Care Quality Commission

Manchester Mental Health and Social Care Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
TAE01	Edale House	Central Home Treatment Team A&E Liaison Team Central	M139PH M13 9WL
TAE03	Park House	Safire Ward Home Treatment Team North	M8 5RB
TAE02	Laureate House	A&E Liaison Team South Home Treatment Team South	M23 9LT M20 2LR.

This report describes our judgement of the quality of care provided within this core service by Manchester Mental Health and Social Care Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by Manchester Mental Health and Social Care Trust and these are brought together to inform our overall judgement of Manchester Mental Health and Social Care Trust.

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement	🟠
Are services safe?	**Requires improvement**	🟠
Are services effective?	**Good**	🟢
Are services caring?	**Good**	🟢
Are services responsive?	**Good**	🟢
Are services well-led?	**Requires improvement**	🟠

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

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

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

Summary of findings

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Summary of findings

Overall summary

Section 136 of the Mental Health Act 1983 gives power to the police to take someone from a public place to a place of safety if they have a mental illness and are in need of care. The place of safety can be in a police station or health service premises such as a hospital.

The CQC inspected hospital places of safety. These were located at Wythenshawe hospital and at Manchester Royal Infirmary (MRI).

The place of safety at Wythenshawe hospital had a safe and suitable environment. At Manchester Royal Infirmary, in addition to the place of safety in the A&E department, there was a mental health assessment suite behind A&E for patients which opened in January 2015. We identified fixed ligature points in the mental health assessment suite that posed a risk.

The places of safety premises were provided by the acute hospitals but were staffed by Manchester Mental Health and Social Care NHS Trust staff.

At both places there were appropriate staffing levels and skill mix, assessment processes, multi-agency involvement and learning from any incidents. At the home treatment team, and the Swift Assessment for the Immediate Resolution of Emergencies (SAFIRE) unit we observed safe environments, staffing levels and skill mix, effective systems in place to assess people's needs and monitor risks. The teams used an incident reporting system, multidisciplinary staff worked well together and with others outside their teams, and they learned from incidents to improve future practice.

A clear assessment and physical health check was undertaken when patients arrived at both places of safety and on the SAFIRE unit, and any physical health problems were followed up appropriately.

Qualified staff undertook the co-ordination of admissions to the places of safety and clear guidance was available to them.

Throughout the services we visited we found that the care and support received by patients was positive. Patients told us that staff took their time, they didn't feel rushed when they were carrying out an assessment. Staff told us they were proud of the work they did.

Patients were fully involved in planning their care. Although care plans followed a set format and were not always individual to the person. Advocates were involved as appropriate and according to the person's wishes.

Patients had access to information in different accessible formats, and to interpreting and advocacy services if necessary.

The home treatment teams visited patients in their own home or met with them at the crisis and access team offices dependent upon their needs and level of risk. Patients were also supported by regular telephone calls or a level of contact agreed by both parties.

The teams had daily contact with the acute wards to identify people who might be appropriate for early discharge with support from the team. This included providing support to people during leave periods from the ward.

Staff told us they sometimes had problems accessing beds within the trust when a person required an inpatient admission. This often meant that out-of-area placements had to be arranged, resulting in delayed transfer from the place of safety.

Patients we spoke with knew how to raise any concerns they may have had.

Some staff were aware of the chief executive and board level leadership in the trust and were able to identify the trust values. Some staff told us they did not identify with senior managers within the trust.

Staff working in community teams did not feel they were valued by the trust and told us they did not think that staff engagement within the trust was meaningful. They cited being asked about the development of new services only to be told how they were going to be run just after the consultation. Staff felt management knew how they wanted to run the service and the staff input had no meaning.

It was not clear how data was used to measure performance improvement. The data provided at trust level about training uptake showed significant gaps in training.

Summary of findings

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

Are services safe?

We rated the mental health crisis services and health-based places of safety as **requires improvement** because;

- The environmental risk assessments of SAFIRE Unit, for ligature points did not include the grab rails in the bathroom and the use of plastic bags in the bedroom bins.

- Information was not provided at the ward door of SAFIRE Unit as to how an informal patient could leave the ward
- Staff did not have a safe environment to work in and the environment was not safe for patients who were in crisis and at risk of suicide.
- There was no separate day/dining area was provided for female patients.
- Blanket restrictions on the use of the outside space had not been reviewed and patients were not risk assessed as to how they could access this space.
- Staff at the MRI A&E liaison team did not have any equipment that would enable them to summon for assistance in an.
- Not all staff had completed the mandatory training.

However staff numbers were maintained at levels to ensure that patients' needs could be assessed. Whilst agency staff had been used to cover for vacancies and staff sickness they had used regular agency staff. The use of agency staff had been reduced.

Staff reported incidents and these were assessed to ensure correct action was taken to ensure these did not re-occur. Staff were informed of any lessons learned through team meetings and daily e-mails.

Requires improvement ●

Are services effective?

We rated the mental health crisis services and health-based places of safety as **good** because:

- Patients were included in the planning and development of their care plan. In the SAFIRE unit the care plans contained clear focussed goals to facilitate appropriate discharge.
- The managers had identified that supervision had not been provided consistently and had devised a plan for completion of supervision for the next 12 months. All of the managers spoken with recognised that staff performed better when they felt well supported and had development opportunities.

Good ●

Summary of findings

- Patients' rights were safeguarded as they had mental capacity assessments where necessary and staff consulted with them with regards to their treatment plans.
- Patients received a prompt and thorough assessment of their needs.

However we also found:

- That copies of paperwork for detained patients were not made by ward staff before the original paperwork left SAFIRE Unit.
- The roles and responsibilities regarding patient care were not clear between the acute and mental health trust.
- There was no audit system in place to ensure patients were receiving the most appropriate service from the Home Treatment Team.
- The daily handover of information for the north home treatment team was chaotic and suffered from several interruptions. This did not allow for the safe handover of sensitive information.

Are services caring?

We rated the mental health crisis services and health-based places of safety as **good** because:

- Staff were attentive and responded to patients in a calm and professional manner. This enabled them to obtain as much information in order to ensure the appropriate follow up services could be identified, if the patient needed any follow up support.
- Patients told us they were listened to and their preferences were included in their care plan where appropriate.
- Patients told us that staff respected the confidentiality of information they shared with staff.

Good ●

Are services responsive to people's needs?

We rated the mental health crisis services and health-based places of safety as **good** because:

- In all services the different needs of patients were taken in to account when planning and delivering care.
- There was good use of advocates and interpreters
- Care met culturally specific needs such as meal choice as well as choice of the gender of staff where possible.
- Patients told us they had been given information on how to complain. They told us complaints were dealt with in a satisfactory manner.

However we also found:

Good ●

Summary of findings

- That patients were not allocated named worker as they accessed the service this led to delays in the development of their care package.
- When patients on the acute wards needed support from the home treatment team on discharge there was no clear guidance of when to start the care planning process to ensure this was available on discharge.

Are services well-led?

We rated the mental health crisis services and health-based places of safety as **requires improvements** because:

- Staff did not think the trust engaged with them in a meaningful way.
- The central home treatment team was previously two separate teams and had not yet established systems for joint working.
- Staff were not aware of the whistleblowing policy.
- Staff did not have any reflective peer supervision sessions to ensure they could discuss and examine their decision making process.
- Staff told us they did not have confidence that they could raise concerns in a structured and confidential way.
- Staff in the teams told us that they did not feel as though they were part of the larger trust.

Requires improvement ●

Summary of findings

Background to the service

Manchester Mental Health and Social Care Trust was formed in April 2002 as one of only five mental health and social care NHS organisations in the country.

The trust offers a wide range of mental health, social care and wellbeing services to meet the needs of adults of working age and older adults in Manchester.

The mental health crisis service and health-based places of safety were situated in the Manchester City Council Area and included:

The Swift Assessment For the Immediate Resolution of Emergencies (SAFIRE) Unit provides support to individuals who were suffering from mental health crisis. The aim of the nine-bed unit is to provide an environment where further assessment could be carried out in order to find an alternative to inpatient admission.

The Trust's Mental Health Home Treatment Teams (MHHTTs), formerly Crisis Resolution and Home Treatment Teams provided an alternative to inpatient care by offering intensive community support. We visited the central, north and south teams. The aim of the service was to assertively engage with service users in crisis whilst minimising the degree of disruption to their lives and offering clear information to promote service user choice.

Support in a crisis could also be provided by the Mental Health Liaison Teams in A&E at Wythenshawe Hospital, Manchester Royal Infirmary and North Manchester General Hospital.

We also inspected the health based place of safety at Wythenshawe Hospital and Manchester Royal Infirmary.

SAFIRE was inspected as part of a responsive inspection in July 2012 following a serious untoward incident. On that inspection, we found that there were not enough qualified, skilled and experienced staff to meet the needs of people on Safire Ward. When we returned in November 2012 we found that the trust had addressed these issues and there were sufficient staff on Safire Unit.

The health-based places of safety and formal admission into hospitals processes were looked at as part of an MHA monitoring visit in 2013.

Our inspection team

Our inspection team was led by:

Chair: Steve Shrubb, Chief Executive Officer, West London Mental Health NHS Trust

Team Leader: Brian Burke, Care Quality Commission

Head of Inspection: Nicholas Smith, Care Quality Commission

The team that inspected this core service included CQC inspectors and a variety of specialists:

- A consultant psychiatrist
- An expert by experience who was a user of services
- A mental health act reviewer
- A mental health nurse
- An occupational therapist
- A psychologist

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

Summary of findings

How we carried out this inspection

To get to the heart of the experience of people who use services we always ask the following five questions of every service and provider:

· Is it safe?

· Is it effective?

· Is it caring?

· Is it responsive to people's needs?

· Is it well-led?

Before visiting, we reviewed a range of information we hold about mental health crisis services and health-based places of safety and asked other organisations to share what they knew. We carried out an announced visit during the week 23 March to 27 March 2015.

During the visit we met and interviewed 42 members of staff who worked within the service, including:

- Area managers
- Grade 6 nurses
- Grade 7 nurses

- Managers
- Pharmacist
- Pharmacy technician
- Psychiatrists
- Psychologists
- Senior house officer
- Students
- Support workers
- Social workers

We met with 10 patients who were using the services who shared their views and experiences of the services we visited. We spoke with two carers. We carried out four home visits.

We observed how patients were being cared for and reviewed care or treatment records of 24 patients. We looked at a range of records including clinical and management records.

During the inspection of the core services we completed a Mental Health Act monitoring visit on the SAFIRE Unit.

What people who use the provider's services say

Patients who used the service all told us that the service they received was positive, supportive and staff took in to account their personal preferences. This included the gender preference of the worker allocated to support them.

Patients told us they were involved in their care plans and staff talked to them about what they wanted to achieve.

Areas for improvement

Action the provider MUST or SHOULD take to improve
Action the provider MUST take to improve

- The must ensure that environmental risk assessments for ligature points of SAFIRE unit are updated to include the grab rails in the bathroom and the use of plastic bags in the patients' bins.
- The trust must ensure that it provides care in line with the same sex accommodation guidance.

Action the provider SHOULD take to improve

- The trust should ensure that Information is provided at the ward door as to how patients who are informally detained can leave the ward.
- The trust should ensure that blanket restrictions placed on the use of the outside space for patients on SAFIRE unit are reviewed based upon an individual risk assessment.
- The trust should ensure that staff are provided with equipment which will enable them to summon assistance if required.

Summary of findings

- The trust should ensure that all staff complete the mandatory training.
- The trust should ensure that copies of paperwork for detained patients are made before the original paper work leaves the ward.
- The trust should ensure that a copy of the AMHP report is available in the patients file.
- The trust should ensure that roles and responsibilities regarding patient care are clear between the acute and mental health trust.

- The trust should develop an audit system that monitors patients who receive treatment from the HTT for longer than six weeks to ensure patients are receiving the most appropriate service and are not being disabled by service provision when it is not needed.
- The trust should ensure that the daily handover of information is done without interruption.

CareQuality Commission

Manchester Mental Health and Social Care Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Central Home Treatment Team A&E Liaison Team Central	Edale House
Safire Ward Home Treatment Team North	Park House
A&E Liaison Team South Home Treatment Team South	Laureate House

Mental Health Act responsibilities

Staff understood their responsibilities with regards to the Mental Health Act (MHA). The teams we visited delivered care in line with the MHA and the MHA Code of Practice.

Detention paperwork seen was filled in correctly. However when detained patients arrived on the ward the paperwork was sent to the MHA office without copies being made. This meant there was time that detention paperwork was not available on the ward, this could lead to errors in treatment. We also noted that none of the files reviewed contained a copy of the Approved Mental Health Professional (AMHP) report.

Staff had access to training around the MHA. However compliance with this varied across the service. Staff had access to advice and support from a mental health officer within the trust team.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with were aware of the statutory requirements of the Mental Capacity Act(MCA) .

We saw that capacity was recorded in people's care plans within the holistic assessmen. People were presumed to have capacity and this was evidenced by a tick box within the assessment which would be completed when initially completing the assessment. This appeared to be part of the assessment for all patients and this reflected the principles of the MCA.

Are services safe?

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

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

Summary of findings

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Our findings

SAFIRE Ward

the Swift Assessment for the Immediate Resolution of Emergencies (SAFIRE) unit was clean and tidy. The ward consisted of nine beds which included a four-bed bay for female patients with dedicated bathroom facilities. Another four-bed bay was for male patients and they had separate bathroom facilities. There was one single room which had en suite facilities. This room was used when patients between 16 and 18 years of age were admitted to the ward, or when someone was very unwell. The en suite facilities included a shower. This meant that patients' dignity was maintained.

Bathroom, shower room and toilets were not identified as gender specific. No separate day/dining area was provided for female patients.

The environment had been risk assessed for ligature points. The last audit was carried out on the 22 July 2014. However this did not identify the grab rails in the bathroom or the plastic bags in the waste bin as risks. This meant that risks were not reduced or managed.

There was no dedicated seclusion room on the ward. If a person needed to be secluded they had to be taken to the psychiatric intensive care unit on Juniper ward to use their seclusion facility. The use of this facility was dependent on the seriousness of the patient's condition but we did not see any evidence that it was used on a regular basis.

The ward operated as a locked ward and accepted both detained and informal patients. There were no instructions near to the door as to how someone who was an informal patient might leave. However, staff and patients told us they could leave the ward if they asked.

The use of the outside space was restricted to allowing patients 15 minutes an hour outside. This restriction had been put in place following an incident involving a patient attempting to abscond. The fence had since been made higher but the restrictive practice had not been reviewed.

Safe staffing

Staffing on the ward included two qualified nurses and three support staff per shift during the day. Staff confirmed that these staffing levels were maintained during the day time except in exceptional circumstances such as someone calling in sick at the last minute. Night staffing was provided by two qualified nurses and two support staff. The ward used the same bank staff on a regular basis although the use of bank staff was reducing as permanent staff had been recruited to post. Patients had a named nurse or support worker whilst on the ward. They also had access to occupational therapists and a doctor if they required extra support.

We were informed that staff training was recorded by the unit manager and the unit was achieving 93% in core mandatory training.

Assessing and managing risk to patients and staff

SAFIRE ward was an assessment ward designed for patients to spend a maximum of 72 hours whilst they had a full assessment of need and where necessary future care pathways were identified. Patients arrived on the unit with a risk assessment carried out by the referring agent. Staff re-assessed the patient on a daily basis until they were discharged. Patients who required extra support such as 1:1 observations were known to the staff and appropriate support was provided.

Reporting incidents and learning from when things go wrong

Incidents were reported on a system called DATIX. Staff completed the form and the information was reviewed by a manager, who determined if further action was needed. Incidents recorded included medication errors, incidents of violence, issues with drugs and alcohol, and any form of abuse to either other patients or staff. Incidents were discussed at the daily multidisciplinary team meeting and more serious matters were fed back to staff in a daily email.

Are services safe?

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

Manchester Central, North and South Mental Health Home Treatment Teams (MHHTTs)

Safe and clean environment

The base was used for appointments with patients whilst they received a service. Risks had been identified and mostly addressed. However, the home treatment team (HTT) at Park House were still waiting for personal alarms to use in an emergency. The manager informed us that they were expecting delivery of these alarms within the week.

Safe staffing

The central HTT had used a high proportion of agency staff due to staff shortages within the team. The vacancy rate was 7.8% in the north team, 11.6 in the central team and 4.4 in the south team. The sickness rate was 5.7% in the north team, 7.3 in the central team and 4.6 in the south team.

Managers told us these shortages were due to long term sickness and the failure to recruit to vacancies promptly following the reorganisation of the service. During our visit we met agency workers whose contracts were not being renewed as permanent staff had been recruited. All of the teams felt they were understaffed for the quantity of work they were expected to manage. The managers of the three teams told us that they had been carrying a high proportion of people who used the service. At the start of the year the North team had 90 patients between 17 care co-ordinators and the central west team had 78 patients between 19 care co-ordinators that they were providing a service to. During the inspection we noted these figures had dropped to approximately 45 this meant staff case loads were more manageable.

We reviewed mandatory training records across all the service visited. We found that in one service 61% of staff had completed the core mandatory training whilst in another unit only 57% of staff had completed the training. This included training for managing violence and aggression and disengagement including conflict resolution. This represented a low proportion when compared to similar services.

Assessing and managing risk to patients and staff

The assessment and treatment records reviewed showed us that staff had assessed people's historical risks and behaviours. Care plans were in place to address current risks and individual needs. These had been regularly reviewed and re-assessed following staff engagement with the person who used the service.

Individual concerns about people who used the service were discussed at team meetings and daily handover meetings. Training records provided showed that a maximum of 57% of staff had completed the mandatory managing violence and aggression training.

When patients had been assessed as requiring particular support this was provided such as to whether two staff should visit, what the gender of staff should be and should visits take place at the home address or in the office. Staff were aware of the lone working policy and used a system called 'ARGYL' for checking in and out of visits via their phone. This ensured that other people knew if staff were late or could be in trouble.

We found that only 71 to 73% of staff had completed safeguarding of vulnerable adults training. Staff knew what action to take if they suspected a safeguarding incident had occurred. We saw records to demonstrate what actions had been taken where safeguarding had been identified. Information was available in each of the offices to remind staff about cultural differences that may constitute a form of abuse such as forced marriages.

Reporting incidents and learning from when things go wrong

There were mechanisms in place to report and record safety incidents, concerns and near misses.

Staff used a system called DATIX to report all incidents. Whilst learning from serious incidents throughout the trust was shared with all staff we did not see any evidence to show that incidents on DATIX were assessed with any themes being identified and being fed back to staff.

Manchester A&E Liaison North, South and Central Teams

Safe and clean environment

The trust did not manage the environment of the health based place of safety which were based within the emergency department of the acute trusts. The environments of these suites did not meet the requirements of the Mental Health Act Code of Practice and

Are services safe?

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

best practice as determined by the Royal College of Psychiatrists. The place of safety comprised of a room or a suite of rooms with specialist furniture that provided a safe space for someone who was in crisis.

We visited two A&E Liaison teams. One was situated in the A&E department of Manchester Royal Infirmary (MRI). The other team were situated on the site of Wythenshawe Hospital away from the A&E department. The liaison team situated at the MRI had just moved into dedicated rooms at the A&E department. We found that there were two assessment rooms, a central waiting or sitting area, a staff kitchen and office. There was a staff toilet accessed through a coded lock. These toilets had a suspended ceiling and a door that did not open 180% so was a barricade risk. The environmental issues meant that staff did not allow patients to use these toilets. There were no dedicated toilets for patients, who had to use facilities in the A&E department. This arrangement was not safe for patients who may be at risk of harming themselves.

Within the MRI unit there was a lack of an emergency response system and response staff. This meant that the safety of the patient, other patients and/or the staff was compromised.

Staff working at Wythenshawe Hospital were situated away from the main hospital and had to walk across a dark car park to the A&E department at night, which could present a risk to staff safety as they worked alone at night. There was an interview room in the A&E department but this did not afford good privacy. During one interview we witnessed, staff from the acute trust walked into the room twice during an assessment of someone who had presented with suicidal thoughts.

We have passed these concerns to the CQC relationship holders for these providers for their information and consideration.

Safe staffing

The A&E Liaison units were staffed in such a way that enabled patients who visited to receive a prompt assessment where possible. The night staffing was one qualified nurse on duty. Staff on the day shifts received support from psychologists and consultant psychiatrists as well as health care assistants. Staff working on the night

shift could contact the community mental health teams for advice and support. General medical issues were dealt with either by a doctor from the acute hospital or by the patient's GP.

We reviewed mandatory training records across all the service visited. We found that 76% of staff had completed the training. This included training for managing violence and aggression and disengagement including conflict resolution.

Assessing and managing risk to patients and staff

Assessments of patients in A&E departments were completed by trained staff, either a qualified nurse or a consultant. We witnessed two assessments and staff were observed taking time to record as full a history as possible and to discuss the pathways that were appropriate for the patient.

Staff followed the trust's lone working policy and let their colleagues know where they were. The A&E liaison team based at MRI did not have pin point alarms at the time of our inspection.

Staff knew what action to take if they suspected a safeguarding incident had occurred. We saw records to demonstrate what actions had been taken where safeguarding had been identified.

Staff were still waiting for the pinpoint alarm system, this is a personal alarm that staff can carry and keep with them when they are interviewing patients.

Reporting incidents and learning from when things go wrong

There were mechanisms in place to report and record safety incidents, concerns and near misses. The trust-wide evidence provided showed us that the trust was reporting concerns appropriately through the National Reporting and Learning System.

Staff used a system called DATIX to report all incidents. Whilst learning from serious incidents throughout the trust was shared with all staff we did not see any evidence to show that incidents on DATIX were assessed with any themes being identified and being fed back to staff.

Are services effective?

Good 🟢

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

Summary of findings

Our findings

Safire Ward

Assessment of needs and planning of care

Care plans were stored electronically using a system called 'Amigos'. We looked at four sets of care plans. Each patient had a comprehensive assessment completed as part of the assessment process which included the patient's social, cultural, physical and psychological needs and preferences. There was also a risk assessment for identified risks. A care plan was then developed with the patient. The care plans we looked at were reviewed regularly, centred on the needs of the individual person and demonstrated a knowledge of current, evidence based practice.

Initial care plans were written on admission and reviewed, within the first 48 hours by the allocated named nurse and where possible, with the involvement of the patient. The consent of the patient had been sought in the care plans that we looked at. Family, friends and advocates were involved as appropriate and according to the patient's wishes. However; it was not always recorded when the person had chosen for others not to be involved.

Care plans were goal oriented and had clear pathways of referral to other services such as community teams, inpatient admission, or discharge.

Best practice in treatment and care

The service offered information to patients who used the service about referral to psychological therapies as guided by the National Institute for Health and Care Excellence. However we found that patients who were assessed as being suitable for psychological therapies were waiting up to 18 months to access the service. There had been no growth in provision despite evidence that this issue had been raised with commissioners of the services on numerous occasions. There was no information from the trust about how these delays would be managed.

Staff told us they were able to refer people for their physical health needs to the appropriate health care professionals, such as physiotherapy services or to the person's general practitioner.

Skilled staff to deliver care

SAFIRE ward is a short stay assessment unit. Staff involved in the multi-disciplinary meetings included the consultant psychiatrist, a junior doctor and a qualified nurse. Patients were discussed in detail on a daily basis with the whole team. Pathways were discussed and staff worked with the patients to ensure they received the support they required.

Staff told us they had an annual appraisal and were aware of their own personal development goals. We saw evidence that staff were being supervised on a regular basis.

Multi-disciplinary and inter-agency team work

We observed a team handover on the morning of our inspection which was attended by the majority of staff and included the consultant and junior doctor. We found this to be an effective system for communicating important information between staff on issues such as levels of risk, referrals and assessments, bed management and allocating tasks for the day.

The team had established positive working relationships with the community mental health team, home treatment teams and social services. They also referred patients and/or their carers to voluntary groups where they could also get support.

Adherence to the MHA and the MHA Code of Practice

Data we received from the trust informed us that 10% of staff needed Mental Health Act, refresher training. The ward manger confirmed that this was still to be booked.

SAFIRE ward was subject to a scheduled Mental Health Act monitoring visit during our inspection to check adherence to the Mental Health Act and Mental Health Act Code of Practice.

Four of the patients on SAFIRE ward were detained. We saw from their records they had been told of their rights under the Mental Health Act (MHA) on admission and this had been repeated at different intervals dependent on their acuity. All patients had signed consent forms for treatment.

Detention paperwork seen was filled in correctly. However when detained patients arrived on the ward the paperwork was sent to the MHA office without copies being made. This meant there was time that detention paperwork was not

Are services effective?

Good ●

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

available on the ward, this could lead to errors in treatment. We also noted that none of the files reviewed contained a copy of the Approved Mental Health Professional report.

Information was displayed throughout the ward about independent health advocacy (IMHA) services and patients told us they had been informed that if they wanted an IMHA or an advocate then one would be provided for them.

We found that for all four detained patients no copy of the relevant full AMHP report was contained in the unit case records.

Good practice in applying the MCA

Staff were aware of the statutory requirements of the Mental Health Act, Mental Capacity Act and Codes of Practice.

Capacity assessments had been recorded at the time of detention. This was a simple assessment and patients' capacity was reviewed at the daily care reviews.

Manchester Central, North and South Mental Health Home Treatment Teams (MHHTTs)
Assessment of needs and planning of care

We looked at 12 care records over three teams. They contained detailed assessment information with associated risk assessments. There was a history of previous admissions detailing what the presenting issues were. Patients were called in for appointments to check their medication with the consultant psychiatrist. This gave patients an opportunity to discuss their medication and to be sure it was appropriate for them. Staff told us that they did not have a strategy detailing the patient pathway from accessing the service to their discharge. The service's optimum length of time with the service was six weeks, however on initial assessment patients were not informed of the possible timescale of the admission in to the service.

Services monitored physical health care needs and we found that referrals were made to the patient's general practitioner when concerns were identified.

Best practice in treatment and care

Staff used the Health of the Nation Outcome Scale (HoNOS) to monitor people's progress.

All teams used electronic records which were accessible to all staff.

The service was able to offer information to people using the service about referral to psychological therapies as guided by NICE.

Patients' confidentiality was assured through password protected access to computers. Any faxed information was sent without any identifiable information

Patients told us that staff sought their consent before offering treatment and carers felt they were involved in the assessment process.

Skilled staff to deliver care

We saw one example where a member of staff had been funded to do extra study pertinent to their work. This was only available to staff who have completed 100% of your mandatory training.

The managers for the three services we visited had been in post since December 2014. They all advised that they had not managed to complete a supervision schedule at the time of our inspection. However, they had managed to complete staff appraisals and had planned sessions for the following year to ensure formal supervision was completed. The trust policy on supervision was clear in stating that clinical supervision was the responsibility of the individual to organise and management supervision would be provided by the persons line manager.

Multi-disciplinary and inter-agency team work

Staff reported effective team working within the local teams. This was supported by our initial observations. Teams were multi-disciplinary in composition. The psychologist time in the North HTT had been reduced from five to two days a week. This meant that the psychologist only had time to do initial assessments and then patients were placed on a waiting list for talking therapies.

We observed a multidisciplinary team meeting and a daily handover meeting in three of the services we visited. We found this to be an effective system for communicating important information between staff such as risk, referrals and assessments, and allocating tasks for the day.

However, the daily handovers in the central (west) HTT was less effective. We observed that a member of the community mental health team was working in the HTT office as their office did not open as early. Staff had left private phones switched on and these were continually ringing. No one was seen to answer the office phones. Staff

Are services effective?

Good 🟢

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

were seen to wander in and out of the office which was clearly disruptive to the handover. These interruptions meant information could be lost within the noise and people's care could be compromised with key information about care, treatment and risk potentially being missed. This observation was fed back to a manager before we left the unit.

The managers were starting to identify staff as 'champions'. For example in one team staff had been designated as champions in finance and welfare checks, anxiety, housing and they had access to a nurse prescriber.

We found the communications and systems between the different teams to be confusing. The routes in to the HTT were via the urgent care assessment team (UCAT). This team carried out assessments and then signposted people to the service they needed. If a patient was seen at A&E they determine the HTT was the best route to be treated they still had to be re-assessed by the UCAT. Patients told us that they found the continual need to be assessed before accessing the service they needed, to be time consuming and frustrating. Also the HTT had no maximum case load leading to difficulties in patients ability to move through the appropriate treatment pathway and impacting on the effectiveness of the delivery of care and treatment.

Adherence to the MHA and the MHA Code of Practice

Where patients were on a community treatment order the relevant legal documentation was completed appropriately in those records reviewed. Staff were clear about the procedure and processes involved if a person required assessment under the Mental Health Act.

Staff were knowledgeable about the Act and the code of practice. They were aware of their responsibilities around the practical application of the Act. However training records showed that not all staff had received refresher training. Only 29% of staff working for central area home treatment team had completed their refresher training on the Act, whilst 53% of the north HTT had completed this training.

Good practice in applying the MCA

Staff said they knew about, and had received training on the Mental Capacity Act and the implications this had for their clinical and professional practice. However, in the central HTT only 24% of staff had completed the refresher

training on the Act and only 29% had completed their deprivation of liberty safeguards (DOLs) training. In the North HTT 59% had completed their refresher training in the Act and 59% had completed their DOLs training.

There was evidence in assessment and treatment records that capacity assessments were being completed appropriately and were being reviewed as required.

A&E Liaison Services Manchester North, South and Central

Assessment of needs and planning of care

Patients who accessed the A&E liaison service had an assessment of their needs. The assessments included why they had presented to the service, social and family backgrounds and physical health issues. Staff dealt with patients in a calm and professional manner. This enabled them to get detailed information about the patient. Assessments seen were comprehensive.

Best practice in treatment and care

Where patients between 16 and 18 years of age were seen they were referred to the children's and adolescent mental health service (CAHMS). If they were not able to refer the patient to CAHMS staff consulted with a member of the CAHMS team to ensure the best possible treatment was provided.

Skilled staff to deliver care

Staff working in the A&E liaison services were all experienced nurses. They had an appraisal and their supervision session were planned in for the year. This was in line with trust policy.

Multi-disciplinary and inter-agency team work

We observed an admission at Wythenshawe Hospital to the place of safety where the police had brought someone in. Staff called for the duty AHMP so that a full assessment could be carried out once the police had left.

The police told us they had a good working relationship with all the units.

Adherence to the MHA and the MHA Code of Practice

The relevant legal documentation was completed appropriately in those records reviewed. The access and assessment teams were clear about the procedure and processes involved if a person required assessment under the Act.

Are services effective?

Good ●

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

Staff were knowledgeable about the Act and the code of practice. They were aware of their responsibilities around the practical application of the Act. Training records showed that over 60% of staff had completed the refresher training as required by the trust. staff had been booked on to update their training whilst some staff had been on long term sick and needed to organise an update.

Good practice in applying the MCA

Staff were aware of the statutory requirements of the Mental Capacity Act . However on Ward A8 at Wythenshawe Hospital we visited, a patient who was ready for discharge. The liaison staff found the patient was on observations and their movements were restricted. Staff on the acute ward and staff from the liaison team were unclear as to whose responsibility it was to provide a capacity assessment and apply for a deprivation of liberty safeguard, or whether the restrictions put in place were necessary.

We have passed these concerns to the CQC relationship holders for these providers for their information and consideration.

Capacity assessments had been recorded at the time of detention. This was a simple assessment and patients' capacity was discussed at the daily care reviews.

Are services caring?

Good 🟢

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

Summary of findings

Our findings

Safire Ward
Kindness, dignity, respect and support

We saw staff working on the ward deliver care to patients who were in acute phase of their illness. This was done in a caring and response way. One interview had to be suspended as the staff member was needed to attend an incident. Staff responded to the patient in calm, swift way with care and dignity and this situation was resolved quickly.

The involvement of people in the care they receive

The service provided support to patients who were experiencing an acute crisis and deterioration in their mental health. They were assessed and if possible staff discussed options for follow up care following their visit to the emergency department.

Patients told us "staff are respectful and kind", "they respect my personal space and my confidentiality". Another person told us "staff are great. They respect us, give us time and help us with our issues".

The involvement of people in the care they receive

The service is a short term assessment ward with an optimum admission time of 72 hours. Patients are unwell and often distressed on admission. Staff explained their rights to them and where possible included them in the care planning process. One patient told us "yes I got a care plan but due to the short nature of my stay it was only a little one".

Manchester Central, North and South Mental Health Home Treatment Teams (MHHTTs)
Kindness, dignity, respect and support

We attended four home visits and found interactions during these visits to be respectful and friendly.

We observed staff treating patients with dignity and respect and they delivered support and treatment in a way that took into account patients' wishes. Staff were aware of the requirement to maintain person confidentiality at all times. People told us; "they (the staff) always ask what I want to happen and they are the best" and "they have helped me to find other support and they encourage me to go out and to try new things"

The involvement of people in the care they receive

Staff involved patients with their decisions and care planning. We found that assessments were detailed with individual preferences including the preferred gender of staff. People were asked their opinions and these were documented.

Carers told us that they felt involved by staff in the assessment and treatment being provided to their relative.

A&E Liaison Services Manchester North South Central
Kindness, dignity, respect and support

We observed several assessments. One patient described their last interaction with the service as 'terrible'. One of the assessments we observed did not appear to have any structure, with the assessor asking a series of questions that appeared to jump from one thing to another. The patient told the observer "they have missed big pieces and it was like an interview". This was said in front of the nurse. The other assessments observed were completed in a calm and professional manner. They completed a risk assessment and a basic assessment of their immediate needs. Patients said 'they took their time talking to me, I didn't feel rushed' and 'I feel better for speaking to them'.

Other staff observed undertaking patient interviews were polite, patient, caring, and respectful, had good listening skills and patients' privacy and dignity were maintained.

The involvement of people in the care they receive

The service provided support to patients who were experiencing an acute crisis and deterioration in their mental health. They were assessed and if possible staff discussed options for on going care following their visit to the emergency department.

Are services responsive to people's needs?

Good ●

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

Summary of findings

Our findings

Safire Ward
Access, discharge and bed management

SAFIRE Unit was a nine bed short term assessment ward. Patients were moved to more appropriate services after a maximum of 72 hours. Discharges were discussed each morning and a check on available beds was carried out twice a day. We saw that patients were being directed to other services such as alcohol services, an inpatient bed, and discharge home with support.

The ward optimises recovery, comfort and dignity

The ward had two four bed units that had partition walls between the beds plus curtains. Whilst some privacy was maintained, distressed or restless patients resulted in the other patients having disturbed nights. There was one single room and this was used for patients with a high acuity or for a patient between the ages of 16 - 18. What this meant was that patients were often moved around to accommodate the most distressed/unwell patients.

There was a communal lounge, a dining room and two small interview rooms. Access to the courtyard was through the lounge. There was no dedicated activity room on the ward but staff did facilitate some activities dependent on patients' acuity and interests.

Meeting the needs of all people who use the service

There was information on the ward about advocacy services and this was available in different formats for people from different cultural backgrounds, patients with learning disabilities and patients with sensory problems. Patients told us they could access support for their faith if they wanted to. Patients were asked for their menu choices two days in advance and cultural and social choices were available.

Interpreters were used when necessary to ensure that patients fully understood what had happened.

Patients did not have access to the internet while on the ward.

Listening to and learning from concerns and complaints

Information about raising concerns and complaints was available to patients who used the service and their carers. Information was also available on the trust's website. This information could be made available in different languages.

Patients could raise their concerns about their care and treatment through a number of trust supported services. For example, the independent mental health advocacy service and the PALS (patient advisory and listening service).

Some people told us that when they had raised individual concerns, these had been addressed appropriately.

Manchester Central, North and South Mental Health Home Treatment Teams (MHHTTs)
Access and discharge

Senior staff in the home treatment teams reported that some people were difficult to discharge due to staffing shortages in the teams in the Manchester area.

They also told us that they were discouraged from discharging anyone from the HTT when they required support from another team, such as the community mental health team, until those services had capacity to take on new referrals. This meant that staff had to continue supporting people who needed a different service.

We saw that some people had remained with the service for six months when the service aim was six weeks. We found that because other services such as early intervention and community mental health team had stopped accepting referrals because of their work load, patients requiring these services continued to require on going support by the HTT.

At the central west team the manager had carried out a named worker review of patients held since September 2014. The manager had been in post only since January 2015. They identified that patients had waited as long as 2 months for a care coordinator to be allocated. We identified three patients who had not had a care coordinator allocated. None of these patients had a clear care plan, two had since been discharged from the service but one patient had been admitted to SAFIRE ward because their mental health deteriorated.

Are services responsive to people's needs?

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

We identified In another instance, a patient who was identified as requiring additional support from the community mental health team (CMHT). The CMHT did not have capacity to take this referral so the patient continued to be supported by the home treatment team. There was no clear care plan for the handover of this patient, and this had not happened at the time of our inspection.

We noted that with the exception of the central team phones were answered in a timely manner

Meeting the needs of all people who use the service

Staff had access to translation services and interpreters where required. Some staff had received their mandatory equality, diversity and human rights training. We found that the training figures varied between 31% and 57% according to those training records seen in different services.

There was a trust provided interpreter and translation service. There was an independent advocacy service available and staff were aware of this. Information leaflets were available in all of the services inspected. Staff informed us that these would be given to people as required. Some people told us that they had received condition specific information leaflets from staff.

Listening to and learning from concerns and complaints

Information about raising concerns and complaints was available to patients who used the service and their carers. Information was also available on the trust's website. This information could be made available in different languages.

Patients could raise their concerns about their care and treatment through a number of trust supported services. For example, the independent mental health advocacy services and PALS (patient advisory and listening service).

Some patients told us that when they had raised individual concerns, these had been addressed appropriately. Staff discussed any issues raised in team meetings and they received daily emails raising any issues around practice or highlighting where something has been done well.

A&E Liaison Services Manchester North, South and Central
Access and discharge

Patients accessed A&E Liaison through the accident and emergency department, and also through wards in the hospital. The majority of patients seen by the team were people who had self-harmed or attempted suicide.

Two of the three services inspected contained low stimuli rooms with soft furnishings that enabled patients to be seen in a safe environment. At the Manchester Royal Infirmary, the S136 Place of Safety was in the A&E department. A separate mental health assessment suite was opened in January 2015 to allow the ongoing management of people once diverted or discharged from the A&E department.

Staff told us they were under pressure to move patients from the emergency department and patients were transferred and moved to the place of safety within the four hour emergency department indicator. Patients had to be checked back in to the emergency department if they required general treatment once their mental health had been assessed. We received information from an anonymous source that indicated this was usual practice. Staff in the units confirmed they were under these pressures.

The majority of patients seen by the emergency department liaison team did not usually require further treatment but they were signposted to alternative support services that might be able to offer help in the future. These services included MIND, drugs and alcohol services, counselling services and their GP.

Meeting the needs of all people who use the service

There was a trust provided interpreter and translation service. There was an independent advocacy service available and staff were aware of this. Information leaflets were available in all of the services inspected. Staff informed us that these would be given to people as required.

Some patients told us that they had received condition specific information leaflets from staff.

Listening to and learning from concerns and complaints

Information about raising concerns and complaints was available to patients who used the service and their carers. Information was also available on the trust's website. This information could be made available in different languages.

Are services responsive to people's needs?

Good ●

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

Patients could raise their concerns about their care and treatment through a number of trust supported services. For example, the independent mental health advocacy services and PALS (patient advisory and listening service).

Some patients told us that when they had raised individual concerns, these had been addressed appropriately. Staff discussed any issues raised in team meetings and they received daily emails raising any issues around practice or highlighting where something has been done well.

Are services well-led?

Requires improvement 🟠

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

Summary of findings

Our findings

SAFIRE ward
Vision and values

Management and staff were clear about the purpose and function of the ward. Staff told us what the trust values were and how they related to their work. Staff had met senior members of the management team.

Good governance

The team manager had sufficient flexibility within the team, to ensure that the ward was appropriately staffed when required. Where problems arose these were discussed and resolved in discussion between appropriate senior staff in relevant agencies.

Leadership, morale and staff engagement

The team was well-led at local level. They were motivated to continually improve and develop the service. Staff told us they felt proud working for the team. They also told us that they felt supported by their manager and felt they could approach them if needed. Staff told us that their manager was very accessible and contactable. They worked closely with the doctors within the team who provided them with specialist medical advice, support or supervision as needed. Staff felt valued within the team, and felt comfortable discussing any issues they may have with colleagues within the team.

Staff were aware of the trust's whistleblowing procedure and told us they would raise any issues if they were unable to this this within the team.

Commitment to quality improvement and innovation

The Trust sends out a daily email communication to all staff called "Midday Mail". These emails often contained information about lessons learned and incidents that have occurred in different parts of the trust.

Incidents that occur on the ward were discussed at team meetings.

We did not see any evidence of regular audits carried out that would inform improvement to the service.

Manchester Central, North and South Mental Health Home Treatment Teams (MHHTTs)
Vision and values

Only a few staff spoken with were able to explain the trust's vision and values. Staff told us they were reminded about the vision and values on a regular basis. However staff did not feel valued by the organisation and said that the listening events were only a "token" way of involving staff in the development of the services. We did not see any other evidence of the trust engaging with staff to embed the vision and values.

Good governance

The corporate risk register identified that staff engagement was poor throughout recent changes to the service. This initially came on to the risk register in July 2013 and remains on their risk register.

The risk register also identified staff sickness as a risk. The sickness levels had improved due to the implementation of existing policies. The sickness rate was 5.7% in the north team, 7.3 in the central team and 4.6 in the south team.

However, staff spoken with did not appear to understand that the change in the trust attitude towards sickness was about the implementation of the trust policy. Several members of staff expressed their fear of losing their jobs if they were off sick too much.

Leadership, morale and staff engagement

We found that staff morale was low. For example staff did not feel their inclusion in recent listening events was valued by the senior management of the organisation. Many of the staff we spoke with had little if any trust in the senior management of the trust. They told us "even if things change as a result of your visit they will only be making those changes because you ask them to not because it is good for patients or staff".

We found staff morale particularly low at the central HTT. Staff were reluctant to engage with the inspection process. Staff had been asked to arrange some visits so that people from the inspection team could accompany them but none had been arranged. Staff reluctantly told us the team worked well together, although at that time we did not realise we were only speaking to half of the team.

The central team was operating as two separate teams, east and west. Each part of the team stayed in their office

Are services well-led?

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

and used their own consultants. Staff from the east or west team were reluctant to ask for help from the other team. An example of this might be when they needed advice from a clinician and one was in an office, staff from one team were reluctant to ask the other for advice. The general manger had a outlined a plan on how they were going to get them working as one unit, but the manager on the unit did not show any understanding of the problem.

Staff did not have any confidence that the whistle blowing policy would protect them if they raised any concerns.

Commitment to quality improvement and innovation

We did not see an effective clinical audit programme in place to monitor and review the quality of the service provided. There was no system in place to actively gather feedback from people who used the service and implement changes as a result.

Staff did not hold reflective peer supervision sessions. Staff told us they were too busy and did not have the time to take out of their day to look at their practice.

We also found there was a lack of locally driven audits taking place in all the services we visited or bench-marking. It was therefore difficult to measure performance improvement locally or across services.

A&E Liaison Services Manchester North, South and Central

Vision and values

Staff were aware that the trust had a vision and values. They couldn't tell us what they were. We saw evidence of the vision and values around the environments. Staff told us they had discussed them in team meetings but could not repeat any of them to us.

Good governance

As part of the inspection process the trust told us about issues that were on their risk register. Two items on the register were:

- Staff sickness/recruitment to reach establishment levels
- Staff survey results/lack of engagement

The chief executive told us that staff morale was low across the trust but she also stated that they were developing methods to improve staff engagement for example listening into action. During our visits to this core service we found this to be the case when we were talking to staff.

We visited six teams and in each team we met with staff that were committed to providing a good service to patients. However, they also expressed how they felt the organisation did not value them.

The sickness levels had improved due to the implementation of existing policies. However, staff spoken with did not appear to understand that the change in the trusts attitude towards sickness was about the implementation of the trust policy. Several members of staff expressed their fear of losing their jobs if they were off sick too much.

Staff told us they received information about the trust or lessons learned through a daily bulletin sent via email to all staff. However, staff told us they did not always read it and others did not see this as way the trust was engaging with them. Staff were not engaged in the listening in action meetings.

Weekly meetings are held between managers from the acute trust and managers for the mental health trust. We saw minutes to support this.

Leadership, morale and staff engagement

We saw evidence that team meetings did take place on a regular basis. Minutes seen showed that they discussed breaches in targets such as the two hour initial assessment target and the four hour A&E target. Staff told us that they can be involved in an assessment when they get more than one request so when they exceed the two hour deadline it is usually because they are busy.

We found that staff morale was low. For example staff did not feel their inclusion in recent listening events was valued by the senior management of the organisation. Many of the staff we spoke with had little if any trust in the senior management of the trust.

Staff did not have any confidence that the whistle blowing policy would protect them if they raised any concerns.

Commitment to quality improvement and innovation

The service did not have an effective audit programme in place to monitor and review the quality of the service provided. There was no system in place to actively gather feedback from patients who used the service and implement changes as a result.

Are services well-led?

Requires improvement 🟠

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

Staff did not hold reflective peer supervision sessions. Staff told us they were too busy and did not have the time to take an hour out of their day to look at their practice. Management told us that when it had been organised staff did not turn up.

We also found there was a lack of locally driven audits taking place in some of the services we visited or bench-marking. It was therefore difficult to measure performance improvement locally or across services.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: We found that the registered person had not ensured that the privacy and dignity of some patients was being met. At SAFIRE care was provided in mixed sex accommodation which did not meet the guidance on same sex accommodation (SSA) and the Mental Health Act (MHA) Code of Practice (CoP). Regulation 10 (1)(a)