Requires improvement

Pennine Care NHS Foundation 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)
RT201	Bury Mental Health Services	Rapid assessment interface and discharge team and home treatment team	BL9 7TD
RT201	Bury Mental Health Services	Health based place of safety	BL9 7TD
RT204	Rochdale Mental Health Services	Rapid assessment interface and discharge team and home treatment team	OL12 9QB
RT204	Rochdale Mental Health Services	Health based place of safety	OL12 9QB
RT202	Tameside Mental Health Services	Rapid assessment interface and discharge team and home treatment team	OL6 7LR

Summary of findings

RT202	Tameside Mental Health Services	Health based place of safety	OL6 9RW
RT203	Oldham Mental Health Services	Rapid assessment interface and discharge team and home treatment team	OL1 2JH
RT203	Oldham Mental Health Services	Health based place of safety	OL1 2JH
RT205	Stockport Mental Health Services	Rapid assessment interface and discharge team and home treatment team	SK7 4RQ
RT205	Stockport Mental Health Services	Health based place of safety	SK7 4RQ

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?	**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

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

- The health-based place of safety at Stockport was particularly dirty, especially in the en-suite room which made it not fit for use. The en-suite did not have toilet paper, towels or soap readily available for patients to use. There was no evidence that monitoring of the cleanliness of this room took place or monitoring of the water system in line with trust policy to prevent the risk of legionella disease. This posed an avoidable risk to the health of patients. The health-based places of safety at Stockport and Tameside were not in good decorative order and the chairs were stained. The rooms were sparse, not welcoming and resembled a seclusion room. The rooms did not contain a bed where patients could comfortably lie down. There were no sheets, pillows or blankets in the rooms. At Stockport there was not a clock to orientate patients to time in line with national guidance.
- At Tameside, there was a window which could be overlooked from the outside. Although the window faced the wall of another building, it was possible for a person to access the outside of the window and see into the room. The window did not have a blind which could impact on a patient's privacy and dignity.
- Patients using the health based places of safety were unable to see staff in the staff room through the one way mirror. There was no intercom system, or other way for a patient to directly communicate with staff or know that staff were present in the staff room. The rooms had CCTV monitoring systems but no notices informing patients of this. If a patient wanted to communicate with staff or summon assistance, they would need to do so via the CCTV camera.
- Compliance with mandatory training, appraisals and supervision was inconsistent across the service and much lower than the trust's target in some teams.
- The quality of assessments, risk assessments and care plans was inconsistent across the service. Patients' allergies, physical health needs and medication were not routinely recorded. Some patients did not have up to date risk assessments or care plans in their care records.
- Staff did not always have timely access to the care records of young patients detained under section 136 of the Mental Health Act.
- There were inconsistencies across teams regarding staff skill mix which meant that not all teams could provide the same level of service to patients.
- There was a lack of evidence to demonstrate effective use of performance indicators and audits to drive improvement in most teams.
- The quality and effectiveness of the local governance arrangements within each team was inconsistent. The issues we found regarding the health based places, care plans and risk assessments had not been identified through existing monitoring arrangements.

However:

- Staff morale was good and staff turnover was low. The teams had enough staff to meet the needs of patients.
- The teams had developed and maintained good working relationships with the acute wards, acute trust and other external stakeholders such as the police.
- There was effective, embedded monitoring in relation to the use of section 136 of the Mental Health Act.
- Two home treatment teams had recently begun supporting patients with Clozapine initiation within the community. This meant that patients did not have to be admitted to hospital because staff carried out monitoring in the patient's own home.
- Staff ensured patients knew how to access help including out of hours.
- The feedback from the friends and family test questionnaires and patients we spoke with was extremely positive.

Summary of findings

- Staff were responsive to patients' needs. Staff ensured patients knew how to access help including out of hours.
- Patients had access to advocacy.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- In the en-suite facilities within the health based place of safety at Stockport, the toilet was heavily stained, the shower base was dusty and the sink waste was blocked with tissue. There were no completed cleaning schedules for the room.
- There was no monitoring to ensure the water system in the room was flushed when not in use in line with trust policy to prevent the risk of legionella disease. This posed an avoidable risk to patients' health.
- The health-based places of safety at Stockport and Tameside were in need of redecorating. The paintwork on the walls in one was covered in black scuff marks. There were also marks and stains on the chairs in both rooms.
- The four health-based places of safety were visited had CCTV cameras in operation although there were no notices to inform patients of this as required by the Code of Practice of the information commissioner.
- The health-based places of safety used by patients did not have instructions or facilities for patients to summon staff assistance if needed.
- The service was not meeting the trust target of compliance in six out of 14 mandatory training courses across the core service.
- Patients' allergies and medication were not routinely recorded in care records. Prescription charts were not always completed fully. In two teams, patients' risk assessments were not always completed and updated.
- The service and teams did not have oversight or ownership of a risk register for the service.

However:

- Staff had a good understanding of safeguarding and how to raise a concern.
- Staff turnover was low and the teams had enough staff to meet the needs of patients.
- Lone working arrangements were embedded and effective.
- In two teams, the quality of the risk assessments was very high.
- Patients had comprehensive crisis and contingency plans in place.

Summary of findings

- Staff understood the principles of duty of candour.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not always have timely access to the care records of young patients detained under section 136 of the Mental Health Act.
- Staff did not routinely carry out physical health assessments or monitor patients' physical health needs. Patients' allergies and medication were not routinely recorded.
- Not all patients had a care plan. Not all care plans were recovery focused or individualised. Care plans were not always updated to reflect patients' current needs and not all patients had a copy of their care plan.
- Compliance with supervision across the teams were variable with some teams as low as 50%.
- There was no information displayed in the health-based places of safety informing patients of their rights.
- There were inconsistencies across teams regarding staff skill mix which meant that not all teams could provide the same level of service to patients.

However:

- The teams had developed and maintained good working relationships with the acute wards, acute trust and other external stakeholders such as the police.
- There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act. Over the past 12 months, every patient who was detained under section 136 had been taken to a health-based place of safety within the trust in line with current national guidance.
- There was effective, embedded monitoring in relation to the use of section 136 of the Mental Health Act.
- In three teams, all the care records contained a comprehensive and up to date care plan for the patient.
- There were good appraisal rates in most teams.
- Staff explained patients' rights when they were admitted to a health-based place of safety and repeated them until patients understood their rights.
- Staff provided patients with information on advocacy and independent mental health advocacy services.

Summary of findings

- Two home treatment teams had recently begun supporting patients with clozapine initiation within the community. This meant that patients did not have to be admitted to hospital because staff carried out monitoring in the patient's own home.

Are services caring?

Good

We rated caring as good because:

- The feedback from the friends and family test questionnaires patients completed for the service was extremely positive.
- Staff were approachable, supportive and respectful towards patients and their carers.
- Staff involved patients in decisions about their care.
- Patients had access to advocacy.
- Staff ensured patients knew how to access help including out of hours.

However:

Not all patients had been given a copy of their care plan.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Over 99% of all acute admissions were via the home treatment team.
- The home treatment teams worked with the acute admission wards to identify patients who they could support to facilitate early discharge.
- The accident and liaison team staff were integrated with the accident and emergency bases where they worked.
- Feedback from commissioners was very positive about the way the acute and mental health staff worked together within these services to ensure patients were assessed promptly.
- The street triage service enabled police officers or paramedics to contact a qualified mental health practitioner by telephone, at any time seven days a week for help, advice and signposting if they suspected a patient they were dealing with may have a mental illness. The police we spoke with told us they found this to be a responsive and valuable service.
- The home treatment teams provided seven day follow up for patients discharged from hospital. The trust reported that 96% of patients on care programme approach were followed up within seven days of their discharge.

Summary of findings

- The teams were aware of the socio, economic, ethnic makeup of the population they served. They actively linked in with community resources to sign post patients to services aimed at meeting their specific needs.
- The teams had information leaflets displayed within the team bases on a range of subjects and access to translators.

However:

- The health-based places of safety were sparse and not welcoming. The rooms did not contain a bed. There were no sheets, pillows or blankets in the rooms. Staff told us that if these were needed, they could access them from the wards.
- Some of the health-based places of safety did not have a clock to orientate patients to time in line with national guidance.
- At Tameside, there was a window which could be overlooked from the outside. Although the window faced the wall of another building, it was possible for a person to access the outside of the window and see into the room.The window did not have a blind which could impact on a patient's privacy and dignity.
- The health based places of safety were not appropriate environments to meet the needs of a young patient less than 18 years. There was no evidence to show that any consideration had been given to the environment in relation to meeting the needs of this patient group.
- The teams did not have information booklets about the services they provided to give to patients.
- Proposed discharge dates were not always recorded in patients' care records or on the team's caseload information board.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- The quality and effectiveness of the local governance arrangements within each team was inconsistent. The issues we found regarding the health-based places of safety, care plans and risk assessments had not been identified through existing monitoring arrangements.
- There was a lack of evidence to demonstrate effective use of performance indicators and audits to drive improvement in most teams.
- There were inconsistencies across the teams regarding:

Summary of findings

- the staff skill mix of the teams
- compliance with mandatory training
- access to supervision
- access to appraisals
- team meetings
- the quality of risk assessments
- the quality of care plans and
- the implementation of the electronic care record system.

- The teams did not have sight of, or ownership of a risk register for the service

- There was a lack of cohesive working across the boroughs.

However;

- Staff morale was good within the teams. Staff felt supported by their manager and colleagues within their team.

- Staff were aware of the trust's whistleblowing process.

- One home treatment team had implemented the productive team initiative.

- There were good governance structures in place to monitor the use of section 136 across the boroughs.

There was a sense of optimism within the teams that the transformation project would support the service to provide a more structured, recovery focused service which was equitable across the service.

Summary of findings

Information about the service

Pennine Care NHS Foundation Trust had reconfigured the crisis home treatment services it provided within each of the five boroughs of Tameside, Stockport, Bury, Oldham and Rochdale in the months prior to our inspection. This had resulted in the development of a new model of working with the introduction of a single point of entry access team for primary care referrals, rapid assessment interface and discharge team (RAID) and home treatment team in each borough.

The teams and services were based within the acute hospitals sites of:

- Fairfield General Hospital,Bury
- Birch Hill Hospital, Rochdale
- Tameside General Hospital, Ashton Under Lyne
- The Royal Oldham Hospital, Oldham
- Stepping Hill Hospital, Stockport

The exception to this was the Tameside home treatment team which was based in a stand-alone building a short distance away from Tameside General Hospital.

The overall purpose of the service provided was to prevent patients being admitted into hospital where possible by offering timely alternative support within the community. Each team had the following specific roles:

Single point of entry access team

This service provided a single access point for referrals into mental health services from primary care agencies such as GPs with the exception of Stockport which also accepted self-referrals. The teams accepted referrals for patients aged 16-65. The functions of the teams included triage, assessment and sign posting of referrals. The teams provided a same day response for urgent referrals and up to two follow up appointments after initial assessment. The teams operated during the following times:

Oldham; 8.30am-7.00pm Monday to Sunday

Rochdale: 8.00am-9.00pm Monday to Sunday

Bury: 8.00am-9.00pm Monday to Sunday

Stockport: 8.00am-9.00pm Monday to Friday

Tameside: 8.30am-6.00pm Monday to Friday

The differences in operational times between the teams were related to local commissioning arrangements.

Rapid assessment interface and discharge team (RAID)

The rapid assessment interface and discharge team had the following responsibilities: accident and emergency liaison psychiatry, street triage and health based places of safety. The team also took over the function of the single point of entry access team out of hours. For the purpose of this report, we will refer to this team as the RAID team throughout with reference to the specific functions as detailed below:

Accident and emergency liaison psychiatry

The function of this service was to:

- provide timely mental health assessments to patients in accident and emergency
- reduce accident and emergency attendances/re-attendances
- provide effective interventions to patients with alcohol misuse problems and
- provide expert clinical support and education to acute staff on caring for patients with dementia.

The teams were based in the acute accident and emergency departments and operated 24 hours a day seven days a week. The teams provided follow up appointments for brief interventions seven days a week between 9am and 5pm.

Street triage

The street triage service enabled police officers or paramedics to contact a qualified mental health practitioner by telephone at any time seven days a week for help, advice and signposting if they suspected a patient they were dealing with may have a mental illness.

Health based place of safety

Each hospital site had a dedicated health based place of safety. Section 136 of the Mental Health Act 1983 allows

Summary of findings

for someone, believed by the police to have a mental disorder, and who may be in need of care or control, to be detained in a public place and taken to a place of safety. Patients may be detained for a period of up to 72 hours for the purpose of enabling them to be examined by a doctor and assessed by an approved mental health professional to consider whether compulsory admission to hospital is necessary. The health-based place of safety offers a 24 hour, seven day a week service.

Home treatment team

The main purpose of the home treatment teams was to:

- provide intensive support in the community to patients aged between 16-65 years experiencing acute mental health crisis to prevent hospital admission
- provide support to patients on leave from an acute mental health ward to reduce the risk of relapse
- act as gate keepers for the inpatient beds
- support and facilitate the early discharge of patients who were admitted to an acute mental health ward
- provide seven day follow ups for patients discharged from an acute mental health ward

The teams operated over seven days during the following times;

- Bury between 8am and 9pm
- Rochdale between 8am and 9pm
- Stockport between 9am and 9pm
- Tameside between 9am and 9pm
- Oldham between 8am and 10pm.

The gate keeping role of the home treatment team was transferred to the RAID team out of hours.

The differences in operational times between the teams were due to local commissioning arrangements.

The services have not previously been inspected under the CQC new methodology.

Our inspection team

Our inspection team was led by;

Chair: Aiden Thomas, Chief Executive, Cambridge and Peterborough NHS Foundation Trust

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leader: Sharron Haworth, Care Quality Commission

The team which inspected this core service comprised one CQC inspection manager and three specialist advisors. The specialist advisors had clinical or management experience of the types of services we inspected.

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' needs?
- Is it well-led?

Summary of findings

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients who used services at three focus groups.

During the inspection visit, the inspection team:

- visited four of the five section 136 health based places of safety and looked at the quality of the environments
- visited all five of the access and home treatment teams
- spoke with six patients who were using the service
- attended and observed two home visits with staff
- attended and observed one initial assessment of a patient with staff
- spoke with two carers
- spoke with the managers and senior managers for each of the teams
- spoke with 15 other staff members
- attended and observed one hand-over meeting
- reviewed 39 care records and four section 136 care records
- reviewed eight prescription charts.
- 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

Patients we spoke with and their carers were positive about the care they received from staff within the service. They described staff as being approachable, supportive and respectful towards them.

Patients told us that staff involved them in decisions about their care and they felt listened to by staff.

Patients knew how to contact support including out of hours. Carers we spoke with told us they felt supported by staff.

The results from the questionnaires the service had given to patients to complete were extremely positive. Of the 72 patients who completed the questionnaires, 69 stated they were likely or extremely likely to recommend the service. No respondents reported they would not recommend the service to family and friends.

Areas for improvement

Action the provider MUST take to improve

The trust must ensure that;

- the health-based places of safety facilities at Stockport and Tameside are clean, in good decorative order and contain soap, towels and toilet paper. There must be effective monitoring systems in place to evidence this to reduce the risk of infection and promote patients' dignity.
- there is an effective system in place to make sure that the water system in the health-based places of safety is flushed when not in use in line with trust policy to prevent the risk of legionella disease.
- there are effective systems in place to enable patients using the health-based places of safety to communicate with staff and summon staff when needed.
- the health-based places of safety contain appropriate furniture to enable a patient to lie down comfortably. Sheets, pillows and blankets must be made available to patients using the room immediately unless risk mitigate against this.
- the health-based place of safety at Tameside has adequate window covering to prevent it being overlooked from the outside to preserve patient's privacy and dignity.

Summary of findings

- staff receive mandatory training in line with trust policy.
- each patient has a comprehensive assessment of their needs, an up to date risk assessment and care plan in place.
- there are effective systems in place to assess, monitor and improve the quality and safety of services provided.

Action the provider SHOULD take to improve

- The trust should ensure that the health-based places of safety meet the needs of patients and that consideration is given specifically to the environment in relation to meeting the needs of children under the age of 18 years.
- The trust should ensure that all the health-based places of safety have:
- notices to inform patients that CCTV cameras are in operation
- information displayed informing patients of their rights
- a clock visible to patients using the rooms
- The trust should ensure that teams have information leaflets about the services provided for patients.
- The trust should ensure that there is equity across the services regarding staff skill mix.
- The trust should ensure that the electronic care record system is fully embedded across all teams.

Pennine Care NHS Foundation 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
Rapid assessment interface and discharge team and home treatment team, Irwell Unit, Fairfield General Hospital, Rochdale Old Road, Bury	Bury Mental Health Services
Health based place of safety, Fairfield General Hospital, Rochdale Old Road, Bury	Bury Mental Health Services
Rapid assessment interface and discharge team and home treatment team, Laurence House, Birch Hill Hospital, Birch Road, Rochdale	Rochdale Mental Health Services
Health based place of safety, Birch Hill Hospital, Birch Road, Rochdale	Rochdale Mental Health Services
Rapid assessment interface and discharge team and home treatment team, Haughton House, 67 Stamford Street, Ashton-under-Lyne	Tameside Mental Health Services
Health based place of safety, Tameside General Hospital, Fountain Street, Ashton Under Lyne	Tameside Mental Health Services
Rapid assessment interface and discharge team and home treatment team, Parklands House, The Royal Oldham Hospital, Oldham	Oldham Mental Health Services
Health based place of safety, The Royal Oldham Hospital, Oldham	Oldham Mental Health Services

Detailed findings

Rapid assessment interface and discharge team and home treatment team, Oasis Building, Stepping Hill Hospital, Poplar Grove, Stockport	Stockport Mental Health Services
Health based place of safety, Stepping Hill Hospital, Poplar Grove, Stockport	Stockport Mental Health Services

Mental Health Act responsibilities

Training in the Mental Health Act was not a mandatory requirement for staff. However; staff had a good understanding of the duties placed on them when patients were brought in to a 136 suite by the police under section 136 of the Mental Health Act. Overall, staff adhered to the joint agency policy in place for the implementation of section 136 of the MHA. This policy and procedure had been jointly agreed by the trust, local police forces and relevant stakeholders.

Over the past 12 months, every patient who was detained under section 136 had been taken to a 136 suite within the trust. This meant that patients were not being taken to a police station which is in line with current national guidance. Patients were frequently taken to the 136 suites by the police rather than by ambulance which is not in line with best practice. However, this was due to lack of available ambulances and the issue had been escalated by the police in line with the crisis care concordat.

Records showed that when patients were admitted to the health based place of safety, staff explained their rights to them and repeated them until patients understood their rights.

Staff provided patients with information on advocacy and independent mental health advocacy services. However there was no information displayed in the 136 suites informing patients of their rights.

The teams reported they had good access to approved mental health professionals who were employed by the local authority. The approved mental health professionals were co-located within the RAID team bases out of hours which meant the teams had timely access to them during these times.

None of the teams provided care or treatment to patients subject to community treatment orders.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act was not a mandatory requirement for staff. However; staff had a good understanding of the five underlying principles relating to the Mental Capacity Act and how these applied to their work. The teams considered patients capacity to consent to the care and treatment offered at point of referral.

Requires improvement

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 the home treatment teams had a number of designated rooms which could be used to see patients on the premises although the majority of visits were carried out in patients' homes. The interview rooms we saw in each team were clean, welcoming and promoted privacy.

Staff had individual alarms which they could use to summon assistance if required. The alarms went directly to the acute wards and reception with the exception of Tameside which was located in a stand-alone building. The manager at Tameside home treatment team told us that only two percent of visits took place on site and this would always be risk assessed before being agreed.

Staff working within the accident and emergency liaison team had access to interview rooms within the departments where they could see patients in private. Security staff were available within the department if required.

We visited four of the five health-based places of safety. The health-based place of safety at Bury was in use at the time of inspection and it was not appropriate for the team to visit at the time.

The suites consisted of two rooms. One of the rooms was a staff office with a telephone, chairs, desk and computer with monitor. The other room was used to provide a place of safety for patients detained under section 136 of the Mental Health Act. The rooms were separated by a wall which had a lockable connecting door with a vistamatic viewing panel. Above the desk in the staff room, there was a one way mirrored window which directly overlooked the other room. The suites had CCTV cameras in operation covering the room used by patients although there were no notices to inform patients of this.

Staff at Stockport and Oldham told us staff locked the door connecting the two rooms leaving staff to observe the patient through the viewing panel on the door, CCTV monitor or the one way mirrored window. Staff told us that patients were constantly observed by a member of staff when the room was in use and that patients were informed of this. However: it was not possible to see the desk where staff would sit through the viewing panel on the other side of the door due to the angle. It was also not possible for a patient in the room to see staff through the one way mirror, therefore a patient could not be assured that there was a member of staff present in the staff room. There was no intercom system, telephone or call bell in the room used by patients. This meant that if a patient wanted to communicate with staff or summon assistance, they would need to do so via the CCTV camera.

The rooms used by patients were all en-suite and contained a shower, toilet and sink. The door to the en-suite facilities could be locked by staff. Staff told us they would lock the door if they were concerned that a patient may be a risk to themselves. This was because it was not possible for staff to observe a patient if the door to the en-suite room was closed.

The latest patient led assessment of the care environment scores for the five hospital sites where the health-based places of safety were situated were all over 99% for cleanliness. Despite this we found the en-suite facility within the health-based place of safety at Stockport to be particularly dirty. The toilet was heavily stained and had a thick dirty waterline in the pan. The shower base was dusty and dirty. The sink waste had been blocked with tissue. We asked to see a record of the cleaning schedule. We were told by a senior manager that the cleaner had informed them the rooms were checked daily but they did not complete the cleaning schedule. We requested assurance from the senior manager that the water system in the room was flushed when not in use in line with trust policy to prevent the risk of legionella disease. They were unable to provide this or evidence that the water system was flushed. This meant that patients using the suite were potentially exposed to a risk which was avoidable.

There were no toilet roll, soap or hand drying facilities in the en-suite room at Stockport. Staff told us they would provide these if the room was being used. It was not clear why these were not available routinely at point of care.

The rooms all contained weighted chairs which meant they could not easily be moved or thrown.

Requires improvement

Are services safe?

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

The suites did not have a seclusion room. The trust reported one incident involving the use of seclusion between August 2015 and May 2016 at both Rochdale 136 suite and Tameside RAID team.

The health-based places of safety at Stockport and Tameside were in need of redecorating. The paintwork on the walls at Stockport was covered in black scuff marks. There were also marks and stains on the chairs in both rooms.

Staff had access to infection control personal protective equipment such as hand gels, hand washing facilities and disposable aprons if required at all sites. Compliance with infection control level 1 mandatory training was good with all teams achieving over 85% and six attaining 100% compliance. Compliance with level 2 training was inconsistent with five teams achieving over 80% with the lowest rate being 25% in Stockport RAID team.

Safe staffing

The teams had the following number of substantive staff in each:

Bury home treatment team eight

Bury RAID team 10

Rochdale home treatment team 10

Rochdale RAID team 10

Oldham home treatment 15

Oldham RAID team 12

Stockport home treatment team 11

Stockport RAID team 13

Tameside home treatment team 10

Tameside RAID team 18

Staff turnover at each team was low over the past 12 months with only four staff leaving the service overall. One member of staff had left each of the following teams: Bury, Oldham and Tameside RAID team teams and Oldham home treatment team.

Staff vacancy rates (excluding seconded staff) were below seven percent with the exception of:

Bury RAID team 11%

Oldham RAID team 25%

Oldham home treatment team nine per cent

Oldham RAID 14%

Stockport RAID team 10%

Tameside home treatment team 20%

Tameside RAID 40%

Rochdale home treatment team nine per cent

Staff sickness was below seven per cent with the exception of:

Rochdale RAID team 10%

Rochdale home treatment team 10%

Oldham RAID nine per cent

Tameside home treatment team 14%

Any staffing shortages were covered by internal bank or agency. Regular agency staff were used where possible to promote continuity of care and we saw evidence of this when we visited the teams. Staff told us that caseloads were manageable and that appointments were not cancelled or re-arranged due to staff shortages. Patients we spoke with confirmed this.

Tameside home treatment team had the highest average caseload with 41 followed by Rochdale 34, Stockport 32, Bury 29 and Oldham with 19. These included patients in receipt of seven day follow up post discharge from the acute wards.

The trust supplied the following data for the access teams' caseloads (which did not include Stockport): Oldham 44, Rochdale 22, Bury 18 and Tameside 14.

The trust target for compliance with mandatory training was 95% with the exception of PREVENT training which was 85%. This is above the NHS target of 75%.

Manual handling;

All teams were almost or over 80% compliant.

Conflict resolution level 1

All teams were almost or over 80%.

Conflict resolution level 2

All teams were under 75% with the exception of Bury and Rochdale RAID which was 100% compliant.

Requires improvement

Are services safe?

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

Equality and diversity

All teams were over 75%.

Basic life support

Bury and Rochdale RAID were 89% and 100% compliant. All the other teams were less than 75%. Stockport RAID had the lowest compliance with 25%.

Health and safety

All the teams were over 85% compliant.

Infection control level 1

All teams were over 85%.

Infection control level 2

Five teams were 75% or over. The lowest compliance was Stockport RAID with 25%.

Adult safeguarding

All of the teams achieved 90% with the majority achieving 100%.

Child safeguarding level 1

All of the teams achieved 90% with the majority achieving 100%.

Child safeguarding level 2

Four of the teams had achieved 100% and one had achieved 77%. Five teams were below 75%.

Oldham RAID team had the lowest with 50%.

Fire safety

Only two teams were above 75% which were Oldham RAID with 89% and Tameside RAID with 77%. The lowest compliance rates were for Rochdale and Bury RAID with 50% followed by Tameside home treatment team with 55% compliance.

Information governance

All teams were over 75% compliant

PREVENT

Three teams achieved 100% which were Bury, Rochdale and Stockport RAID. Oldham RAID team was 77% complaint. All the others were below 75%% with Tameside RAID the lowest with 50%.

This meant the trust was not meeting the NHS target of 75% compliance in six out of 14 mandatory training courses across the core service.

Assessing and managing risk to patients and staff

All the teams within the RAID service completed a risk assessment at point of referral. All referrals to the single point of access from primary care included a risk assessment which the referrer completed as part of the referral process and faxed to the team. Staff used the referral information to triage if the referral was urgent and required a response the same day or was not urgent and required a response within five days. Staff explained that they would seek further information from the referrer regarding risk if required. The teams used a red, amber and green 'zoning' system to identify the severity of patients' risks and needs. This meant the teams were able to signpost patients to the most appropriate service to meet their needs based on the risks presented.

There were good processes in place to identify and manage risks regarding patients who were taken to a health-based place of safety by the police. These were detailed in the trust's joint 'Section 136 Mental Health Act 1983 – Removal to a Place of Safety' policy which had been developed and agreed with the police and other stakeholders. Before a patient was taken by the police to one of the 136 suites, the police always contacted the team to inform them that they required use of the suite. Two members of staff were always designated to receive a patient brought to a suite by the police.

The policy stated that the police officer(s) would remain in attendance while the patient's health, safety, or the protection of others necessitates this, and in any event until specialist mental health staff formally accepted responsibility for care and custody. A joint risk assessment would be undertaken including a discussion regarding any further police support that may be required if the patient became a risk once the police had left the place of safety. Staff, the police we contacted and the care records we saw confirmed this occurred in practice. However; we did receive feedback from the police at Tameside that there had been occasions where officers were expected to stay for up to eight hours with patients detained under section 136 despite the absence of risk. This was being addressed by the trust.

Staff within the home treatment teams used a red, amber and green 'zoning' system to identify patients' risks. This

was based upon severity of the patient's diagnosis, individual risk, socio-demographic and needs. Patients zoned as red were assessed as requiring intensive interventions to maintain their safety and may need an inpatient admission. Patients zoned as green meant they required longer term support and were near discharge. Patients zoned as amber fell between these two categories. In all the teams we visited, we saw that each team information board identified each patients risk using this system.

Lone working arrangements were very good across all teams. Staff within the home treatment teams explained how two members of staff would visit patients who were assessed as too high a risk for one member of staff to visit. If the risk of visiting a patient at home was considered to be too high, then the patient would only be offered an appointment at one of the team sites where staff could summon assistance if required. Staff told us that patients zoned as being red would always be visited by a qualified member of staff.

There was good evidence that staff safety was a high priority across all teams and that staff supported each other well by the use of a buddy system and safety boards/ forms to document their whereabouts. Staff had telephones supplied by the trust which they used to input the address of patients they were visiting. If they encountered any safety concerns, staff could press the number five on the phone and this would alert a central security patient that they were in need of assistance and where they were.

We looked at 39 care records within the home treatment teams to assess the quality of the individual risk assessments. We looked at eight records within each team with the exception of Rochdale where we looked at seven. In Rochdale and Stockport, all the records we looked at contained a comprehensive risk assessment which was all up to date. The risk assessments were very detailed and of a high quality. In Oldham, each care record contained a risk assessment which was up to date although some of the records contained incomplete data.

In Tameside and Bury, risk assessments were not routinely completed or updated by the home treatment team staff at point of transfer into the service. All the risk assessments we looked at had been completed by the referrer. In Bury, all care records contained a risk assessment. There were some good examples of crisis plans and advance directives which had been developed with patients although only two risk assessments had been updated. In Tameside, only three care records had a risk assessment. These had been updated. There was a lack of evidence in the care records at Bury and Tameside to show that risks were discussed at first assessment.

This meant that in Tameside and Bury, patients' current risks may not be accurately reflected in their care records.

The service did not have a risk register for the teams. All of the staff we spoke with were unable to tell us if a risk register existed for their team or the service as a whole. The service managers for the teams did not have sight of, or ownership of a risk register for the service. They told us they would escalate any risks to their operational manager for the service who had responsibility for escalating these onto the trust risk register. There were no risks relating to the service on the trusts risk register. Staff told us that if they had any concerns regarding risk, they would escalate this to their manager. The lack of team or service risk registers meant that only high level risks relating to the service, which met the threshold for escalation onto the trusts' risk register were captured and monitored by the service.

The trust reported one incident involving the use of restraint at each of the following teams; Bury 136 suite, Oldham home treatment team, Oldham RAID team, Tameside RAID team and Stockport RAID team between August 2015 and May 2016. The incident at Oldham RAID team involved the use of prone or face down restraint and the use of rapid tranquilisation.

All the teams had access to equipment such as ligature cutters, oxygen, first aid kits and a defibrillator in the event of an emergency. However, compliance rates with basic life support were much lower than the trust target of 95% in some teams. Rochdale home treatment and Bury and Rochdale RAID teams were 100% compliant. All the other teams were 50% or less with Stockport RAID team with the lowest compliance rates at 25%.

Staff had a good understanding of safeguarding and how to report any safeguarding concerns they may have. All the teams had an identified safeguarding lead within their team.

The teams did not keep stock medication or administer medication to patients. However, the teams did have locked medicine cabinets where they could store

Requires improvement

Are services safe?

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

prescribed medication for patients who may be at risk of taking an overdose as part of their care plan. Staff would take the patient's medication to them during home visits and supervise them taking it.

Only Oldham home treatment team had any prescription charts for patients. We reviewed eight prescription charts. Six out of the eight charts were not signed or dated and allergies were not routinely recorded.

In the care records we looked at within the teams, there was no central record in patients' care records where medication or allergies were recorded. The teams did not routinely undertake medication reconciliation. Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking, including drug name, dosage, frequency, and route and comparing that list against the medication the patient's doctor has prescribed. The teams only did this at the request of the patient's sector consultant. This meant that staff may not have up to date information about what medication the patient was prescribed or any associated allergies they may have.

Stockport and Tameside home treatment teams had both recently began supporting patients with clozapine initiation within the community. The clozapine was stored at the respective community mental health team and not by the home treatment teams. Clozapine titration is usually carried out in hospital because of the level of monitoring required. Patients did not have to be admitted to hospital when they were prescribed clozapine because staff carried out monitoring in the patient's own home. This practice meant hospital admission was avoided. The service had protocols in place for this.

Track record on safety

Between February and December 2015, there were 10 serious incidents which required investigating within the service. Six of these were suspected suicides, two were attempted suicides and one was a road traffic accident. There were three incidents in both Stockport and Oldham, two in Tameside and one in Bury.

Reporting incidents and learning from when things go wrong

All staff had access to an electronic incident reporting system. Staff were aware of how to use the system to report incidents.

Staff received de-briefs and support following serious incidents. Debriefings included input from a psychologist.

Managers told us that actions from incidents were discussed in team meetings. Learning was disseminated through operational governance meetings to team leaders and then to staff through team meetings.

Duty of Candour

Staff understood the underlying principles of the duty of candour requirements and the relevance of this in their work. The team managers at Tameside and Stockport home treatment teams were able to discuss recent examples of how they had followed the duty of candour principles following incidents which had taken place within their teams. This included being open and transparent with the patients involved and issuing an apology.

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

The home treatment teams were at different stages of implementing the electronic care record system. Tameside and Stockport had fully implemented the system in 2014. Bury, Rochdale and Oldham had introduced the system in the weeks before our visit. However, the system was not fully implemented and the teams were using a combination of paper and electronic records.

The health-based places of safety had been used for young patients detained under section 136 of the Mental Health Act, the youngest being 11 years of age. Staff contacted the child and adolescent mental health team when patients aged under 18 years of age were detained and we saw evidence of this in the case records we saw. However; staff told us that it was difficult to access care records the young patient may have out of hours as the child and adolescent teams did not work outside of office hours. There was no crisis team specifically for young patients. This meant that staff did not always have timely access to information for young patients detained under section 136 of the Mental Health Act.

All the teams used the mental health clustering tool which was developed by the Department of Health as a means of allocating patients referred to the service to care clusters. The care clusters were used to rate a patient's severity and acuity of symptoms to ensure patients accessed the most appropriate service to meet their needs.

Physical health screening and monitoring was not included in the initial monitoring form completed by the access teams.

We looked at 39 care records across the home treatment teams to assess the quality of the assessments staff completed and care plans. There was evidence of physical health assessments in only nine records and of on-going monitoring of physical health in eight. These were mainly in Stockport and Rochdale. Patients' allergies were not recorded in any of the records we looked at.

However; in Oldham, Rochdale and Stockport, all the care records we looked at contained a comprehensive and up to date care plan for the patient. The care plans identified the patients' social, psychological, occupational and physical health needs.

At Bury and Tameside, care plans were only completed by the teams if the patient was referred from the RAID team. We found that in Tameside, only four of the eight records had a care plan although these were up to date. In Bury, only three of the eight records had a care plan of which two had been updated. The care plans were not personalised or recovery focused in these teams. For example, in Bury, two care plans were almost identical despite the two patients having very different needs.

Staff told us that if they suspected a patient who was detained under section 136 had a learning disability, they would contact the learning disability team for advice if required.

Best practice in treatment and care

Staff used National Institute for Health and Care Excellence guidelines in their practice. For example, staff supported the care programme approach by undertaking seven day follow-up arrangements. This was good practice and ensured that patients who used services were supported in the community following discharge from hospital.

At Tameside home treatment team, the manager had arranged for a psychologist to provide staff with weekly sessions on a Friday morning which linked to National Institute of Health and Care Excellence guidance, for example on borderline personality disorders and psychosis. Staff were given protected time to attend these sessions. However; the teams did not have dedicated input from a psychologist for patients who used the service. Teams referred patients to Healthy Minds if they required psychology input.

Stockport and Tameside home treatment teams had both recently began supporting patients with clozapine initiation within the community. Patients did not have to be admitted to hospital when they were prescribed clozapine because staff carried out monitoring in the patient's own home. This practice meant hospital admission was avoided.

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.

In addition the teams undertook some clinical audits looking at the quality of patients' care records for example.

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.

However; there was a lack of evidence to demonstrate effective use of these audits and data to drive improvement in most teams with the exception of Stockport home treatment team.

The street triage service enabled police officers or paramedics to contact a qualified mental health practitioner by telephone at any time seven days a week for help, advice and signposting if they suspected a patient they were dealing with may have a mental illness. This is in line with the Mental Health Crisis Care Concordat. The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

There were good governance structures in place to monitor the use of section 136 across the boroughs. Detailed data was collected monthly to monitor the use of section 136 and this was used to identify trends and gaps in services. There were established multi-agency forums which used this data to drive improvements in the use of section 136. This was scrutinised and processed by the mental health law administrators across each hospital site to identify any trends or outliners. Data was shared both within and outside of the trust through a number of established forums such as the local police and health partnership working groups, mental health law scrutiny group, acute care forum, local police liaison officers, as well as on an annual basis with New Economy as part of the crisis care data dashboard. The police we contacted told us that through the data, the use of section 136 usage for young patients under 18 years of age had been identified as an issue of concern within the local police and health partnership working groups. The police and trust were working together to explore ways they could reduce the use of section 136 for this group.

Skilled staff to deliver care

All the teams had a band 7 team manager. A high proportion of the qualified staff within the teams were band 6 senior clinicians.

There were inconsistencies across the teams regarding the staff skill mix of the teams and medical model within each. All the teams consisted of a mix of mental health nurses, social workers and unqualified support staff. However; Oldham and Bury had occupational therapists as part of the team but the other teams did not. The teams did not have dedicated psychologists attached to them to provide psychological therapy to patients who used the service although staff could refer patients to the psychology service and Healthy Minds.

Stockport and Oldham had full time dedicated medical cover as an integrated part of the teams. Rochdale had dedicated medical cover in the team for two sessions per week. Any other medical input for Rochdale was provided by sector medical staff that were based in the community mental health teams. All the medical cover at Bury and Tameside was provided by sector medical staff.

The teams did not have approved mental health practitioners employed by trust. The local authority employed the approved mental health practitioners although they were co-located within the RAID team bases out of hours.

Staff we spoke with told us their managers supported them to access training to develop their roles. Some teams had nurse prescribers which meant they could prescribe agreed medication for patients in line with trust policy.

Other staff had accessed courses in cognitive behavioural therapy and substance misuse for example.

All the doctors within the adult mental health services in Rochdale and Stockport had been revalidated and over 85% of all doctors in the other three boroughs had.

The appraisal rates for non-medical staff for each team were above 80% with the exception of

Bury RAID 70%, Oldham home treatment team 67% and Oldham RAID with 60%.

Compliance with supervision across the teams was variable. Trust figures showed that Stockport achieved 100%, Oldham and Rochdale 50%, Tameside and Bury between 50-70%. This meant that only Stockport had implemented and embedded the trust's supervision policy fully.

Teams could access informal psychology support for staff although this was not documented.

The teams did not have any members of staff who were subject to suspension or disciplinary procedures. The

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.

managers we spoke with told us they discussed staffing performance in supervision. They were aware of the trust's policies and procedures to manage and deal with any staff performance issues.

Multi-disciplinary and inter-agency team work

The teams within each borough were co-located with the exception of Tameside home treatment team which was located in a stand-alone building. We saw evidence of effective communication and good working relationships between the teams within each borough. However there was a lack of joint working between teams across the five boroughs.

All the teams we visited held at least one handover each day and a multidisciplinary meeting up to three days a week. We attended one handover at Rochdale home treatment team. The operational policy for the team stated that each patient's care plan should be reviewed and future needs identified during these handovers. However the handover lacked focus and there was little discussion or review of patients' care plans and current risks.

We did find evidence to demonstrate that the service had developed and maintained good working relationships with the acute wards and external stakeholders.

There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act. This policy and procedure had been jointly agreed by the trust, local police forces and relevant stakeholders. Feedback we received from the police was overall very positive about the relationship they had developed with the trust and staff within the teams. In Rochdale, the police told us about how they had worked with trust staff to increase their understanding of the role of the police and with officers to ensure they were clear on expectations. This had included joint training sessions on the Mental Health Act with the police and trust staff.

The feedback we received from the police was positive in relation to the service they could access through the street triage 24 hour phone line. They reported that staff were responsive and supportive when they phoned the line for advice.

The home treatment teams had regular contact with the acute ward staff to identify patients who may be appropriate for early discharge. If patients were discharged under the care programme approach and had a care co-ordinator allocated, the teams worked closely with the patient's care co-ordinator.

The accident and liaison team staff were integrated with the accident and emergency bases where they worked. Feedback from commissioners was very positive about the way the acute staff and mental health staff worked together within these services.

The home treatment teams had all developed good links with a range of statutory and non-statutory community based services which provided housing, spiritual, vocational and health promotion support and advice.

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

Training in the Mental Health Act was not a mandatory requirement for staff. However; staff had a good understanding of the duties placed on them when patients were brought in to a health-based place of safety by the police under section 136 of the Mental Health Act. Overall, staff adhered to the joint agency policy in place for the implementation of section 136 of the MHA. This policy and procedure had been jointly agreed by the trust, local police forces and relevant stakeholders.

Over the past 12 months, every patient who was detained under section 136 had been taken to a health-based place of safety within the trust. This meant that patients were not being taken to a police station which is in line with current national guidance. Patients were frequently taken to the health-based places of safety by the police rather than by ambulance which is not in line with best practice. However, this was due to lack of available ambulances and the issue had been escalated by the police through the crisis care concordat.

Records showed that when patients were admitted to the health based place of safety, staff explained their rights to them and repeated them until patients understood their rights.

Staff provided patients with information on advocacy and independent mental health advocacy services. However there was no information displayed in the health-based place of safety informing patients of their rights.

The teams reported they had good access to approved mental health professionals who were employed by the

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.

local authority. The approved mental health professionals were co-located within the RAID team bases out of hours which meant the teams had timely access to them during these times.

None of the teams provided care or treatment to patients subject to community treatment orders.

Good practice in applying the Mental Capacity Act

Training in the Mental Capacity Act was not a mandatory requirement for staff. However; staff had a good understanding of the five underlying principles relating to the Mental Capacity Act and how these applied to their work. The teams considered patients capacity to consent to the care and treatment offered at point of referral.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

In total, the service had received feedback from 72 respondents who had completed the friends and family test between 1 December 2015 and 31 May 2016. Data was not received for the following five teams; Bury, Rochdale, Stockport and Oldham home treatment teams and Tameside access team.

The feedback from the questionnaires patients completed was extremely positive. Of the 72 patients who responded, 69 stated they were likely or extremely likely to recommend the service. One respondent did not know if they would recommend the service and two were neither likely nor unlikely to do so.

The trust had received eight compliments for the service in the past 12 months. There was one each for Oldham access team, Tameside home treatment, Rochdale access and Bury access and two each for Stockport and Rochdale home treatment teams.

Patients we spoke with and their carers were positive about the care they received from staff within the service. They described staff as being approachable, supportive and respectful towards them. Staff respected patients' confidentiality.

Patients told us that staff did not cancel or re-schedule their appointments. If staff were running late, they would contact the patient to let them know in advance.

We observed staff treating patients and their carers with respect during the home visits and assessments we observed. Staff demonstrated active listening skills and used positive, warm language towards patients during the interactions we saw.

The involvement of people in the care that they receive

During the home visits we observed, staff completed thorough reviews of patients' care plans with them. This included discussions about the patient's medication, social, housing, psychological and physical health needs. Staff also made appropriate referrals to other agencies such as occupational therapy and housing with the agreement of the patient.

Patients told us that staff involved them decisions about their care although they had not all been given a copy of their care plans by staff. In Stockport, Oldham and Rochdale, all the care records we looked at contained an up-to date care plan for the patient. However, in Tameside and Bury, only seven of the 16 care records we looked at had a care plan. The care plans were not personalised or recovery focussed in these teams.

All the patients we spoke with however confirmed they had been given written information and the contact details of how they could access help including out of hours.

Staff provided patients with information about advocacy services including independent mental health advocacy.

Carers we spoke with told us they felt supported by staff.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

All of the teams operated a single point of access which dealt with all referrals into mental health services from primary care agencies such as GPs with the exception of Stockport which also accepted self-referrals. The function of the service included triage, assessment and sign posting of referrals. Referrals were assessed and rated as urgent, priority or routine. Urgent referrals were seen the same day, priority referrals were seen within five days and routine within 10 days. The team were able to offer patients up to two follow up appointments if required.

The accident and emergency liaison team provided triage and assessment for patients referred to the team by the acute trust staff presenting with self-harm and mental health crisis. The teams also offered follow up appointments for patients within seven days.

The home treatment teams 'gate kept' the acute admission beds. Patients were only admitted into hospital if the risk of them remaining in the community was assessed as being too high. Over 99% of all acute admissions in the previous 12 months had been via the team.

None of the teams we visited had a waiting list.

The home treatment teams worked with the acute admission wards to identify patients who they could support to facilitate early discharge. At Tameside and Stockport, the teams were very proactive and visited the acute wards daily. All the teams also supported patients in the community who were on leave from hospital. This was in line with the 'least restrictive' principle of the Mental Health Act 1983 Code of Practice.

The home treatment teams held daily meetings to identify patients who were ready for discharge. However; we found that proposed discharge dates were not always recorded in patients' care records or on the teams case load information board. The exception being Stockport home treatment team which had a very clear structured pathway from referral to discharge.

The home treatment teams provided seven day follow up for patients discharged from hospital in line with the care programme approach principles. The trust reported that 96% of patients on care programme approach were followed up within seven days after discharge in between January and March 2016.

The teams all had an established discharge pathway to GPs which included timely discharge summaries being sent to GPs when a patient was discharged from the service.

In Rochdale RAID team, patients who had been referred for a follow up outpatient appointment with a doctor remained on the team's case load until they had been seen which could be several weeks. However; the other teams discharged patients from their case load once an outpatient appointment had been made for the patient. This meant that in Rochdale, the team case load did not reflect the actual work load of the team.

The teams told us they actively followed up patients who did not attend appointments in line with trust policy. We saw evidence of this in the care records we looked at. However; during a handover we attended, a member of staff reported they had left a 'calling card' for a patient who was not in when they had visited them. There was no discussion about planned next steps if the patient failed to make contact.

The street triage service enabled police officers or paramedics to contact a qualified mental health practitioner by telephone, at any time seven days a week for help, advice and signposting if they suspected a patient they were dealing with may have a mental illness. The police we spoke with told us they found this to be a responsive and valuable service.

All patients detained under section 136 by the police were taken to one of the services health-based places of safety. There had been no cases were a patient detained under section 136 had been diverted to a police custody suite between January 2015 and March 2016. This is in line with the Mental Health Crisis Care Concordat and best practice.

Trust figures showed that between January to December 2015, no episodes of section 136 detentions had exceeded the maximum 72 hour detention period. The average length of detention under section 136 was 6.2 hours January 2015 to December 2015. This had decreased between January to March 2016 to 5.6 hours.

Are services responsive to people's needs?

Good

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

Between January 2015 and March 2016 the trust reported a total of 578 episodes of use of health-based places of safety. The highest usage was at Stockport with 187 episodes and the lowest was at Rochdale with 64.

The incidence of patients under 18 years old being detained on section 136 fluctuated between eight and no incidences per month over the same period with a total of 61 episodes reported overall. However; on 19 other occasions the age of the patient was recorded as 'not known' therefore it is not possible to determine if these incidents related to children under 18 years of age or not.

The total number of patients discharged without follow up (or discharged and no further details recorded) following detention under section 136 was 198 (34%). Figures for each team were:

Rochdale 48% (31)

Bury 43% (62)

Oldham 36% (39)

Stockport and Tameside 25% (47 and 19)

The total number of patients discharged with follow up from a GP or community team was 135

(21%). Figures for each team were:

Rochdale 17% (11)

Bury 19% (28)

Oldham seven percent (eight)

Stockport 33% (62)

Tameside 34 (26)

The total number of patients detained on section 2 or 3 of the Mental Health Act following detention under section 136 was 96 (16.6%). Figures for each team were:

Rochdale 16% (10)

Bury 11% (16)

Oldham 21% (23)

Stockport 19% (36)

Tameside 14% (11)

The number of patients informally admitted to hospital following detention under section 136 was 149 (26%). Figures for each team were:

Rochdale 19% (12)

Bury 26% (38)

Oldham 34% (37)

Stockport 22% (42)

Tameside 26% (20)

These figures show that in Rochdale, patients were more likely to be discharged without follow up and less likely to be admitted into hospital informally following their detention under section 136 of the Mental Health Act. In Oldham, patients were much more likely to be discharged without follow up from a GP or community team than with this follow up.

The facilities promote recovery, comfort, dignity and confidentiality

All the teams had a number of designated rooms which could be used to see patients on the premises although the majority of visits were carried out in patients' homes. The interview rooms we saw in each team were clean, welcoming and promoted privacy and confidentiality.

However; there were a number of issues with the health-based places of safety which meant they did not always meet patients' needs;

- The rooms were sparse and not welcoming. They only contained three weighted chairs. The walls were completely blank. The rooms resembled a seclusion room.
- The rooms did not contain a bed. Staff told us they could push the chairs together to make an area where a patient could lie down although the depth of the chairs was not wide enough to meet the needs' of patients with bariatric needs.
- There were no sheets, pillows or blankets in the rooms. Some of the rooms did not have toilet paper, towels or soap readily available for patients to use. Staff told us that if these were needed, they could access them from the wards. It was not clear why these were not readily available for patients using the room.
- Some of the 136 suites did not have a clock to orientate patients to time in line with national guidance.
- At Tameside health-based place of safety, there was not a blind on the window. Although the window faced the

Are services responsive to people's needs?

Good

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

wall of another building, it was possible for a person to access the outside of the window from between the two buildings and see into the room. This could impact on a patients' privacy and dignity.

- Staff told us they locked the en-suite door if they locked the connecting door as it was not possible for them to observe the patient. This meant the patient would need to ask staff to open the door if needed.
- It was not possible to see the desk where staff would sit through the viewing panel on the other side of the door due to the angle. It was also not possible for a patient in the room to see staff through the one way mirror. There was no intercom system or other way for a patient to directly communicate with staff or know that staff were present in the staff room.
- The health-based places of safety were not appropriate environments to meet the needs of a young patient less than 18 years. There was no evidence to show that any consideration had been given to the environment in relation to meeting the needs of this patient group.
- Patients using the health-based places of safety did not have direct access to drinks however; staff could provide drinks and snacks for patients at any time. Staff were able to provide any dietary requirements a patient may have.

This meant the rooms did not promote patients' recovery, independence or dignity. This is not in line with best practice guidance. The rationale for providing hospital based places of safety as an alternative to patients being detained within police custody is to provide a more appropriate, recovery focussed environment for patients detained under section 136. The 136 suites we saw did not meet this standard.

Meeting the needs of all people who use the service

Staff within the teams were aware of the socio-economic and diverse cultural backgrounds of the patients they supported within their locality. We saw evidence that the teams actively linked in with community resources to sign post patients to services aimed at meeting their specific needs.

All teams were almost or over 80% compliant with equality and diversity training.

The team bases were compliant with the Disability Discrimination Act requirements regarding access.

The teams had access to translators. The teams did not have information booklets about the services they provided to give to patients.

The teams did have information leaflets displayed within the team bases on a range of subjects. These included health promotion material and leaflets informing patients about how they could make a complaint. These were available in a number of different formats and languages. However; most patients were seen at home and therefore would not have access to these.

There were no complaints leaflets or any other patient information displayed in the health-based places of safety we visited. Patients we spoke with told us they felt comfortable raising any issues they had with staff but they were not sure how they could make a formal complaint.

Listening to and learning from concerns and complaints

Between 26 May 2015 to 25 February 2016, the service had received nine formal complaints.

Bury RAID had received three complaints of which one was partially upheld, one was not upheld

and the other was ongoing. Stockport RAID had received two complaints which were both ongoing. Tameside RAID received four complaints from two patients. One complaint was not upheld and the other three were ongoing. All the complaints the service had received had been fully investigated in line with trust policy.

Staff discussed complaints in team meetings. They told us the outcome of complaints was fed back to them through these meetings by their manager.

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.

Our findings

Vision and values

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

Staff were aware of the trust's values and there were posters in all the team bases we visited displaying these.

All the teams had a recovery based ethos. All staff we spoke with understood that the overarching aim of the service was to reduce hospital admissions and the length of stay of patients admitted to hospital by providing intensive support to patients in the community.

Staff knew who the senior managers of the trust were and reported that they had visited the teams.

Good governance

The operational policies for the teams were recovery focused. However; the policies for the home treatment and RAID teams in Oldham, Rochdale and Bury were not dated and did not contain the same level of detail that the Tameside and Stockport polices contained. For example, the Oldham and Bury RAID policies did not mention the street triage service. The Bury and Rochdale RAID teams were jointly funded but the Bury RAID policy did not mention Rochdale and there was no policy for Rochdale.

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. The teams also received a priority brief from the trust which identified lessons learnt and key messages for all staff.

Some clinical audits were completed however; there was a lack of robust evidence to demonstrate effective use of these audits and data to drive improvement in most teams.

Staff had a good understanding of safeguarding and each team had an identified safeguarding lead.

The quality and effectiveness of the local governance arrangements within each team was inconsistent. Some teams kept comprehensive team meeting minutes which were circulated to staff electronically whilst other teams did not have full records of team meetings available for scrutiny.

There were also inconsistencies across the teams regarding:

- the staff skill mix of the teams
- compliance with mandatory training
- access to supervision
- access to appraisals
- the quality of risk assessments
- the quality of care plans and
- implementation of the electronic care record system.

The teams worked well together within the boroughs they served. However; there was a lack of cohesive working across the boroughs. The teams within the boroughs functioned as separate entities from each other. This meant that there was limited opportunity for teams to share learning across the service.

However; there were good governance structures in place to monitor the use of section 136 across the boroughs. Detailed data was collected monthly to monitor the use of section 136 and this was used to identify trends and gaps in services. There were established multi-agency forums which used this data to drive improvements in the use of section 136. For example, the use of section 136 usages for young patients under 18 years of age had been identified as an issue of concern within the local police and health partnership working groups. The police and trust were working together to explore ways they could reduce the use of section 136 for this group.

The teams did not have sight of, or ownership of a risk register for the service. Only high level risks relating to the service, which met the threshold for escalation onto the trust's risk register were captured and monitored by the service.

Leadership, morale and staff engagement

Overall, staff morale was good within the teams. Through speaking with a range of staff within all the teams, it was clear that they were proud, motivated and committed in their work.

There were no bullying or harassment cases being investigated at the teams we visited. No staff were subject to suspension or disciplinary procedures.

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 turnover within the service was low over the past 12 months with only four staff leaving the service overall. Staff sickness was below seven percent in six out of the 10 teams. The highest sickness rate was in Tameside home treatment team at 14% however; this was being managed by the use of regular bank staff.

Staff were aware of the trust's whistleblowing process. Staff reported they would feel confident in raising any concerns they may have with their manager and they would address them. Staff felt

supported by their manager and colleagues within their team.

Staff were aware that the trust had secured funding from the clinical commissioning groups to develop and improve the acute care pathway including the services which the teams provided. The 12 month transformation project had only recently started being implemented although there was a sense of optimism within the teams that the project would support the service to provide a more structured recovery focused service which was equitable. The manager in Stockport and Tameside told us that they had started to attend weekly meetings to look at the transition pathway as part of the project. However; other teams were not involved in the project at the time of our visit.

Commitment to quality improvement and innovation

Stockport home treatment team had implemented the productive team initiative.

The street triage service enabled police officers or paramedics to contact a qualified mental health practitioner by telephone at any time seven days a week for help, advice and signposting if they suspected a patient they were dealing with may have a mental illness. This is in line with the Mental Health Crisis Care Concordat. Feedback we received from the police was very positive about the service provided.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust did not ensure that care and treatment was provided in a safe way for patients because; • The en-suite facility within the health-based place of safety at Stockport was particularly dirty. The toilet was heavily stained, the shower base was dusty and the sink waste was blocked with tissue. The furniture was stained and dirty. Some of the rooms did not have toilet paper, towels or soap readily available for patients to use. • There were no completed cleaning schedules for the suite available for scrutiny at the time of our visit. It was not possible to determine when the suite was cleaned or how often it was. This posed an avoidable risk to patients' health. • The service was unable to provide assurance that the water system in the health-based place of safety at Stockport was flushed when not in use in line with trust policy to prevent the risk of legionella disease. This posed an avoidable risk to patients' health. • Patients using the health-based places of safety were unable to see staff in the staff room. Staff locked the en-suite door in the room if a patient was using the health-based places of safety. There was no intercom system, telephone or call bell in the room used by patients. This meant that if a patient wanted to communicate with staff or summon assistance, they would need to do so via the CCTV camera. • The health-based places of safety were sparse, not welcoming and resembled a seclusion room. The rooms did not contain a bed where patients could comfortably lie down. There were no sheets, pillows or blankets in the rooms.

This section is primarily information for the provider

Requirement notices

- The health-based place of safety at Tameside did not have blinds on the window which could be overlooked from the outside. This could impact on a patient's privacy and dignity.

This is a breach of regulation 12 (1) (2) (a) (b) (d) (e) (h)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust did not ensure that the care and treatment patients received was appropriate and met their needs because;

- In Tameside home treatment team, only four of the eight records had a care plan and in Bury, only three of the eight records had a care plan of which two had been up-dated. The care plans were not personalised or recovery focussed in these teams. For example, in Bury, two care plans were almost identical despite the two patients having very different needs.
- We looked at 39 care records across the home treatment teams. There was evidence of physical health assessments in only nine records and of on-going monitoring of physical health in eight.
- Patients' allergies were not recorded in any of the 39 care records we looked at.
- Patients' medication was inconsistently recorded across the teams.
- In Tameside and Bury, risk assessments were not routinely completed or updated by the home treatment team staff at point of transfer into the service.

This is a breach of regulation (9) (1) (a) (b)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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 The trust did not have established systems in place to assess, monitor and improve the quality of the service provided because; • The quality and effectiveness of the local governance arrangements within each team was inconsistent. The issues we found regarding the 136 suites, care plans and risk assessments had not been identified through existing monitoring arrangements. • There was a lack of evidence to demonstrate effective use of performance indicators and audits to drive improvement in most teams. • There were inconsistencies across the teams regarding: • the staff skill mix of the teams • compliance with mandatory training • access to supervision • access to appraisals • team meetings • the quality of risk assessments • the quality of care plans and • the implementation of the electronic care record system. • The teams did not have sight of, or ownership of a risk register for the service. This is a breach of regulation 17 (1) (2) (a) (b)
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 The trust did not ensure staff were suitably competent and skilled because; • Compliance with mandatory training across the service was inconsistent and compliance with some training was much lower than the NHS target of 75% in some teams.

This section is primarily information for the provider

Requirement notices

- The service was not meeting the NHS target of compliance in six out of 14 mandatory training courses across the core service.

This is a breach of regulation 18 (1) (a) (2)

This section is primarily information for the provider

Enforcement actions

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.