and alcohol are not permitted at Atherleigh Park, and such incidents are taken seriously. We engage our Police Liaison officer who attends Atherleigh Park regularly to talk to staff and service users about illicit substances and alcohol related incidents. We also commissioning the detection dog to assist when this is indicated.

- We have a contraband items list regarding drugs and alcohol and this information is displayed upon the wards. We allocate a 'safety and security' nurse per shift and one of their roles is to search patients (where a risk exists) on their return to the ward from leave. We are currently completing a service improvement PDSA around how we can support our nurses to complete this role confidently and safely to improve safety. Staff also have access to search training to support them with this.

- We have successfully recruited a dedicated Co-occurring Needs role to work across our adult of working age inpatient units. We are actively working with 'With You' to develop a co-occurring needs pathway for people with both mental health and substace misuse difficulties whilst they are in hospital. We will also be looking how we can support people during their hospital stay at Atherleigh Park to engage with drug and alcohol treatment, where appropriate to do so.

Recommendation 9:
To consider the redesign of the patient reviews and how many people are on the review.
- Involve the patients, carers, and relatives in the redesign of the review meetings.
- Support from the advocate

Progress to Date:
- We recognise that large numbers of people in the review can be overwhelming, and we need to ensure that we have the right balance of people in the room that can contribute to the persons care plan, and that this feels supportive.

- To improve peoples experience, we will include a question in our multidisciplinary team (MDT) prompt sheet completed with the patient before the review to ask for an individual's preference regarding attendance and will endeavour to support their preferences where possible. This will also support the conversation around advocacy and the opportunity have them join care reviews.

Recommendation 10 and 11:
A better oversight and training of agency staff to ensure they adhere to professional standards and provide safe good quality of care and support to patients. The need for improved staff-patient interactions, including increased presence and engagement from staff, efforts to build rapport with patients, and active listening to patient concerns and feedback. Build a culture of open communication and mutual respect between staff and patients

Responses

Progress to Date:
We acknowledge there are issues with agency staff, and we are working closely with NHSP who provide agency staff to GMMH. We are listening to our patients at Atherleigh Park and have triangulated themes from incidents and complaints and are making changes based on this feedback. As a result, we now have mechanisms in place with our NHSP which enables us to share any concerns we might have in relation to NHSP staff behaviours and professional standards in a timely way and monitor the outcomes from these concerns.

- As part of Our Improvement Plan, we audit local inductions for any new staff including NHSP staff. The local induction focuses on the ward environment, including local safety procedures and provides an overview of the people we are caring for. Information regarding mobile phones is also provided advising all staff that mobile phones are not permitted in patient areas and must be securely stored off the ward during the staff members shift.

- We are offering our regular agency staff access to training courses to ensure they can support our patients. This includes Prevention and Management of Violence and Aggression Training (PMVA) and training on care pathways such as the Self Harm Pathway and Positive Behavioural Support model (PBS).

- We have developed a dedicated Equality, Diversity, and Inclusion (EDI) team across the Wigan Division, which is led by BAME members of staff. In December 2023, we agreed to participate in the Trusts Culturally Appropriate Advocacy Services pilot programme which supports Black, Asian and Minority Ethnic people accessing mental health services funded by the Department of Health and Social Care. The Trust is one of two pilot schemes in England funded as part of the governments ongoing work into the reform of the Mental Health Act.

- We are working closely with our Recruitment team, Human Resource Team and the Wigan leadership teams to create development opportunities to grow and develop and attract new people to join our workforce because we know that the best possible care is provided by consistent permanent staff and we have plans to reduce our bank and agency use over the coming months. We have recently recruited 11 permanent international nurses to our inpatient services who have a wealth of knowledge, skills and experience which is enhancing our workforce.

Recommendation 12:
To audit the recovery teams organised/planned visit to patients to establish how many visits do/ do not take place for the patient.
Progress to Date:

- We receive weekly caseload reports from our Business Intelligence team. These reports provide oversight of each pathway across our Specialist Community Mental Health Team and are shared with the pathway leads to review when a patient was last seen, and appropriate plans are put in place based on the persons needs. When a

patient does not attend an appointment, a clinical discussion and review of care takes place in the weekly multidisciplinary team meeting and a plan of care is agreed based on the persons needs.

- One of the Trust strategic priorities is Community Mental Health Transformation. This is a large programme of work to transform the way we deliver our community services. There is a lot of work taking place which is evidenced based, and research driven involving people with lived experiences, service users, carers and our staff. GMMH are moving away from the Care Programme Approach (CPA) framework in line with the national position set out by NHS England. There is real focus on providing a person-centred approach that focuses on delivering outcomes based on what a person needs. Therefore, the way we monitor these outcomes will change from a qualitative and quantitative perspective.

Recommendation 13:
To co-produce with patients the co-ordinated schedule of activities for the wards.
Progress to Date:

- There is a lot of work taking place across Atherleigh Park to improve the offer of therapeutic activities.

- We are currently going through a HR consultation process with our existing staff to extend the provision of services from the Atherleigh Park Inpatient Therapy Hub, to move to a 7 day a week service: broadly an 08:00 to 20:00 hours service. This staff consultation will be completed in July 2024. Alongside the staff consultation, we are actively recruiting five new activity workers to work across all of our inpatient services at Atherleigh Park.

- In February 2024, we moved to single sex wards at Atherleigh Park this means Priestners Unit is now an all female 8 bedded Psychiatric Intensive Care Unit and Prospect Unit is an all male 16 bedded male unit. Based on feedback from our PALs officer and patient feedback, we have recently completed a review of the exercise facilities across the hospital. As a result, the gym on Priestners Unit is being transformed into a ladies gym and will be redecorated and updated to reflect feedback.

- One of the activity rooms on Priestners Unit is being transformed into a multi purpose room – to enable patients to utilise for exercise classes and also movie nights.

- Gym equipment is being placed onto Prospect ward to support access to fitness for those who do not have leave.

- Staff in the inpatients therapies hub are reviewing ways to gain feedback about the groups, activities and the times these take place. This is being supported by our PALs Officer to help us capture the feedback from across Atherleigh Park and make changes to the activities provided.

- We are creating an 'information hub' in our reception area at Atherleigh Park. The hub went live in March 2024 and creates an opportunity for external agencies to come

Responses

along and provide advice and guidance to our patients and carers attending Atherleigh Park. We have a programme of external agencies including Citizens Advice, Employment Support and Wigan and Leigh Carers Centre. We are looking at ways to promote what is available in the 'information hub'.

Recommendation 14:

Privacy and Dignity. Staff to explain to individuals how they might be observed when.

- Taking showers on the ward
- Being taken to the 136 suite and what the suite is like explaining the facilities

Progress to Date:

- For every person admitted to Atherleigh Park a personalised risk assessment is completed. These are reviewed and updated weekly, or sooner should there be a change to a persons presentation. The personalised risk assessment may indicate the need for someone to be supported by an enhanced level of therapeutic observations, which includes being observed by staff at various times or continuously should this be indicated. This may include observing someone whilst they are asleep or when needing bathroom privacy. All observations levels are discussed and agreed with the multidisciplinary team.

- As part of Our Improvement Plan, the Trust now has a new Therapeutic Observation policy. There is a real focus on collaborating with our patients who are placed on enhanced levels of therapeutic observations so they understand why this is happening and how staff and the patient can work together to agree what may need to happen to reduce the level of therapeutic observation for the individual.

- We now have the Mental Health Response vehicle working in collaboration with our local police. This means we a dedicated team of professionals working together to provide an emergency response to people when experiencing a mental health crisis. The aim is to reduce the number of people who are detained by the police on a Section 136 and taken to a place of safety. If a person is detained and taken to place of safety suite the person has a right to know where they are going. Feedback from staff tells us when a person is supported by the Mental Health Response vehicle their experience is significantly more positive. However, due to the financial challenges across Greater Manchester, staff are not able to attend all such requests.

- We recognise the whole process of being detained and taken to a place of safety suite can be upsetting for people. We have been working with our Home-Based Treatment Team who have developed a plan in line Care Quality Commissioner standards to ensure people are provided with information when they arrive. This includes, where they are, visibility of the date and time, information on facilities, food and drink and outdoor space.

Recommendation 15:

To work with the providers to establish patient champions to ensure that patients, carers and the public voice are and can continue to give feedback from all mental health services across Wigan Borough.

Responses

- There is a lot of work taking place across the Wigan locality to ensure we are developing mental health services based on the needs of Wigan residents. Wigan GMMH will continue to work with all providers to look at ways to develop opportunities and receive feedback.

- We have introduced our Service User and Carer Forum to provide service users and carers with the opportunity to share their views about accessing our services, including what we are doing well and what we could be doing better. This forum also gives us the opportunity to share what is happening across our services with services users, carers and other services and provide an opportunity to ask questions and seek feedback.

Acknowledgements

This project would not have been possible without the full support from the Wigan Division of Greater Manchester Mental Health Foundation Trust. Support from our partners across the Wigan Borough.

We would like to thank all the patients, carers and relatives who took time out of their day to share their experiences of using mental health services, which we are very grateful for. We recognise that many accounts the patients shared were distressing for them, also how privileged we were to hear at times very personal stories.

We would like to thank all the staff who made us welcome. From the reception staff, volunteers, domestics, chaplains, nursing teams, psychologists, Doctors/Consultants and the Senior Leadership Team, the staff in the supported accommodation units and the staff in the independent hospitals.

Also, a special thank you to Healthwatch Wigan and Leigh staff/ volunteers who worked on the project and to our Advisory Committee Volunteer Sponsor for supporting the project.

Key Findings
Community Services

Attention Deficit Hyperactivity Disorder (ADHD) Service

We received a very warm welcome from the receptionist and all the clinical staff.

People told us:

•They found the service to be remarkably beneficial.

"Specific praise for the ADHD Nurse (name mentioned) which indicates the service is performing well and are appreciated by those using it."

- They are experiencing delays in receiving their medication. This appeared to be a significant issue, especially for medications that need to be taken consistently. However, staff reported that the development of an online request for medication, which is reviewed daily, will hopefully improve things for people.

- About instances of appointments being cancelled due to staff sickness. People expressed their frustration, especially when they have made arrangements, such as taking time off work, to attend these appointments.

- They hadn't taken part in putting their care plan together or received a copy of their care plan.

Clozapine and Depo Clinic

We received a very warm welcome from the receptionist and all the clinical staff.

People told us:

"People have been attending the clinic for several years, some even up to 25 years, indicating a long-term and stable relationship with the service."

- They feel well cared for and commended the staff, describing them as excellent.

- That the service has improved recently, particularly in terms of reduced waiting times for appointments.

- About the anxiety of coming to the clinic.

- Staff are actively informing patients about changes regarding the provision of Clozapine, including distributing information leaflets.

- About developing diabetes whilst taking Clozapine due to the medication causing an increase in their weight.
- They appreciated that staff monitored their diabetes in addition to their GP.

- About not seeing their Community Psychiatric Nurse for several months, despite the patients expecting to be seen every two months.

- That they were involved in a care plan and had a copy of the plan. However, others said they had not either been involved or received a care plan

"We're disappointed over the discontinuation of the friendship groups across the borough".

Later Life and Memory Service Carers(LLAMS)

We received a very warm welcome from all the staff.

People told us:

- They enjoyed the relaxation sessions at the end of the LLAMS session.
- About the lack of information when carers meetings are taking place.
- They receive a lot of support from the voluntary groups and the Alzheimer's society.
- They received check-ups via the telephone from the memory service.

"The later life memory service is excellent".

- About no follow up appointments from the memory service.

Specialist Psychological Therapies

We received a very warm welcome from all of staff.

People told us:

"About Talking Therapies and how it has helped them recovery from an eating disorder"

- They gained confidence and had a positive outcome from having therapy.
- They felt more confident and were now looking at volunteer work.
- About the Autism pilot scheme assessment process, highlighting the ease of access of self-referral.
- They expressed satisfaction with the specialist psychological therapies services, stating that the staff have listened to them and provided valuable assistance.

Community Therapies Service

We received a very warm welcome from all the staff.

People told us:

- The service proves more effective from Claire House as opposed to Leigh.
- The service at Leigh only offered morning appointments, which isn't ideal when taking the prescribed medication causing morning drowsiness.
- Claire House, on the other hand, accommodates appointments to suit the patients, which was appreciated by the patient.
- They felt heard as they discussed their concerns privately.

"A well-structured care plan is in place, which outlined 6 to 12 months of one-on-one treatment followed by group sessions, continuing care for another 6 to 12 months, and eventually transitioning to GP care. The patient's expressed the professionalism of the staff"

Home Based Treatment Team

We received a very warm welcome from all the clinical staff.

People told us:

- Despite having been involved in a care plan, they hadn't received a copy, but mentioned the possibility of obtaining one during the day's session. The patient did come back to the Healthwatch staff to tell us that they received the copy of the care plan and a copy of their safety plan.

- The exceptional care provided by the mental health team.

- They had receiving dignified treatment.

- They would like to consistently engage with the same two staff members, sparing the need to repeatedly relate their story.

"The Home-Based Treatment Team gave exceptional care."

- Their concerns about the lack of privacy and dignity, referring to using the toilet on the 136 Suite. They described the scenario where others could observe them while they were using the toilet, leading to a sense of discomfort and vulnerability.

Early Intervention Team (Claire House)

We received a very warm welcome from all the staff.

People told us:

- That the care given to them by the staff was textbook style.

- Since leaving Atherleigh Park their care had been good.

- They feel that there is no follow up help from the drug and alcohol services.

Inpatient Care

We gathered experiences from the wards by holding two ward focus groups on each ward. We held one session in May/June and one session in October/November. We had some specific things that we wanted to ask.

Did people feel they:

- Were involved in their care plan.
- Were treated with dignity and respect.
- Were listened to.
- Felt safe.
- Was there anything else people wanted to tell us.

We prebooked our focus groups via the ward managers. When we arrived to undertake the focus groups on the wards the staff seemed unaware of the sessions taking place and wasn't ready for our arrival on the ward. There seemed to be a lack of communication between the management and the staff on most of the wards about the focus group and the role of Healthwatch Wigan and Leigh.

Prospect ward.

Focus Groups told us:

- They told us that they didn't know what a care plan was or had been involved in developing a care plan. Others told us that they knew what a care plan was. One person commented "they had waited nine months for a care plan"

- They didn't know what discharge looked like or had been involved in any discharge planning.

- They felt listened to.

- Sometimes they felt safe on the wards and other times they did not.

- They were treated with dignity and respect.

- They would like more activities on the wards.

- They were being well looked after by the staff.

- They wanted to go into supported accommodation rather than their own home.

- About having the right medication to help them to get home sooner without any delays.

- About the agency staff not listening to you, they just sit there. The agency staff get together in groups and talk in their first language and are always on their phones.

- They are frightened to approach the staff who speak in their first language, as you think the staff are talking about you.

- The bathroom door being left open so everyone can see you having a wash , there is no dignity.

- Staff being in the office all the time, your rarely see them.

- About not being treated with privacy and dignity when attending Accident and Emergency.

"How good the domestics are as they always clean the rooms to a good standard"

- That there is always a member of staff in the communal area to make sure it is safe.

- They have not seen a social worker at the 72-hour review.

- About the importance of having appropriate housing allocated for when they are discharged.

- Not being asked if they had any ongoing support at home such as a complex dependency worker, tenancy officer or care home provider.

- They knew who the ward manager was. The ward manager attends the patient meeting every morning where people can raise any issues they have. But the outcomes from the issues raised at the patient meeting are not displayed anywhere.

- People are not asked to give their views on their experiences of their stay on the ward.

- About the consultant being brilliant, as he had stayed behind to speak to the person late at night.

- About the different activities on the ward such as the animal therapy and bingo.

We asked the patients if we could improve one thing in mental health services what would that be.

- There needs to be improvements around being involved in the development of their care plans.

- They need more activities on the ward.

- Communication between staff and patients needs to be improved. This was particularly with what was happening with their care and recovery .

- The way that they are treated in Accident and Emergency needs to be improved. We shouldn't be judged by staff.

"That staff on the ward need to get to know who we are as a person and not just our diagnosis"

Westleigh Ward

Focus Groups told us:

- They hadn't been involved in a care plan or given a care plan.
- They had no safety plan when they felt suicidal.
- Sometimes felt listened to but very often didn't feel listened to and not communicated with.
- Didn't feel safe on the ward.
- There was a lot of fighting and bullying on the ward.
- That confidentiality should be adhered to.
- They were given a razor to shave. The razor wasn't taken off them so they self-harmed with the razor.
- Staff made inappropriate comments to us about self-harming.
- Treated with dignity and respect on the ward.
- Agency staff are less proactive and not attentive to us. They told us about seeing agency staff gambling on their phones and how the agency staff need more training in caring for us.
- About staff being rude to them.
- There is no interaction and lack respect. Staff not talking to you and not getting to know who we are.
- Some health care assistants, qualified staff, agency staff, are amazing and some just don't care.
- The students are brilliant at what they do.
- I don't always see the same Psychiatrist.
- About Drs being abrupt and inconsistent.
- Patients knew who the ward manager was. Others didn't know who the ward manager was. They have morning patient meetings so they could raise any issues with the ward manager.
- That staff stay in their offices and do not interact with the patients.
- That there was no one clinically or physically trained on the ward to have their catheter reinserted. Having to wait two hours for a district nurse to attend to reinsert a catheter.

“The reception staff in the main entrance (Atherleigh Park) were accommodating when families come to visit. Which is so welcoming for our families”

- Not asked to give feedback on their experience of staying on the ward.
- They told us that the laundry room was always locked, and you could not access the room when you needed to wash your clothes.
- There is nothing to do at the weekend.
- Didn’t know that there was a gym in the hospital.
- They sat in Accident and Emergency(A&E) waiting to be seen for two days.
- The RAID Team was nice.

The food was excellent on the ward.

- They were content on the ward as they can make their own tea and have a smoke.
- To be discharged home with a care package in place. Others wanting the care package to be supported by their direct payments.
- Not seen a social worker at the 72-hour review.
- They had not been asked if they had a complex dependency worker, home care support or tenancy officer.
- They missed the peer-to-peer support on the ward.
- They missed the activities on the ward. The ward had stopped the activities due to staff sickness.
- They had bought paint and flowers out of their own money, so they could paint the flower boxes in the courtyard and put plants in.
- They had not been referred to the Independent Mental Health Advocate.

We asked if we could improve one thing in mental health services what would that be.

- Improved communication between the staff and the patients.

- To have a care plan and be involved in that care plan.

- To have more activities on the wards. One suggestion was a beautician to make the women feel beautiful again.

- They told us that they wanted an admission pack, so they know all about the ward and what to expect during their stay.

- To improve the reviews that we have, as they are intimidating and daunting. There are lots of people up to six on the review panel as well as me.
Could the panel be made smaller to make it more friendly. I recently had a review with my consultant my mother and me and it was much better. A lot of patients are saying the same thing.

- They asked for better checks when you come back on the ward to stop people bringing drugs and alcohol on the ward.

Golborne Ward

Focus Groups told us:

- There was no continuity of care plans, some patients had received a care plan, others had not.
- They felt listened to by staff and that the staff communicated with them very well and that they were always courteous.

"They felt safe on the ward and were treated with dignity and respect"

- They had been involved and consulted with on their discharge plan, others had not.
- Hoping to go into supported accommodation or go to their own homes at discharge.
- They didn't know who the ward manager was.
- Their rooms were very good.
- The food was good. Sometimes you get three choices of meals to choose from.
- About having animal therapy on the ward which is good. Some people told us that they don't like the animal therapy.
- They are not allowed off the ward unsupervised.
- They are not asked to give their views on their stay on the ward.
- They had not seen any QR codes or posters about giving their views or experience.
- They didn't feel safe on the ward. They were frightened when people on the ward get aggravated.
- The staff do not listen to you.
- They sometimes had a 72-hour review.
- Not seen a social worker.
- They had not been asked if they had a complex dependency worker, home care support or tenancy officer whilst they were at home.

We asked if we could improve one thing in mental health services what would that be.

- They told us the beds need to be more comfortable as they dip in the middle.
- The patients said that one thing that they would like to see improved is more companionship and support for patients on the ward.

Priestners Ward

Focus Groups told us:

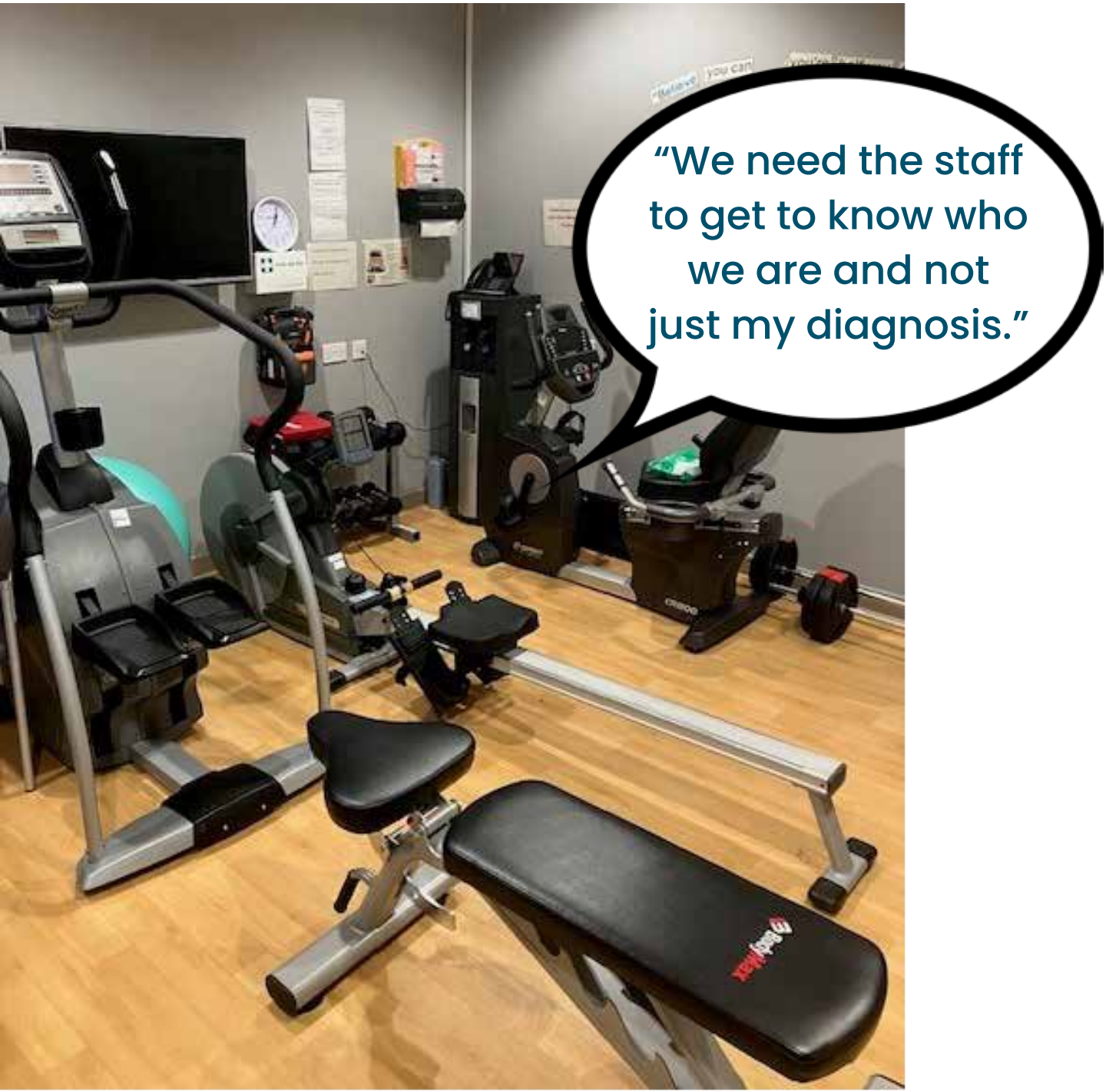
- About being in seclusion and not being given any cutlery and told to eat with their hands.
- They hadn't been involved in a care plan or given a care plan. Others didn't know what a care plan was.

"Don't feel safe on the ward due to some patients being aggressive"

- They were treated with dignity and respect on the ward.
- They knew who the ward manager was and named the person. The ward manager occasionally comes and talks to the patients. Others say the ward manager sits in the office and doesn't come and speak with the patients.
- Staff are good at communication and good at listening to you. Others say they go to speak to staff, and the staff say go and speak to someone else. It feels like you are being passed from pillar to post with no outcome. Staff don't speak to you at all.
- Patients with ADHD/Autism find it a lot harder to communicate with people. Staff think that you are being awkward because you are raising your voice, but it is our condition.
- We are sometimes asked to give views about our experience on the ward.
- The police come on the wards and give talks about racism, which was very good.
- How community services insist on using the crisis plan. There are no beds available when you need one.
- When we were in Prestwich at 17 years of age (children's) that service was good.
- We have been treated terribly.
- They had not seen a social worker.
- They didn't know where they were going to on discharge as discharge has not been discussed with us.
- Not been asked if we had any ongoing support at home such as a complex dependency worker, tenancy officer or home provider.
- We have good support in our supported accommodation.

We asked if we could improve one thing in mental health services what would that be.

- More access to beds when you need them.
- More communication between staff and patients.
- They asked if they could have a newspaper trolley/convenience trolly that goes around the wards.
- They asked for more access to talking therapies and bereavement counselling.
- They said communication between staff and patients' needs to be improved and we need to be treated like humans.
- Improve the mental health system it is so disorganised.



Sovereign Ward

Focus Groups told us:

- They had been involved and had knowledge of their care plans. Others didn't know anything about their care plans.
- Staff checked up on patients and providing lots of useful information, for example support groups for alcoholism and mental health after suicide attempts for when they are discharged.
- About not feeling safe on the ward. Others felt safe on the wards.
- Constantly pursue information.
- Been treated with dignity and respect from both staff and patients.
- That communication is an issue.
- When asking for medication we had to wait many hours for it to be given.
- They new what their discharge looked like; others had not spoken about their discharge.
- They would need to support with their discharge such as:

- They hadn't been asked if they had ongoing support at home such as a complex dependency worker, tenancy officer or homecare provider.
- They have had their mobile phone stolen which had all their private information on.
- They had been attacked by other people.
- They have been seen by the recovery team every day and the team had been very good.
- That social care services should be involved in the armed forces.

(veteran) discharge.

- How universal credits were threatening to send them to decision making appointments even though they were an inpatient (voluntary).
- Have a patient meeting every morning between patients and nurses to discuss issues like safety/improvements. But don't see any actions for improvement with the issues raised.
- They knew who the ward manager is.
- Staff never come out of their offices even when there are riots on the ward.
- When you want to speak to staff, they always say that they are too busy and to come back later. Other patients commented "staff are very good, approachable and are good at communicating with you".
- The ward manager does ask for their experiences of stay on the ward. Others had not been asked to give feedback on their experiences. The QR codes are no use as people don't have smart phones to scan them.
- We need to give honest feedback to improve the service.
- Others had a good experience of their stay on the ward.
- That staff could help more with the activities on the ward.
- They told us that the food was good.
- Are allowed to go off the ward for a few hours.
- Family visits are good.

"We are encouraged to do activities. We are having cooking classes, psychotherapy, pet therapy. Man Leigh comes on the ward which is good. We get together and just chat about anything and everything".

- They couldn't understand the clinical processes.
- Felt safe on the wards. We have security bands to let us in and out of our bedrooms.
- Felt listened to by the clinicians around their medication.
- Praised the social worker who was supporting them with housing/accommodation.
- How the support in the community fails. Staff from the recovery team not arriving when the visit has been planned.
- About being told you must be discharged to a homeless shelter/night shelter when we are vulnerable and there is a temptation of drugs/alcohol and fighting.
- The Dr wanted to increase my medication, but he listened to what I had to say about not increasing it.
- The Home-Based Treatment Team are good.

If we could improve one thing in mental health services what would that be?

- They told us that they would like more mindfulness activities as relaxation is needed.
- They asked could they have the pool table back on the ward as this gave the patients something to do socially, and it helped to pass the time on.
- The crisis team needs reorganising as they don't meet you halfway.
- Improve the visits from the recovery team as they don't come and visit when you say that they will.
- There are no patient information leaflets about any of the services provided.
- We need aftercare services like care in the community to support us properly when we are discharged.

General Comments

- I am transgender it was difficult trying to be allocated to the right ward. I didn't feel safe on the ward so locked themselves in their room especially at night.

- I don’t feel the hospital doesn’t enforce its own policies.

- I was brought in on a Section 136. It was so degrading in the 136 suites. There is no privacy and dignity when you go to the toilet. Everyone can see you what you are doing on the toilet. Staff stand there watching you.

Urgent Care

The new Makerfield Streaming Area is in the Emergency Care Department, Royal Albert Edward Infirmary, became operational in July 2023. We were keen to include this area in our project but wanted to give the service time to embed. We attended the service in mid-November to engage with the patients using the service.

Healthwatch Wigan and Leighs first impressions of the area as you walk on is that there are no windows on the suite and the area gives a feeling of being in a cellar or being underground. They have picture lights in the ceiling which can be changed to different pictures e.g. from daytime to evening. Unfortunately, the pictures cannot be changed due to not having the pin code to change them from night to daytime or any other picture or theme.

Makerfield Suite Streaming Area

People told us:

- They told us that that had been waiting for a bed for four days.
- They are willing to go anywhere in the country for a bed.
- They have been sleeping on two chairs that have been put together, they have a blanket and pillow.
- That the streaming area is good.

“The support workers have looked after me and have met some of my needs”

- That they have not had any medication since Sunday.
- The AE staff arrived with only one tablet and told the person that medication will need writing up and sending to pharmacy and that could take a while.
- That the last time they visited AE they were on the corridor for four days. They just got up and left as couldn’t.
- They asked someone to bring them a joint up to the area.

- They feel safe living in supported accommodation.
- They don't know if they have a care plan.
- They have been treated with dignity and respect whilst using mental health services.
- That they had positive stay on Sovereign ward.
- They had not been asked to give their views on their experiences of their stay, but the service was good.
- They don't have mental health they are here to see the alcohol specialist nurse.

Healthwatch Wigan and Leigh observations

- The support worker went across to Accident and Emergency Department to ask for the persons medication.

- Patients in the wrong place- should be with the alcohol services.

- A person trying to obtain illegal drugs from an outside source.

Independent Hospitals

We wanted to include independent hospitals in our project so that we could give the residents there an opportunity to give us their experiences of using mental health services.

Making Space Ashwood Court Independent Hospitals

We were given a warm welcome from the staff.

People told us:

- They liked the unit it was clean and well run.
- The staff were very kind and caring and that they were treated with dignity and respect.
- They felt safe living there.
- They liked doing the activities.
- They were going swimming and the driving range which was going to be free of charge.
- They have never seen a social worker for over eight months.
- They want to see a social worker more often.

HC One Rosebridge Court Independent Hospital

We were given a warm welcome.

People told us:

- That the staff were very busy seeing to the poorly patients.
- They were treated with dignity and respect.
- Discharge had not been discussed with them.
- They spoke to their social worker via a team's link and not face to face.
- The nursing staff were great.
- They were well looked after at Atherleigh Park.

Fir Trees Independent Hospital

We were given a warm welcome.

Healthwatch staff observations.

The building was very well kept and very well laid out. The rooms for the residents were well prepared and had great facilities to enable the residents to live as independently as possible. There was lots of information and artwork across the building that the residents had to help to make.

People told us:

Sovereign Ward

- There was nothing much to do in Sovereign Ward.
- They did not feel safe on the ward.
- The ward can be quite chaotic, that people were physically and verbally assaulted.
- That they didn't feel listened to.
- They did not have a care plan or had never been involved in the care plan process.

"We were not offered an Independent Mental Health Advocate (IMHA), others said that they did have an IMHA whilst on the ward".

- They didn't know who the ward manager was, others commented that the ward manager communicated well with them.
- They were not asked to give any views on their experience of their stay.
- They told us about violence, and they felt frightened and said it was horrible.
- They were treated with dignity and respect on the ward.
- They had had a 72-hour review and saw a social worker; discharge was discussed, and they asked if they had any ongoing support at home. Others commented that they saw a Dr but didn't see a social worker and no one asked them about discharge.
- They felt as though were going through a process on the ward.
- They felt as though they were in the wrong place for their needs.
- The food was good on the ward.
- They feel that the community mental health services are good.

"We do activities at Fir trees such as walking and going on outings. We are going to Chester tomorrow"

- They have been allocated an Independent Mental Health Advocate here at Fir Trees who is incredibly supportive.
- They were discharged to Fir Trees from Atherleigh Park. I like it here at Fir Trees
- They really like it here at Fir Trees
- They like doing the gardening here at Fir trees.


YOU ARE
capable
OF
amazing
THINGS


WELCOME TO FIRTREES
Denise O
Gill S
Neliah M
Jeff S
Matt J
Viv W
Kiel W
Julie C
Hannah S
Drew G
Lisa P
Julie W


faith
TRY
SMILE
TRUST
Kindness
HOPE
PEACE
LOVE
love

Supported Accommodation

We wanted to give the residents in supported accommodation a chance to give their views and experiences of mental health services.

Brookfield Supported Accommodation

We were given a warm welcome.

Healthwatch Wigan and Leigh reflection.

The accommodation felt homely and welcoming. The peer support process that is in place is outstanding.

People told us:

- They had a good smooth transition from Atherleigh Park to Brookfield.
- The peer support at Brookfield was also good.
- Residents come back for visits to Brookfield for support after leaving.
- About the residents going out together, watching sports, and having family visits.
- About supported pre-visits to move on accommodation so they are comfortable.
- That the Brookfield discharge pack was good and helped.

"How the staff supported them in the settling-in period at Brookfield"

- About their experience of Tunstall House and its member-led approach
- How staff support the various activities like cooking meals, newsletters, pool teams,

and computer room and the vibrant and supportive environment.

Feedback on Atherleigh Park

- That Atherleigh Park was the worst experience of their life.
- They felt ignored by staff especially during anxiety attacks.
- About being threatened to be discharged from the ward when they were having what they called " an episode.
- That staff were very often found sitting in their offices waiting for incidents to occur.
- That mental health services had the least investment compared to other health services.
- That their experience of Edenfield was characterised by a lack of attentiveness and disrespect.
- How they felt traumatised and stigmatised when the emergency services arrived at their home. They felt as though they could never go back to live in that neighbourhood again.
- About the ineffectiveness of the crisis line. Contacting the Crisis line whilst experiencing anxiety was an awful experience. The crisis line doesn't get answered all the time. They told us how slow the Crisis Team at Claire House are at responding to inquiries and the lack of communication even from duty officer.
- How the agency nurses prioritised medication for convenience and spoke to you in a condescending manner.
- About the incidents of drug dealing on the wards, including MDMA, cocaine and weed.
- About drug dealing being blatant at Atherleigh Park.
- They were never asked for any feedback on services provided to them.
- People have outdated phones that would not be able to cope with the QR codes on the feedback posters. "If the service wants us to feedback about our experiences, then we need the appropriate tools and methods to do so".

"How they had tried to get an emergency appointment with the recovery team and how they had to wait for seven days before they got a response. Access to medication reviews by the Recovery Team at Claire House are always delayed or your medication is discontinued without anyone contacting you"

- They spoke about how they waited for 12 hours in the emergency department to see the RAID Team. They had 5-minute conversation before they were sent home.

- About the RAID team allowing their abusive partner in the room during consultation, compromising their safety. “They should have asked me in private if I wanted to have my partner in the consultation with me”.

- They felt that they were discharged too early from the ward before a full recovery.

- They felt that there was a lack of support from the wards which caused them to be more stressed.

- What they considered to be inappropriate decisions to change medication without involving the patient.

- They felt that their condition got worse during their hospital stay.

- They felt that there was disregard to patient follow up appointments on the ward. They gave the example, by sending male personnel to female patients when females do not like males.

- They felt that Brookfield staff were left to manage the aftermath of the negative experiences that they had using the mental health services provided by Greater Manchester Mental Health Services.

The impact the focus group at Brookfield had on the residents from the manager at Brookfield.

“Thank you so much for your feedback at the Mental Health Forum yesterday, it was very humbling to hear. More importantly, the people at Brookfield really enjoyed the experience and appreciated being given the opportunity to share their experiences. Some said that it felt “therapeutic” and now feel that they can move on from some of the challenges, they have experienced within mental health services.”

Hardybutts Supported Accommodation

People told us:

- How they benefitted from the therapeutic and recreational activities provided. Such as relaxation therapies, gym sessions, cooking classes, table tennis, and animal therapy.
- Themed nights, like Jamaican nights were most enjoyable.

“The supportive services such as the quit smoking team who offered smoking patches to help to quit smoking”

- How the Depo clinic addressed specific needs and side effects related to medication.
- The pressure on staff having to deal with the demands from patients.
- They told us that the ward can be a crucial part of mental health support, providing a sense of community and understanding.

- They had faced some challenging and negative experiences within the mental health services, particularly at Atherleigh Park.
- They had concerns over the quality of the care they received.
- The staff responsiveness and concerns to the overall quality of care was not very good.
- The staff remaining in the office and didn't come and speak with the patients.
- Lack of care plans.
- Safety concerns, instances of assaults and drug related incidences on the wards.

Peoples suggested recommendations for improvements

Could we have admission packs for the wards. This will give us some insight into the ward and what to expect

When we are on the wards, and we have our reviews could we have the style of them changed please. Instead of six people facing you on the review could we fewer people please as this is so intimidating and daunting. I recently had a review just with the doctor myself and my mother and it was much better

We need more talking therapies and bereavement counselling.

Communication between staff and patients' needs to be improved, we need to be treated like human beings.

I would like to physically see the supported accommodation or have a video tour of the place rather than just be sent there.

Make the mental health system a proper system, as it's so disorganised.

We need more companionship and peer support

Complex needs shouldn't be under mental health services

The service could be improved by purchasing some more remote controls for the TVs. All the rooms shared one remote control.

Not to have to repeat myself day in and day out.

We should have a care plan and make sure that we are involved in the planning.

Change the way we are treated in AE on what judgement we are going to receive.

Employ empathetic people who are understanding and caring

Look at the beds on the wards to check the mattresses for comfort they are dipping in the middle

Feedback to the patients on any issues they have raised at the daily patient meetings

Would it be possible to have a diagonal door on the toilet in the 136 suites to aid our privacy .

Patients would like to see the community groups reinstated across the borough.

Home visits from the Clozapine Clinic.

Agency staff not to use their phones and speak in their first language whilst on the ward. They need listen to us. We are frightened to approach the agency staff especially when you have psychosis, and you think they are talk-ing about you.

Improve the streaming area in AE it only takes two people

Your voice for social care and health services in Wigan & Leigh

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