The Southmoor Suite

Enter and View Report

Contact Details	Southmoor Suite, Wythenshawe Hospital, Southmoor Road, Wythenshawe, Manchester M23 9LT
Visit Date and Time	15/05/2025 13:00pm-14:00pm
Healthwatch Manchester Representatives	Thomas Carr (HWM Staff) Neil Walbran (HWM Staff) Daniel Roberts (HWM Staff) Ada Mok (HWM Staff) Dan Stears (HWM Volunteer) Lilian Pons (HWM Volunteer)

Disclaimer

This report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Contents

About Us

Healthwatch Manchester (HWM) is the independent consumer champion for health and care. It was created to listen to and gather the public's and patients' experiences of using local health and social care services. This includes services like GPs, pharmacists, hospitals, dentists, care homes and community based care.

Emerging from the Health and Social Care Act 2012, a Healthwatch was set up in every local authority area to help put residents and the public at the heart of service delivery and improvement across the NHS and care services.

As part of this role HWM has statutory powers to undertake Enter and View visits to publicly funded health or social care premises. These visits give our trained authorised Enter and View representatives the opportunity to observe the quality of services and to obtain the views of the people using those services.

What is Enter and View

Local Healthwatch representatives carry out Enter and View visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act 2012 allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families and carers in premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

Healthwatch Enter and View visits are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch safeguarding policies.

In addition, if any member of staff at the healthcare service being visited wishes to raise a safeguarding issue about their employer, they will be directed to the Care Quality Commission (CQC) where they are protected by legislation if they raise a concern.

1. Background and Rationale

General information about the Service

Name of service: The Southmoor Suite
Type of service: Mental Health Assessment Unit
Description of service: 'The Southmoor Suite' is a dedicated space for patients experiencing a mental health crisis who present at the Emergency Department of Wythenshawe hospital. The Suite is a purpose-built mental health assessment area, providing a calm and comfortable environment for people in a mental health crisis, as part of the Trust's main Emergency Department. The area is be staffed by mental health professionals who complete mental health assessments and signpost people to the most appropriate treatment or service[1].
CQC Rating: There is no available CQC Rating due to this service only being opened recently (*December 2024*).

Purpose of the visit

The purpose of the visit was to:

- Observe the environment and routine of the venue
- Speak to patients about their experience in the practice, focusing specifically on the appointment booking system and consultations.
- Give staff an opportunity to share their opinions and feedback about the service.

[1] *New space opens at Wythenshawe Hospital to help people in mental health crisis*. NHS Greater Manchester Mental Health NHS Foundation Trust. Date Accessed 29/05/2025. Website link.

2. Methodology

2.1 Prior to the Enter and View taking place

All Enter and View representatives have been briefed and have agreed to abide by the HWM Code of Conduct and Infection Control policy.

HWM were offered a tour of the Southmoor Suite(SS) by Declan Meehan(DM), Interim Urgent Care Service Manager for South & Central Manchester at Greater Manchester Mental Health NHS Foundation Trust. This was refused by HWM, and he was told that we would be making an unannounced Enter and View visit in the future.

The visit was carried out over the course of one hour. The visit date and times are shown on the front cover of this report.

2.2 During the visit

Interviews and observational methods were used to give an overview of this service from a layman's perspective. This data was recorded using standard observation sheets and questionnaires developed by HWM.

Upon our arrival to the SS, we found that the department was locked and thus we couldn't go inside. Despite ringing the buzzer outside the department, no staff answered the alert.

Enter and View lead Thomas Carr(TC) walked to the A&E reception to inform their staff about our presence and intention. After providing the contact details for DM, the receptionist attempted to contact him to no avail. It was later established that DM does not work on the date we visited.

Nonetheless, a member of the reception staff subsequently allowed us access to the SS via key fob access. Upon entering the SS, we were surprised to find there were no staff or patients present in the department and that the door automatically locked behind us. As no HWM staff or volunteers had access to a key fob, we were locked in the department.

During this time, HWM staff and volunteers completed their observations of the internal environment.

Shortly after this, the Team Manager from the Mental Health Liaison Team was notified of our arrival and came to the department to speak with HWM and unlock the door for us to exit. TC then interviewed this manager.

This manager escorted TC into the A&E to a department colloquially known as 'Majors' whereby two further Mental Health assessment rooms were revealed for patients experience major mental health crisis, *see picture A for reference*.

Picture A

2 members of staff were interviewed in total. 0 patients were interviewed.

2.3 Following the Enter and View Visit

Immediately following the visit initial findings were fed back to the provider and other relevant parties in accordance with the HWM escalation policy.

An initial draft was circulated to the service provider to enable a response. The service provider was obliged to acknowledge and respond within 20 working days of receipt of the draft report. The response from the service providers is included at the end of this report.

3. Enter and View Observations

3.1 The External Environment

The building is accessible via wheelchair with complete step free access from the entrance to the A&E Department to the SS.

There was no external signage regarding the SS on any of the direction boards located outside the hospital, *see pictures B & C for reference*. However, inside the A&E Department there was clear signage towards the SS.

There are numerous large car parks as well as both Metrolink and bus stops within a close proximity to the hospital.


Picture B

Picture C

3.2 The Internal Environment

Grab rails have been installed within the SS however in order to get to this department, a person would have to walk through the A&E department where there were no handrails.

There were no staff upon our arrival to the SS to greet us nor to allow us entry into the department and thus the question of staff in this department being friendly and welcoming cannot be answered.

However, the staff in the A&E department were friendly and helpful when approached by HWM. Moreover, the Team Manager of the Mental Health Liaison Team was friendly and welcoming once she arrived.

Inside the SS, all doors were correctly signed. Specifically, the toilets in the department were signed both text based and in analogue form, *see picture D for reference*.

Picture D

There was staff contact information available in the A&E department, but this was not relevant to staffing at the SS where there was no information available.

There was no information available about advocacy in the SS. However, there was a poster about Samaritans however this was small and hard to see due to it being placed high on a notice board, s*ee picture for E reference*.

The main A&E had ample room for people however the SS was a lot smaller with only 1 chair in the department that could be classed as a ‘waiting area’, *see picture F for reference*. The SS itself was comfortable and relaxed albeit rather small.

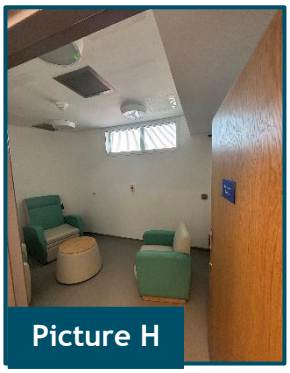
Picture E


Picture F

When TC was escorted to the 'major unit' in the A&E, he noticed PALS information was available in multiple different languages, *see picture G for reference*.

The lighting inside the SS was bright and made the department clear. There were some windows in the assessment rooms of the SS allowing for natural light to come in, *see picture H for reference*

Picture G


Picture H

The department itself was mostly clean however HWM staff/volunteers noticed that the bins were full and had not been emptied. These bins were also not secured to the floor, allowing for patients in distress to potentially use them to harm themselves or others.

HWM could not find any complaints / feedback policy on display in the SS. Moreover, there were some welcoming phrases on a notice board in the SS however they were all in English. There was no welcome sign in English nor any other language.

The hand towel dispenser and soap dispenser in the SS were both identified by HWM staff and volunteers as potential ligature points. The soap dispensers were also empty and thus posed the question as to why there were there, *see pictures I & J for reference*.

HWM staff and volunteers noticed numerous panic alarms located throughout the area to alert other staff and security when necessary, *see picture K for reference*.


Picture I

Picture J

As previously mentioned the bins inside the SS were not secured to the floor and thus were identified as a potential hazard to enable someone to harm themselves or others. The door fixtures were also sharp and could harm someone, *see pictures L & M for reference*.


Picture K


Picture L


Picture M

Further to this, Mental health team Leader Lottie Casson(LC) told TC that all staff wear PIP alarms when working in the SS.

Mental Health Laison Team Leader LC informed TC that the disabled access toilets contained ligature points and patients were assessed for ligature risk before being allowed to use them.

HWM noted that as the doors required key fob access to both enter and leave the SS, a patient would be unable to abscond easily for the department, making it a safe place for patients.

The location of the SS meant that patients entering the children's service next door would be able to view patients in the SS who would be experiencing mental health distress. This in turn could make the SS patients feel as though they are 'on show' and potentially worsening their condition.

3.3 Accessibility in the building

Although the corridors were wide enough for a wheelchair to be used, the chair in the corridor may block a wheelchair from getting through if a person is sat on it, *see picture F above for reference*.


Picture N

There was a disabled access toilet in the SS however this was locked so we could not assess this.

There were no ramps / lifts in the SS as it was only on one floor. Step free access was evident throughout the department, *see picture N for reference*.

3.4 Internal Safety

There was a fire exit door clearly marked in the SS however, no fire extinguishers were locatable – it may well be that these are kept in a locked area of the SS due to the nature of the care being provided there, *see picture O for reference*.

As previously mentioned, both the chair in the corridor and the bins were identified as potential hazards as they were not secured to the floor and thus could be an obstruction if moved.

There was a Fire Action Sign on the wall informing people what to do in the event of a fire however the assembly point was missing from this plaque, *see picture P for reference*.

Picture O

Picture P

5. Findings from speaking to Management

During the visit on 15th May 2025, we had the opportunity to interview the Team Manager for the Mental Health Liaison Team Lottie Casson. We asked a total of 9 questions ranging from whether or not they have enough training to carry out their duties well to their knowledge of other similar services in Manchester.

Lottie told TC that the SS is for low risk patients. She told TC that if a patient is of a higher risk, they will be sent to another part of the A&E via the 'streaming team' who prioritise patients based on their condition.

The Team Manager also told TC that she believes the staff have enough training to carry out their duties well. When asked about staff training, LC said that the majority of staff are up to date on their training however, the ones who are not are currently booked in to complete this.

LC also told TC that the department is not well staffed. She admitted that the department has not been used at times in the past due to their not being enough staff to operate it. LC felt as though there was an effective handover and continuity of care during shift changes and that she herself felt as though she was generally supportive towards her staff.

Moreover, LC said her working conditions were good as the SS itself is a brand new building which is comfortable and modern.

When asked to explain the procedure for someone to be sent to the SS. She said that if a person arrives in A&E and are presenting with a mental health issues, the A&E nurse will triage them and refer them onto the Mental Health Team (LC). From here, the patient will again be triage, this time by LC to assess the patient risk. If deemed appropriate, they will be taken to the SS. The SS is referred to as a 'Diversion Suite' and is specifically for low level risk patients.

SS is for patients who present minor mental health concerns. If a patient is in major mental health distress and are being /have a history of being physical toward staff (can be checked via their patient notes), they will be taken to the 'Majors' department in the A&E by the A&E Response Team. There are two rooms in this department for these 'high profile' patients, see *picture A above*.

When questioned about her knowledge of other services in Manchester like SS, LC told TC that there is a place known as 'The Green Room' in North Manchester General Hospital. Moreover, LC noted there was a further service based in Manchester Royal Infirmary however she couldn't provide the name.

LC told TC that the disabled access toilet in the SS was not ligature free due to the adaptations made for a disabled person when using a bathroom such as hand rails alongside the toilet. When questioned about this further, she said that a patients risk would be assessed before allowing them to use these toilets – if they are at risk then they will be escorted to another bathroom in the hospital or accompanied by a career or member of staff.

Moreover, LC noted that the security team present in A&E are trained in mental health awareness by their own company, not GMMH or MFT. However, they work closely with the staff in A&E and have a good understanding of patient needs.

7. Recommendations

A full access audit and signage review needs to take place in the Southmoor Suite.

Staff in the A&E reception should be made familiar with the Southmoor Suite and its necessity.

Staffing information should be made available for service users to see in the Southmoor Suite, for example an 'On-duty' staff board.

Make the Southmoor Suite space more flexibly by converting one of the assessment rooms into a waiting area to better ensure patient privacy.

Provide information on the notice board in the Southmoor Suite that is in both a larger print and alternative languages in order for it to be more comprehensible for service users.

Provide welcoming imagery and posters in the Southmoor Suite to improve the atmosphere for services users.

A review of all potential and current ligature points should be conducted as a matter of urgency.

An explanation of what the service is, when and how it should be used and how it is different from other pre-established crisis services should be made available for patients and carers to read as part of a publicly available Standard Operating Procedure.

Response from service provider

Healthwatch Manchester contacted staff from both the Greater Manchester Mental Health NHS Foundation Trust(GMMH) and the Manchester University NHS Foundation Trust(MFT) for a response to this report.

In collaboration with GMMH Chief Nurse Salli Midgley, Director of Nursing at MFT Paul Joynson-Robbins provided the following response:

17 June 2025

Dear Thomas,

Following your visit to the Southmoor suite, at Wythenshawe hospital on the 15th May 2025. Thank you for the report.

We have collaborated closely with colleagues in Greater Manchester Mental Health (GMMH), as this is a facility ran by them.

Below are our comments in response to your recommendations.

1. A full access audit and signage review needs to take place in the Southmoor Suite. Staff in the A&E reception should be made familiar with the Southmoor Suite and its necessity.

The ED Reception manager has shared the communication and briefing note re purpose of Southmoor suite, and accessibility to the unit. The telephone number has been reiterated to GMMH and an explanation given that it is a 'streaming service' whereby patients must be seen by an ED triage nurse, and discussed with GMMH Liaison Services and if accepted, will be taken to Southmoor suite by a member of GMMH staff. Due to the low usage of the unit at present, staff are not present in the unit 24hrs a day, but there would be staff if there was a patient in the unit.

2. Staffing information should be made available for service users to see in the Southmoor Suite, for example an 'On-duty' staff board.

Due to the functionality of the unit and the dynamics of the mental health team, if a patient is streamed to the unit, the next available practitioner would be allocated to the unit, therefore a staff on duty board would not be relevant. However, the Service Manager sets out clear expectations and standards about how to introduce themselves with their name and profession, what their role is and what the assessment process entails.

3. Make the Southmoor Suite space more flexibly by converting one of the assessment rooms into a waiting area to better ensure patient privacy.

Both MFT and GMMH staff do not consider this to be an appropriate use of the space. The rooms are purpose-built rooms, designed to safely assess MH patients.

4. Provide information on the notice board in the Southmoor Suite that is in both a larger print and alternative languages in order for it to be more comprehensible for service users.

GMMH staff have reviewed the information that they have on display and will consider use of larger prints and accessibility for other service users. Translator services are accessed when indicated.

5. Provide welcoming imagery and posters in the Southmoor Suite to improve the atmosphere for services users.

GMMH are sourcing some appropriate materials to soften the atmosphere for services uses and considering medical illustrations to detail the patient journey, like the ones in ED.

6. A review of all potential and current ligature points should be conducted as a matter of urgency.

Risk assessment re-reviewed. Health and Safety visit scheduled wc 16/6/26 with GMMH, ED and MFT MH Safeguarding team.

7. An explanation of what the service is, when and how it should be used and how it is different from other pre-established crisis services should be made available for patients and carers to read as part of a publicly available Standard Operating Procedure.

GMMH do not have a publicly available Standard Operating Procedure, and this is not something available in other areas of ED. GMMH have a patient information leaflet that details the purpose of the unit, as well as relevant information leaflets upon discharge.

As Director of Nursing for WTWA Clinical Group, I will work closely with GMMH and the Wythenshawe ED regarding the Southmoor suite and associated improvement work, and then this report is final. We will take this through the WTWA Governance process including our newly formed WTWA Quality & Patient Experience Improvement Group.

Acknowledgements

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