CareQuality Commission

Requires improvement 🟠

Pennine Care NHS Foundation Trust

Community-based mental health services for adults of working age

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)
RT2HQ	Trust Headquarters	Bury Early Intervention Team	BL9 0EQ
RT2HQ	Trust Headquarters	Heywood, Middleton and Rochdale Community Mental Health Team	M24 2HW
RT2HQ	Trust Headquarters	Rochdale West Community Mental Health Team	OL11 3EU
RT2HQ	Trust Headquarters	Stockport Early Intervention Team	SK8 2JF
RT2HQ	Trust Headquarters	Stockport Sector Two Community Mental Health Team	SK8 2JF
RT2HQ	Trust Headquarters	Tameside North Community Mental Health Team	OL6 6QQ

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Pennine Care NHS Foundation 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.

Where applicable, we have reported on each core service provided by Pennine Care NHS Foundation Trust and these are brought together to inform our overall judgement of Pennine Care NHS Foundation 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?	**Requires improvement**	●
Are services caring?	**Good**	●
Are services responsive?	**Good**	●
Are services well-led?	**Good**	●

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

We rated community-based mental health teams for adults of working age as requires improvement because:

- Information relating to the risks of patients were not included in patients' care records.

- Staff did not maintain an accurate, complete and contemporaneous record that included a plan of care. This meant that information needed to deliver care was not available to staff when needed.

- Staff were not up to date with basic life support and fire safety training.

- Copies of forms showing that patients had the capacity to consent to treatment were not attached to medication charts at any of the teams we visited.

- Patients were not involved in making decisions about the service. There were no formal meetings for patients to attend to give feedback on the service.

- Some teams did not have a target time for referral to assessment and treatment. We found little evidence of staff routinely planning discharges with patients.

- Staff did not receive regular clinical supervision and there were no records of clinical supervision taking place. Staff at Bury early intervention team did not have access to regular team meetings.

However:

- Caseloads within the teams were manageable. Cover was provided when staff were off work. Agency staff were employed to cover long term sickness.

- Regular multidisciplinary meetings were held to discuss patients. Staff communicated effectively within the team and with other teams and organisations.

- Patients told us they were actively involved in discussions about their care and treatment and were happy with the treatment provided.

- We observed staff being supportive, caring and respectful towards patients who used services.

- Staff made attempts to engage patients who had failed to attend their appointment. Staff also made efforts to engage with patients who were reluctant to engage.

- Staff felt able to raise concerns and were supported by managers and their teams.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- Of the 43 records we reviewed 11 records had no risk assessment. This meant that staff could not be certain of the risks for individuals and could not put management plans in place to reduce any risks to patients.
- Staff were not up to date with basic life support and fire safety training.

However:

- Caseloads within the teams were manageable. Cover was provided when staff were off work. Agency staff were employed to cover long term sickness.
- Crisis and contingency plans were in place. There was urgent access to a psychiatrist when needed. Staff responded quickly to deterioration in patients' mental health.
- Staff reported incidents and learning from incidents was shared. Staff were open and transparent and provided an explanation to patients when something went wrong.

Requires improvement ●

Are services effective?

We rated effective as requires improvement because:

- We found 15 out of 43 care records that did not have a plan of care for patients who were receiving treatment.
- Staff did not maintain an accurate, complete and contemporaneous record for all patients who used services. This meant that information needed to deliver care was not always available to staff when needed.
- Copies of forms showing that patients had the capacity to consent to treatment were not attached to medication charts at any of the teams we visited.
- Staff did not receive regular clinical supervision and there were no records of clinical supervision taking place. Staff at Bury early intervention team did not have access to regular team meetings.

However:

- There was access to psychological therapies and support with employment, housing and benefits.
- There were a variety of disciplines within the teams and staff were experienced and knowledgeable. Staff attended additional training courses to enhance their knowledge and skills.

Requires improvement ●

Summary of findings

- Regular multidisciplinary meetings were held to discuss patients. Staff communicated effectively within the team and with other teams and organisations.

Are services caring?
We rated caring as good because:

- We observed staff being supportive and respectful to patients. Patients told us that staff were caring, helpful and enthusiastic.
- Patients told us they were actively involved in discussions about their care and treatment and were happy with the treatment provided.
- There was good access to support for carers of patients.

However:

- Patients told us that they were not involved in decisions about the service. There were no formal meetings for patients to attend to give feedback on the service.

Good ●

Are services responsive to people's needs?
We rated responsive as good because:

- Referrals to the teams were seen quickly and prioritised if needed. Staff were able to respond quickly to urgent referrals.
- Staff were accessible and responded quickly to patients when they contacted the teams. Patients were aware of how to seek help out of hours.
- Staff made attempts to engage patients who had failed to attend their appointment. Staff also made efforts to see patients who were reluctant to engage.
- There was good provision of information at all of the team bases and access to information in different languages or formats when needed.
- Staff knew how to handle complaints and learning from complaints was shared.

However:

- Some teams did not have a target time for referral to assessment and treatment.
- Staff did not routinely plan for discharge and some patients were unsure about how long they would be with the service.
- At Bury early intervention, staff did not routinely provide information to patients on how to complain.

Good ●

Are services well-led?
We rated well-led as good because:

Good ●

Summary of findings

- Staff were aware of the trust's values and senior managers were visible within the teams.
- Generally, there were good monitoring systems in place that identified areas for improvement. Managers met regularly to discuss the performance of the teams and gave feedback to staff with actions required.
- Staff felt able to raise concerns and were supported by managers and their teams.
- Staff were involved in giving feedback on services and contributed to discussions about service development.

However:

- Staff in three of the six teams had not acted on areas identified in monthly reports to ensure that all information was included in patients' care records.

Summary of findings

Information about the service

Pennine Care NHS Foundation trust has 13 community mental health teams for adults of working age across Bury, Oldham, Rochdale, Stockport and Tameside. They have four early intervention teams for patients who have experienced their first episode of psychosis.

The trust's community mental health teams provide assessment and treatment for patients aged 16 to 65 with mental health illnesses including schizophrenia, bi-polar disorder and personality disorder.

The trust's early intervention teams provide assessment and treatment for patients aged 14 to 65 who have experienced their first episode of psychosis. Patients who are assessed as suitable for the service are treated for a three year period.

We visited four community mental health teams and two early intervention teams as part of our inspection visit. The teams we visited were:

- Bury early intervention team
- Heywood, Middleton and Rochdale community mental health team
- Rochdale west community mental health team
- Stockport early intervention team
- Stockport sector two community mental health team
- Tameside north community mental health team

Our inspection team

The team was led by:

Chair: Aidan Thomas, Chief Executive of Cambridgeshire and Peterborough NHS Foundation Trust

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leader: Sharron Haworth, Inspection Manager, Care Quality Commission

The team that inspected the community service for adults of working age comprised two CQC inspectors, two nurses and two doctors all with experience of community mental health services for adults of working age.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of patients 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 patients's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited four community mental health teams and two early intervention teams
- spoke with 13 patients who were using the service
- spoke with two relatives of patients

Summary of findings

- spoke with the managers or acting managers for each of the teams
- spoke with 29 other staff members; including doctors, nurses and social workers
- attended and observed one multidisciplinary meeting
- looked at 43 treatment records of patients
- shadowed five home visits
- looked at 12 staff records
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

During our visit we spoke to 13 patients who used the service. Patients were positive about staff and told us they were supportive, respectful and caring. Patients told us that staff were accessible, easy to contact and always responded.

Overall, patients told us they were involved in discussions about their care and treatment and were happy with the treatment provided. However, one person told us they were not involved in discussions about their care.

Carers and relatives were kept informed and were involved in patients' care. One relative told us they attended meetings with the psychiatrist. One person told us that their family member had attended a course provided by the trust. Feedback from carers' information sessions was positive and carers felt that the sessions had increased their knowledge of psychosis.

Patients we spoke to told us that they were not involved in discussions about changes to the service. Some patients told us they gave feedback about their experience through their care co-ordinator, however some patients were unaware of how to give feedback.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all patients have an up to date risk assessment.
- The provider must ensure that all patients have a plan of care.
- The provider must ensure that an accurate, complete and contemporaneous record is kept for each patient.
- The provider must ensure that staff are up to date with mandatory training.

Action the provider SHOULD take to improve

- The provider should ensure that staff receive regular clinical supervision and that this is recorded.
- The provider should ensure that staff at Bury early intervention team have access to regular team meetings.
- The provider should ensure that copies of forms showing that patients have the capacity to consent to treatment are attached to medication charts.
- The provider should ensure that patients are given the opportunity to be involved in decisions about the service.
- The provider should ensure that patients are provided with information about the length of treatment and discharges are planned with patients in advance.

CareQuality Commission

Pennine Care NHS Foundation Trust
Community-based mental health services for adults of working age
Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Bury Early Intervention Team	Trust Headquarters
Heywood, Middleton and Rochdale Community Mental Health Team	Trust Headquarters
Rochdale West Community Mental Health Team	Trust Headquarters
Stockport Early Intervention Team	Trust Headquarters
Stockport Sector Two Community Mental Health Team	Trust Headquarters
Tameside North Community Mental Health Team	Trust Headquarters

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Overall, we found good adherence to the Mental Health Act 1983 for patients receiving treatment under a Community Treatment Order. Consent to treatment and capacity requirements were adhered to and documentation had been completed correctly. However, capacity to consent to treatment forms had not been attached to medication charts at any of the teams we visited.

Training in the Mental Health Act was not mandatory for staff. However, staff had a good understanding of the Mental Health Act and the Code of Practice.

Detailed findings

Patients had their rights read to them regularly and there was access to independent mental health advocacy services.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act was not mandatory. However, staff had a good working knowledge of the Mental Capacity Act. Some staff had completed best interest assessor training and we found evidence of best interest meetings being held.

Staff assessed patients' capacity when there was a reason to do so and involved family members in making decisions when patients lacked capacity.

Staff knew where to access support and advice regarding the Mental Capacity Act when needed.

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

Our findings

Safe and clean environment

All of the teams we visited had appointments with patients at the team base. Alarms were not fitted in any of the interview rooms. Staff wore personal safety alarms and all teams had a reception where patients, staff and visitors checked in and out of the building.

Staff carried out regular assessments of the environment, including ligature risk assessments, at all of the teams we visited. A ligature point is a place which patients intent on harming themselves might tie something to strangle themselves. Records showed that work was requested and completed to improve the safety of the environment when risks had been identified.

The six clinic rooms that we visited were clean and had the necessary equipment to carry out physical examinations. Staff carried out temperature checks of fridges that were used to store medication. Staff also carried out internal temperature checks of medication cabinets used to store medication at room temperature. Records showed that temperature checks were regularly carried out and staff took action when temperatures were outside of the recommended range. Incident forms reviewed confirmed that staff reported unsafe fridge temperatures. At Stockport sector two, there was no fridge to store medication; staff told us that they would access medication requiring refrigeration from pharmacy.

All the areas we visited were clean and free from unpleasant odours. The building used at Tameside north was tired and in need of redecorating. In one of the rooms used to see patients there was a large patch on the wall where the paint had flaked away. Staff told us that the trust were discussing moving the team base elsewhere, however there had been some difficulties identifying a suitable place for the team to move to.

The teams carried out regular infection control audits. There was evidence of staff acting on findings of the audits. This included staff ordering the necessary equipment to manage spillages and displaying a poster for staff to use in the event of a spillage.

Safe staffing

Initial data provided by the trust detailed information relating to staffing as at May 2016.

Bury early intervention team

Total number of substantive staff 26

Number of vacancies: qualified nurses 1

Number of vacancies: nursing assistants 0.7

Staff sickness rate: percent in last 12 months 4

Staff turnover: leavers in the last 12 months 0

Heywood, Middleton and Rochdale community mental health team

Total number of substantive staff 12

Number of vacancies: qualified nurses 0

Number of vacancies: nursing assistants 0.5

Staff sickness rate: percent in last 12 months 13

Staff turnover: leavers in the last 12 months 2

Rochdale west community mental health team

Total number of substantive staff 6

Number of vacancies: qualified nurses 3

Number of vacancies: nursing assistants 0

Staff sickness rate: percent in last 12 months 3

Staff turnover: leavers in the last 12 months 3

Stockport early intervention team

Total number of substantive staff 7

Number of vacancies: qualified nurses 1

Number of vacancies: nursing assistants 0

Staff sickness rate: percent in last 12 months 1

Staff turnover: leavers in the last 12 months 0

Stockport sector two community mental health team

Total number of substantive staff 6

Number of vacancies: qualified nurses 2

Are services safe?

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

Number of vacancies: nursing assistants 2

Staff sickness rate: percent in last 12 months 10

Staff turnover: leavers in the last 12 months 0

Tameside north community mental health team

Total number of substantive staff 20

Number of vacancies: qualified nurses 1

Number of vacancies: nursing assistants 0

Staff sickness rate: percent in last 12 months 3

Staff turnover: leavers in the last 12 months 2

Staff told us that staffing levels were agreed with community service managers and senior managers within the trust. There were vacancies at all of the teams we visited. Team managers told us that they could request agency staff to cover vacancies and long term staff sickness. Managers told us that recruitment of staff was underway, however there were ongoing difficulties in this area due to national issues with the recruitment of nursing staff.

Overall, caseloads within the teams were manageable. Bury early intervention had an average caseload of 15. Heywood, Middleton and Rochdale had an average caseload of 22. Rochdale west had an average caseload of 22. Stockport early intervention had an average caseload of 20. Stockport sector two had an average caseload of 20 and Tameside north had an average caseload of 35. Staff at Tameside north told us that although they were managing their caseloads, they recognised that any further increased pressure of work would lead to staff working outside of their contracted hours and this would be difficult to manage.

At the time of our inspection, there were no patients awaiting allocation at the early intervention teams and Stockport sector two. There were four patients at Rochdale west, one patient at Tameside north and 34 patients at Heywood, Middleton and Rochdale awaiting allocation to a care co-ordinator. Managers at Heywood, Middleton and Rochdale told us that there had been a longer waiting list, however they had carried out a piece of work to reduce the waiting list and ensured that patients waiting were

discussed within the multidisciplinary meeting held weekly, which included a discussion around risk. Managers told us that the duty worker would see patients on the waiting list if patients' mental health deteriorated.

Staff told us and records showed that caseloads were regularly discussed and reviewed as part of supervision.

Staff told us that in the event of short term staff sickness the duty worker would provide cover. In the event of long term sickness patients were allocated to another staff member to ensure patients continued to receive regular support from staff. There was agency staff at Tameside north and Rochdale west to cover long term sickness to ensure consistency of care. The duty worker provided cover for annual leave. At Tameside north staff completed a handover sheet identifying patients who required input from the team whilst the member of staff was on leave. This information was discussed at the Monday morning meeting and was included in the team and staff diaries for that week.

Urgent access to a psychiatrist for patients who were experiencing a deterioration in symptoms was available at all teams. Staff told us that they requested appointments with the psychiatrist's secretary and patients would be seen within 48 hours.

The courses identified by the trust as mandatory training were child safeguarding level one, health and safety, infection control, basic life support, moving and handling, equality and diversity, adult safeguarding level one, conflict resolution, information governance, preventing violent extremism and fire safety. The trust target for mandatory training was 85%. The average training rate for staff in adult community services was 85%. Basic life support and fire safety fell below the trust target with training rates of 71% and 68% respectively. Out of the six teams we visited, four teams fell below the trust target with Stockport sector two having the lowest training rates of 33% for basic life support and 50% for fire safety.

Assessing and managing risk to patients and staff

We reviewed 43 care records during our inspection. We found that 11 records had no completed risk assessment and in two records the risk assessment had not been updated for over twelve months. At Heywood, Middleton and Rochdale, there were three care records with risk assessments missing and two risk assessments that had not been updated for over twelve months. At Bury early

intervention team there were seven records that did not include a current risk assessment. Staff located one risk assessment which had been stored on the trust computer system rather than the electronic care records system. We raised this with the senior manager at the team base during our inspection, who also could not locate the risk assessments within the care records. We met with the acting team manager of Bury early intervention team within two weeks of our inspection visit. We found that four out of the seven care records initially identified as having information missing still had no risk assessment. We escalated our concerns to the chief executive of the trust during the period of our inspection. The trust provided us with an action plan detailing immediate action taken at Bury early intervention team and Heywood, Middleton and Rochdale community mental health team. The action plan included further action to be taken and completed within a set timeframe and a description of how the trust were mitigating the risks identified whilst action was being taken.

We found crisis and contingency plans included in the care plans we reviewed. Patients told us that they were aware of how to seek help in a crisis and the contact numbers they may need were detailed on their care plan. We found evidence of advance decisions in some patients records. Staff told us that advance decisions was a standard item on the patient's care plan and any information relating to advance decisions would be documented.

Records showed that staff responded quickly to deterioration in patients' mental health. We found evidence of urgent visits being carried out and staff making arrangements for further support when needed.

There was a system in place for storing and checking out medication. Pharmacy delivered medication to the teams which was labelled with the person's details. When medication was leaving the team base staff completed a form to record the time, date, patient details and the member of staff checking out the medication.

The teams we visited had systems in place to monitor patients waiting for treatment. Referrals to the community teams were identified as urgent or routine which related to the level of risk the patient presented with. Urgent referrals were prioritised for assessment. Patients on the waiting list were discussed during the multidisciplinary team meetings and the duty worker was allocated to offer support to patients waiting for treatment when needed. At Rochdale

west there were three members of staff allocated to monitoring patients on the waiting list, this included attending outpatient appointments and offering further support when needed. At Heywood, Middleton and Rochdale we found that staff had carried out close scrutiny of the team caseload and waiting list to identify risk and treatment options. Staff told us that patients waiting for treatment would contact the duty worker when needed.

Staff received training in safeguarding adults and children, the average training rate was over 90%. Staff were knowledgeable about identifying and reporting safeguarding concerns. There were safeguarding leads within each team and staff knew who to approach for information and advice within the trust. Staff also reported good relationships with local authority safeguarding teams.

Staff were aware of the lone working policy and the systems in place to ensure personal safety. At all of the teams we visited there was a staff board that detailed staff whereabouts and the time staff were due back at base. Staff told us that if a member of staff had not returned by the time written on the board staff would contact them to check they were safe. Staff told us that they carried out joint visits if risks had been identified. Staff also used safe words to allow staff to notify others when there was a potential threat to their personal safety. However, at Bury early intervention one member of staff was unclear about the lone working policy and another member of staff told us they could not remember the safe word.

Track record on safety

In total, 11 serious incidents were reported between January 2015 and December 2015. All serious incidents were 'unexpected or avoidable death or severe harm of one or more patients, staff or members of the public'. Heywood, Middleton and Rochdale and Stockport sector two each accounted for three of the reported serious incidents. We found evidence of serious incidents being thoroughly investigated and recommendations being actioned to reduce the risk of repeated events. This included high risk formulation training being delivered to staff.

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents and were able to describe what would be reported as an incident. All staff completed incident forms on the trust's electronic recording system.

Are services safe?

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

From December 2015 to April 2016 the teams we visited reported 80 incidents. The two most common incidents reported were self harm, which accounted for 23 of the incidents reported, and violence and aggression, which accounted for 14 of the incidents reported. Tameside north accounted for 39 of the 80 incidents reported.

Staff we spoke to were able to give examples of being open and transparent and provided an explanation to patients when something went wrong. Staff were aware of their responsibilities under the duty of candour and records showed that staff had demonstrated these responsibilities. An example of this was when a patient's relative had raised concerns about their daughter's assessment. Staff had met with the patient and their relative and had provided a written response which included an explanation and an apology. Duty of candour is a statutory requirement to ensure that providers are open and transparent with people who use services in relation to their care and treatment. It sets out specific requirements that providers must follow when things go wrong with care and treatment.

Staff told us that they regularly received feedback from the investigations of incidents and learning from incidents was shared throughout the trust. A review of minutes of team meetings confirmed that learning was shared. An example of sharing information within the trust was the introduction of a seven minute briefing, which was circulated following the investigation of an incident, managers discussed the briefing in team meetings and this was also displayed on the team notice board. Staff received de-briefs following incidents and were offered occupational health support and counselling. Staff told us they felt supported by their managers and colleagues.

Are services effective?

Requires improvement 🟠

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.

Our findings

Assessment of needs and planning of care

During our visit we reviewed 43 patient care records. We found no care plans in 15 care records we reviewed. At Bury early intervention team eight records had no care plan. At Heywood, Middleton and Rochdale community mental health team four records had no care plan and at Rochdale west one record had no care plan. This meant that the necessary information required to deliver care was not available to staff when they needed it. We met with the acting team manager of Bury early intervention team within two weeks of our inspection visit. We found that seven of the eight care records initially identified as having information missing still had no care plan. We escalated our concerns to the chief executive of the trust during the period of our inspection. The trust provided us with an action plan detailing immediate action taken at Bury early intervention team and Heywood, Middleton and Rochdale community mental health team. The action plan included further action to be taken and completed within a set timeframe and a description of how trust were mitigating the risks identified whilst action was being taken.

Following our inspection visit, we requested further information relating to care records from the trust. The monthly business report for each team identified the percentage of the team caseload for patients with a care plan in place. For April 2016, Bury early intervention was 41%, Heywood Middleton and Rochdale was 83%, Rochdale west was 83%, Tameside north was 65%, Stockport sector two was 70% and Stockport early intervention team was 28%. We asked the trust to provide any audits of care records that staff had completed, however the audits returned related to how records were recorded and stored and did not include an audit of what was included within a person's care record. Minutes of team meetings at Heywood, Middleton and Rochdale and Rochdale west showed that managers had asked staff to ensure all patients who used the service had an up to date care plan uploaded onto the electronic records system. However, staff in three of the six teams we visited had not acted on areas identified in monthly reports to ensure that all information was included in patients' care records.

Assessments were completed using the trust's mental health core document. The assessment was comprehensive and covered health, psychological and social care needs including cognitive deficits, psychotic symptoms, emotional distress, financial, housing, education and employment needs. Within the early intervention teams staff also used the comprehensive assessment for at risk mental state to map the onset of psychosis.

Of the 18 complete care records that we reviewed, 16 care plans were holistic, included patient views and were based on patients' strengths and goals. One person had not been offered a copy of their care plan. Patients told us they were involved in the creation of their care plans and received a copy.

The trust had introduced an electronic recording system for care records to community services in August 2014. Staff told us that they had received training on how to use the system. Staff told us and we observed staff storing information relating to a person's care and treatment on the trust computer system rather than the electronic care records system. Staff told us that there was a system in place for uploading information to the electronic care records system. Staff could print out the document and administrative staff would scan and upload the document or staff could directly upload the document onto the electronic care records system. We found that staff were not routinely uploading information to ensure a complete, up to date and contemporaneous record was kept for patients. This meant that new staff and staff supporting patients out of hours would not have the most up to date information available to them when they needed it.

Best practice in treatment and care

At all of the teams we visited staff were aware of the relevant National Institute for Health and Care Excellence guidance and this was evident in the treatment that was being provided to patients who used services. National Institute for Health and Care Excellence guidance that staff used included guidance for schizophrenia, bipolar disorder and personality disorder.

At Bury early intervention, patients were referred to clinical psychology within two weeks of their first appointment. Staff told us that they provided psychological interventions such as mindfulness and there were cognitive behavioural therapists within the teams.

Are services effective?

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.

At the community teams, access to clinical psychology was through referral to the primary care or secondary care psychological therapies services. We found evidence in care records that patients were referred to psychology.

Staff supported patients with employment, housing and benefits needs. External agencies were also used for additional support. At Tameside north, staff held a regular clinic to support patients receiving benefits and applying for benefits. Support workers within the team had received training on welfare rights and universal credits.

Annual physical health checks were completed by the patient's GP. Staff supported patients to attend for their annual physical health check. The treatment support team carried out monitoring for patients prescribed lithium or clozapine. Records showed that care plans were developed for patients requiring physical health monitoring for lithium and clozapine.

Staff completed the mental health clustering tool of patient's presenting symptoms on assessment and at regular intervals. Staff within the early intervention teams completed the positive and negative syndrome scale, comprehensive assessment for at risk mental state and the process of recovery questionnaire. From April 2016, early intervention teams also collected data on how many patients were offered cognitive behavioural therapy. When patients were engaged in cognitive behavioural therapy staff used the choice of outcome in cognitive behavioural therapy for psychoses, which was an outcome measure used to reflect the aims of cognitive behavioural therapy and the priorities of patients who used services.

Staff were involved in completing audits. Staff completed audits relating to record keeping, infection control and the environment of the team base. Minutes of meetings confirmed that feedback from audits was discussed in team meetings.

Skilled staff to deliver care

The community teams had a variety of disciplines within the teams including nurses, community support workers, psychiatrists, social workers, approved mental health practitioners and occupational therapists. There were regular drop in sessions with psychological therapists for staff and patients using the service to ask for advice relating to therapies available.

Within the early intervention teams there were nurses, social workers and cognitive behavioural therapists. At Stockport early intervention team there were two full time cognitive behavioural therapists with a further part time position being recruited to. Bury early intervention team did not have a dedicated psychiatrist within the team. The team accessed four community consultant psychiatrists and two inpatient consultant psychiatrists. There was an advanced practitioner that worked within the early intervention teams.

Staff had completed a number of additional training courses to assist them with their roles. The courses included motivational interviewing, best interest assessor award, brief cognitive behavioural therapy interventions, family interventions, safeguarding adults investigator training, higher clinical risk formulations, personality disorder training, compassionate mind therapy, mindfulness, psychosocial interventions for psychosis and suicide prevention and self harm training.

The trust had a corporate welcome programme that all new starters attended. Within the teams staff also received a local induction which covered areas such as health and safety, lone working and the team operational policy. Staff we spoke with told us that they had received an induction.

Initial data provided by the trust as of May 2016 showed that in the past 12 months the average clinical supervision rate was 88%. The trust did not have a target rate for clinical supervision. We reviewed 12 staff files during our visit and found evidence of regular management supervision of staff. There were no records that clinical supervision had been undertaken in the files that we reviewed, however, at Tameside north there was evidence that clinical discussions were taking place during management supervision. Across the teams we visited, some staff told us that clinical supervision did not occur regularly. One member of staff told us it was difficult to access clinical supervision as there was a lack of clinical supervisors.

Initial data provided by the trust showed that Tameside north was the team that had the highest appraisal rate of 95%. Bury early intervention team and Stockport early intervention team both had an appraisal rate of 45%. The trust policy stated that staff should be appraised annually. During our visit we found evidence of completed appraisals in the staff records that we reviewed. Staff told us that they were regularly appraised. Minutes of community managers

Are services effective?

Requires improvement ●

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.

meetings identified that there were some inconsistencies with appraisal data on the new electronic system, which was lower than the paper records held for completed staff appraisals.

We found evidence of staff attending regular team meetings at all teams apart from Bury early intervention. Staff told us that they had regular team meetings however these meetings related to clinical meetings rather than meetings to support the team.

Multi-disciplinary and inter-agency team work

The teams held zoning meetings at least once a week. This meeting was a multidisciplinary meeting to discuss all patients open to the team. Patients were allocated to a zone dependent on the level of risk, time open to the service and safeguarding concerns identified. We observed a zoning meeting during our visit. Staff discussed the outstanding needs of patients using the service. Staff also discussed patients who were on the waiting list, patients who had adult and child safeguarding issues identified and seven day follow up visits for patients who had been discharged from hospital. We found evidence of good team working at the meeting we observed.

We found evidence of staff communicating effectively when arranging annual leave and cover for their absence. There were systems in place to ensure effective communication regarding contact with patients when staff were absent from work.

Records showed that there was good communication with other teams and organisations, including communication with inpatient teams when patients were admitted to hospital. One person who used the service told us that there had been excellent liaison between staff and their local mental health team and university in a different area.

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

Training in the Mental Health Act was not part of the trust's mandatory training programme. There were ten members of staff across all of the teams that we visited that had received training on the Mental Health Act. There were no staff from Bury early intervention that had attended the training. Staff at all of the teams we visited told us that they would access advice and support from the Mental Health Act administrator if needed.

Staff we spoke to had a good understanding of the Mental Health Act and the Code of Practice, particularly their role

in relation to community treatment orders. There were approved mental health professionals within the community teams who carried out Mental Health Act assessments.

When patients were receiving treatment as part of a community treatment order, we found that consent to treatment and capacity requirements were adhered to. We found evidence of staff including specific information relating to the conditions of community treatment orders in patients' care plans. Copies of forms showing that patients had the capacity to consent to treatment had been completed, however these forms were not attached to medication charts at any of the teams we visited. There were three capacity to consent to treatment forms at Rochdale west that were not uploaded into the patient's electronic care record.

We found evidence that patients had their rights under the Mental Health Act explained to them at the start of treatment and at regular intervals throughout treatment. However, at Rochdale west there were two patient records that did not include a rights monitoring form, three at Tameside north and one at Bury early intervention.

As part of our inspection we asked the teams we visited for completed audits that staff had completed to ensure that the Mental Health Act was being applied correctly. At Tameside north, staff kept a working document to monitor the use of the Mental Health Act which detailed dates of the community treatment order start date and expiry date, consent to treatment, capacity to consent to treatment and independent mental health advocacy referral. There were no recent audits of the use of the Mental Health Act at the other teams that we visited.

Staff were aware of how to refer patients to independent mental health advocacy and there was information displayed within the reception area of the team bases.

There was a central Mental Health Act administration team that staff used for advice and support when needed.

Good practice in applying the Mental Capacity Act

Training in the Mental Capacity Act was not part of the trust's mandatory training programme. There were two members of staff that had attended training on the Mental Capacity Act. The staff who had attended were based at Heywood, Middleton and Rochdale and Rochdale west. A number of staff within the teams we visited had completed best interest assessor training. Staff were knowledgeable

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about the Mental Capacity Act, including the five principles and an understanding that capacity is decision specific. The trust had a policy on the Mental Capacity Act and staff knew where to find this.

The trust had produced guidance for identifying and authorising a Deprivation of Liberty safeguard for staff to refer to when needed. This guidance included information about various settings where Deprivation of Liberty safeguards may apply and actions to be taken by staff. This included the possibility for an authorisation to run alongside a Community Treatment Order or guardianship for patients within a care home or supported living accommodation.

Staff assessed patients' capacity if there was a reason to do so. We found evidence of staff holding best interests meetings for patients who were assessed to lack capacity. One example was around a patient's accommodation needs. Staff involved family in the decision making process relating to independent living versus residential care for the individual.

We also found evidence that staff supported patients who had capacity to make decisions about lifestyle choices and employment.

Staff knew where to access advice and support regarding the Mental Capacity Act when needed.

Are services caring?

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

Good ●

Our findings

Kindness, dignity, respect and support

During our inspection we observed five home visits with staff to patients who were using the service. We also observed interactions between staff and patients attending the teams for appointments. We found that staff were polite, professional and treated patients with respect. Staff were supportive and had a good understanding of the individual needs of the patients who were using the service. We observed positive supportive relationships between staff and patients.

During our visit we spoke to 13 patients. The feedback we received was positive. Patients told us that staff were supportive, respectful, polite, enthusiastic, helpful, friendly, efficient and caring. One patient told us that the quality of service they received had always been good. Another patient told us that staff were fantastic. Patients who used the service told us that staff were accessible, easy to contact and always responded. One patient told us they had recently transferred between community teams and staff kept them informed about the process. Another patient told us that staff were empathetic and provided a holistic view of their problems, including delivering coping skills and help with moving forward.

Staff maintained confidentiality of patients. We found evidence of information not being shared with relatives when patients had requested their information to be kept confidential.

The involvement of people in the care that they receive

Of the 13 patients we asked about care plans, nine patients told us that they were involved in the care planning process and had received a copy of their care plan. Patients also told us that when their care plan was updated they received a new copy. One patient told us they were awaiting a discussion with staff about their care plan as they had recently transferred between community teams. One patient was involved in developing their care plan and was awaiting a copy. One patient did not have a copy of their care plan. Overall, patients reported being actively involved in discussions about their care and treatment and

were happy with the treatment provided. However, one patient at Rochdale west told us that they were not involved in discussions about risk and felt staff discussed this amongst themselves.

Patients told us that their families were involved in their care and staff kept them informed. One patient told us that their family member had attended a course provided by the trust. One relative told us that staff kept them informed about the care of their daughter and they attended meetings with the psychiatrist.

We found good provision of information and support available for carers. At Bury early intervention and Tameside north, staff carried out carers assessments, either at the team base or at the carer's home. At Stockport early intervention team, we reviewed 12 evaluation forms from carer information sessions. All feedback received from carers was positive and carers felt that the sessions had increased their knowledge of psychosis. During one home visit, we observed staff arranging an appointment with a patient and their family to provide information and support to the family members.

Patients we spoke to were aware of how to contact advocacy. Staff told us that access to local advocacy services was available and they supported patients to access an advocate when needed.

We found minimal involvement of patients in decisions about the service. Staff told us that patients were not involved in helping to recruit staff. Patients who used services told us they were not involved in decisions about the service.

Three patients told us that they gave feedback via their care co-ordinator. One patient told us that they were asked about their experience during an appointment. However, some patients told us that they were unaware of how to give feedback. Staff told us that there were no meetings or forums for patients to attend. One relative told us that they were not aware of a formal procedure for giving feedback, however they were able to give feedback verbally. At Tameside north, staff told us that they previously held meetings for patients to give feedback, however few patients attended. Staff were in the process of developing a forum for patients to attend in conjunction with an external agency.

Are services responsive to people's needs?

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

Our findings

Access and discharge

Referrals to the community teams were received by the 'single point of entry' team, inpatient wards and home treatment teams. For the early intervention teams referrals were received from any source where there was a suspicion of psychosis.

Within both early intervention teams there was no target for referral to triage as the single point of entry team received the referral and completed the triage. There was also no target time for referral to assessment, however both teams were aiming towards the National Institute for Health and Care Excellence guidelines of two weeks for referral to assessment and allocation of a care co-ordinator for patients presenting with first episode psychosis.

Heywood, Middleton and Rochdale and Rochdale west community teams did not have a set target time from referral to triage, referral to assessment and referral to treatment. Staff told us that no targets had been set by the commissioners. At Tameside north there was no target time for referral to triage and referral to assessment. Tameside north had a target of two weeks for referral to treatment. Stockport sector two had a target of one to two days for referral to triage, two weeks for referral to assessment and one to four weeks for referral to treatment. Staff were able to respond quickly to urgent referrals. Staff told us they would aim to see the patient the same day or the next working day. Staff would refer urgent referrals to the home treatment team if deemed necessary to ensure rapid access to treatment.

Data provided by the trust indicated average waiting times and amount of referrals received for the month of April 2016.

Bury early intervention team

Number of referrals received: 65

Average wait from referral to assessment: 9 days

Average wait from referral to treatment: 9 days

Heywood Middleton and Rochdale community mental health team

Number of referrals received: 51

Average wait from referral to triage: 7 days

Average wait from referral to assessment: 46 days

Average wait from referral to treatment: 46 days

Rochdale west community mental health team

Number of referrals received: 77

Average wait from referral to triage: 7 days

Average wait from referral to assessment: 22 days

Average wait from referral to treatment: 22 days

Stockport early intervention team

Number of referrals received: 82

Average wait from referral to assessment: 8 days

Average wait from referral to treatment: 8 days

Stockport sector two community mental health team

Number of referrals received: 52

Average wait from referral to triage: 1 day

Average wait from referral to assessment: 40 days

Average wait from referral to treatment: 40 days

Tameside north community mental health team

Number of referrals received: 156

Average wait from referral to triage 1 day

Average wait from referral to assessment: 28 days

Average wait from referral to treatment: 28 days

There was no data provided relating to average waiting time from referral to triage for both early intervention teams as the 'single point of entry' team received the referral and completed the triage. The waiting time at Heywood, Middleton and Rochdale was long. Managers had carried out a piece of work to reduce the waiting list and ensured that patients waiting were discussed within the multidisciplinary meeting held weekly, which included a discussion around risk. We found that that staff had carried out close scrutiny of the team caseload and waiting list to identify risk and treatment options in an attempt to further reduce the waiting list.

The teams we visited had a clear criteria for which patients would be offered a service. There were three pathways that patients could follow, including psychotic illness, non-psychotic illness and personality disorder. At Heywood,

Are services responsive to people's needs?

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

Middleton and Rochdale and Stockport sector two, the eligibility criteria also included organic illness such as early onset dementia or Korsakoff's syndrome, where no dedicated service existed and a pathway to a more suitable care team was in place. The community teams also assessed patients using the Care Act 2014 eligibility criteria to decide whether adult care and support was needed from the local authority. Patients were assessed using this criteria regardless of whether the person met the criteria for ongoing support from the community team.

Patients told us that their care co-ordinators were accessible and always responded quickly when they contacted the teams. One patient told us that when they contacted their care co-ordinator they got a response within one hour. There was an out of hours service for patients to use outside of the teams working hours. Patients we spoke to were aware of how to contact the out of hours service. All the teams that we visited had a duty worker that would respond to patients, including arranging urgent visits if care co-ordinators were unavailable.

There was a trust 'did not attend' policy. Staff told us and records showed that staff made attempts to engage patients who had failed to attend their appointment. Staff told us they would contact carers and other agencies to assist them in engaging patients who were reluctant to engage in treatment. Staff would also increase frequency of visits and offer alternative support. One patient told us they found it difficult to attend their appointments at the clinic due to the location. Staff had arranged for the patient to attend a different clinic that was closer to the person's home.

We found little evidence of staff routinely planning for discharge with patients. Some patients told us that they were unaware of how long they would be with the service. Early intervention teams provided treatment over a three year period. One patient told us they were aware of how long they would be receiving treatment with the team.

Staff told us that there was flexibility in the times of appointments offered to patients. At Stockport early intervention team, early evening appointments were offered to patients who could not attend appointments between office hours. Overall, patients reported being happy with the frequency and time of their appointments. However, one patient told us that occasionally staff contacted them with an appointment which was arranged for the same day and this could be difficult to attend due to

the short notice. Patients and staff told us that appointments were carried out as arranged and only cancelled due to staff absence. We found evidence in one care record that staff contacted the patient to explain the reason for cancelling an appointment and another appointment was arranged.

The facilities promote recovery, comfort, dignity and confidentiality

All team bases had a sufficient number of rooms to support care and treatment. These included interview rooms, reception areas and clinic rooms. Interview rooms had adequate sound proofing to maintain confidentiality.

The trust had a generic information leaflet for patients. There was information displayed at all team bases which included advocacy, welfare rights, complaints and compliments, carers groups, rights and interests, exercise, healthy lifestyles, mental health, alcohol, smoking, sleep and young carers.

Meeting the needs of all people who use the service

All team bases had access for people with mobility difficulties. Staff told us that they would provide home visits for patients who found it difficult to attend the team base.

There were no information leaflets available in other languages, however there was a large poster displayed advising patients to ask staff for leaflets in other languages or a different format including easy read or audio. The poster included this information in 11 different languages. Staff told us that they could provide information in different languages or different formats if needed.

At Stockport early intervention team, staff had used large print when providing a copy of a care plan for a patient who had a visual impairment. At Stockport sector two, we observed staff using flashcards to explain the possible symptoms that may indicate early warning signs of a relapse to a patient.

Staff had access to interpreters and signers and could access information in braille.

Listening to and learning from concerns and complaints

Data provided by the trust showed nine complaints were recorded from 1 March 2015 to 31 June 2016. Bury early intervention had no complaints. Tameside north had the

Are services responsive to people's needs?

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

most complaints with three recorded. The main themes highlighted were poor/lack of communication and lack of/ timeliness of support. Four of the complaints were being investigated by the trust at the time of our inspection. One complaint had been upheld and there were no complaints that had been referred to the ombudsman. There was one compliment recorded for Rochdale west which was received from the relative of a patient.

Patients we spoke to told us they knew how to make complaints, however, they had no reason to complain. Patients told us they would speak to staff or advocacy if they wanted to complain and that there was information on how to complain available at the team base. One

patient at Bury early intervention team told us they had not received information on how to complain. Staff told us that they did not routinely provide information on how to complain to patients.

Staff we spoke to were aware of the complaints procedure and how to handle a complaint. We found evidence in minutes of staff meetings of complaints routinely being discussed. An example of a change made following a complaint was including an explanation in appointment letters to ensure patients were made aware that student nurses may attend home visits and who to contact if patients did not wish student nurses to attend visits.

Are services well-led?

Good 🟢

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.

Our findings

Vision and values

The trust's vision was "to deliver the best care to patients, people and families in our local communities by working effectively with partners, to help people to live well".

The trust's values included ten principles of care which had been developed by staff and were relevant to all staff regardless of their role. The ten principles were:

- Safe and effective services
- Meaningful and individualised
- Engaging and valuing
- Constructive challenge
- Governance procedures enable
- Focused and specific
- Competent skilled workforce
- Clear and open communication
- Visible leadership
- Shared accountability.

Staff we spoke to were aware of the trust's values and we found information relating to the trust's values displayed at team bases.

Staff knew who the senior managers of the trust were and reported that they had visited the teams. Staff told us that community services managers were visible, approachable and supportive.

Good governance

Overall, we found good monitoring systems in place to ensure that staff received mandatory training, supervision and appraisals. Monitoring systems in place were effective in identifying areas for improvement. However, staff had not acted on areas identified in monthly reports to ensure that all necessary information was included in patients' care records.

Community managers meetings were held regularly. We reviewed minutes of these meetings and found regular discussions about the performance of the teams, safeguarding and communication with other teams within the organisation such as learning disability services and

child and adolescent services. There was evidence that managers had acted on discussions held in relation to medicines management and management supervision records.

The trust used key performance indicators to monitor the performance of the teams. Team managers were sent a monthly report which included data relating to sickness, appraisals, mandatory training, referrals, care plans, care programme approach reviews and incidents. Managers told us that once received they provided a commentary to explain the data presented and identified any areas where improvements were required. In minutes of team meetings at Heywood, Middleton and Rochdale and Rochdale west, managers had requested that staff uploaded care documents onto the electronic care record system. However, staff in three of the six teams we visited had not acted on areas identified in monthly reports to ensure that all information was included in patients' care records.

The quarterly mental health community teams activity return collected data on the number of patients on care programme approach who were followed up within seven days of discharge from psychiatric inpatient care. The trust recorded 96% of patients on care programme approach who were followed up within seven days after discharge between January and March 2016. This was below the England average of 97%. The previous three reports of data collected for 2015 and 2016 showed the trust performance had been either the same as or below the England average. Minutes of team meetings showed that staff had been provided with guidance for completing seven day follow up visits, following staff not completing some visits within seven days.

Team managers were aware of the trust risk register and told us that they would add an item to the risk register by escalating any concerns to their managers. There were no items relating to the teams we visited on the risk register at the time of our inspection.

Leadership, morale and staff engagement

The average sickness absence rate across the teams we visited was 5.6%. There were high levels of sickness absence at Heywood, Middleton and Rochdale and Stockport sector two. There had been agency staff employed to cover long term sickness. Managers told us that they were recruiting staff to fill vacancies, however there were ongoing difficulties in this area due to national issues with the recruitment of nursing staff.

Are services well-led?

Good ●

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.

There were no bullying or harassment cases being investigated at the teams we visited.

Staff we spoke to were aware of the whistleblowing process. Staff felt able to raise concerns with their team manager and service manager. Staff told us they were supported by their managers and their colleagues within the teams.

Overall, staff morale was good within the teams we visited. At Tameside north, staff reported an increased pressure on their workload which had led to higher levels of stress. However, staff told us that they managed their workloads and felt supported by their colleagues and team manager.

Staff told us that they had opportunities for professional development and some team managers had attended leadership courses.

We saw examples of staff being open and explaining to patients when things had gone wrong, including providing an apology.

Staff were offered the opportunity to give feedback on services and input into service development. The trust held a number of sessions that staff attended, staff were given the opportunity to discuss any ideas or concerns they had relating to proposed changes to services. However, one member of staff at Stockport early intervention team felt disconnected from the trust and reported that there was little consultation with staff about changes to services.

Commitment to quality improvement and innovation

The teams were not participating in any national quality improvement programmes.

This section is primarily information for the provider
Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that 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 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of this part **How this regulation was not being met** Staff did not maintain an accurate, complete and contemporaneous record for patients. Out of 43 records we reviewed, 11 patients did not have a current risk assessment and two risk assessments had not been updated for over twelve months. We found 15 out of 43 care records that did not have a plan of care for patients who were receiving treatment. This was a breach of regulation 17 (2) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in oder to meet the requirements of the part. **How the regulation was not being met** Staff were not up to date with basic life support and fire safety training. This was a breach of regulation 18 (2) (a)