Greater Manchester Mental Health NHS Foundation Trust

Community-based mental health services of adults of working age

Inspection report

Prestwich Hospital
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Ratings

Overall rating for this service	Not inspected
Are services safe?	**Inadequate**

Our findings

Community-based mental health services of adults of working age

Not inspected

We carried out this short notice focussed inspection of the trust's community based mental health services for adults of working age in Central West and Central East teams because we received information which gave us concerns about the safety and quality of the services provided.

We focussed our inspection on specific key lines of enquiry within the safe domain.

Following this inspection, the trust was served with a Section 29A warning notice as the Care Quality Commission formed the view that the quality of health care provided within this service required significant improvement. The trust was required to take immediate action to make improvements within this service. The safe key line of enquiry was rated inadequate.

We last inspected the community mental health services for adults of a working age between 18-20 June 2019. We rated safe and responsive as requires improvement and effective, caring and well led as good with an overall rating of requires improvement.

We issued the trust with two requirement notices for breaches in Regulation 12 (Safe care and treatment) and Regulation 9 (Person-centred care) and instructed the trust that it must:

- ensure that risk assessments are completed for each new patient admitted to the service
- ensure that waiting times for referral to assessment and referral to treatment do not impact on the care and treatment of patients.

Greater Manchester Mental Health NHS Foundation Trust provides community mental health services for adults of a working age to people resident in Bolton, Wigan, Salford, Trafford and the City of Manchester. The services aim to provide recovery focussed care and treatment for people with severe mental illnesses such as schizophrenia, severe affective disorders or complex personality disorders within the community.

Our rating of safe went down. We rated safe as inadequate.

In response to our findings, we issued a warning notice to the trust under Section 29A of the Health and Social Care Act. This means that the rating for this key question is limited to inadequate.

- There were ineffective systems and processes to monitor patients who were waiting for assessment and treatment. The risk management of patients waiting for assessment and treatment was not robust to ensure all patients were safe.
- All patients did not have an up to date risk assessment and that risks within the teams were not managed well. There were many patients under the care of the team with unknown and unmanaged risks.
- There were ineffective systems and processes to ensure that all safeguarding alerts were acted upon promptly. Both teams had outstanding safeguarding referrals that had not been fully addressed.

Our findings

- Patients were unable to contact the service easily via telephone or other method. Patients and carers had significant difficulty attempting to liaise with staff when needed regarding care and treatment. This meant that patients and carers were often unable to inform staff about a deterioration in a patients mental health or seek support in a crisis.
- A staffing establishment review had not taken place promptly to ensure that demand meets capacity. Staff did not have enough time to complete all tasks necessary to keep patients safe.
- Care plans and crisis plans did not always contain relevant and up to date information about patients care and treatment.
- There were significant problems within the mental health care pathway that meant access to crisis teams and inpatient beds was limited. Therefore, the acuity of community patients was high and very burdensome to the service. This was an additional pressure to staff who were already working at capacity or beyond.

However:

- Newly qualified staff did not have an excessive number of patients on their caseloads. Managers were supportive of newly qualified staff and offered them regular formal and informal supervision and guidance.

How we carried out the inspection

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

During the inspection visit, the inspection team:

- visited two teams
- spoke with two patients who were using the service and three carers
- spoke with two team managers and one operations manager
- spoke with five social workers, two nurses and one support worker
- looked at 12 care and treatment records of patients
- Looked at 13 records of patients on wating lists for assessment or treatment
- looked at a range of policies, procedures and other documents relating to the running of the service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

Carers stated that their experience of the service was poor due to the lack of contact from the service, difficulties getting through on the telephone, staff shortages that have led to waiting lists, a lack of consistency with staff and approaches, and having periods of time with no allocated care coordinator.

Patients said the service they received was good but also that they struggled to get a response from the service when needed.

Our findings

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Safe staffing

The service did not have enough staff to meet the needs of the service. Staff were not able to see patients as frequently as required to keep them safe. The number of patients on the caseload of the teams was too high and prevented staff from giving each patient the time they needed.

Nursing staff

The service did not have enough care coordinators and support staff to keep patients safe. The staffing levels did not meet the high demand for the service. This meant that there was a significant waiting time for initial assessment and to be allocated to a care coordinator. Patients were waiting too long to access the service and staff were unable to always review patients on the waiting list. This meant that low staffing levels were having an impact on the safety of the service. Many staff were newly qualified nurses and social workers requiring smaller caseloads and extra support.

Patients and carers reported that waiting times and lack of contact was of concern.

The service had high vacancy rates. The Central East team had four care coordinator posts vacant. In Central West vacancies included one qualified nurse, one support worker and one physical health nurse.

The service had high rates of bank and agency nurses. In the Central East team five agency staff were employed to cover gaps within service provision. One agency nurse was being utilised in the central west team.

There were no bank or agency nursing assistants.

Managers made arrangements to cover staff sickness and absence. Patients whose care coordinator was on sick leave or who had recently left the service were placed on the unallocated waiting list and any issues were addressed via the duty system. This meant that patients received very little contact from the service unless they self-presented. Staff told us that this was usually due to a crisis which they would try to resolve.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

The service had high turnover rates. Both teams had experienced a high turnover of staff. In particular, in the Central East team most of the experienced staff had left and only newly qualified staff remained.

Managers supported staff who needed time off for ill health. Managers spoke about staff sickness and how they were supporting staff back to work. Staff confirmed that when they returned they had reduced caseloads or were allocated less stressful tasks.

Our findings

Sickness levels were high. In the Central East team there were three staff on long term sick. Managers explained that most staff sickness involved an element of work-related illness. There had been sporadic short term staff sickness due to the Covid 19 pandemic.

Managers had not used a recognised tool to calculate safe staffing levels recently. Managers informed us there had not been a review of staffing establishment levels for some time and there were no current plans to increase the establishment to meet the demand.

The number and grade of staff mostly matched the provider's staffing plan. Managers had a flexible approach to recruiting staff into posts. Managers were aware of national difficulties in recruiting nurses and sought to recruit alternative professions if this could meet the needs of the service safely.

Care coordinators caseloads were not excessively high. In the Central West team caseloads varied between 28 and 45. In the Central East team most care coordinators had a caseload of 28 to reflect that most staff were newly qualified. However, the acuity and complexity of patients was very high. Managers were supportive of newly qualified staff and offered both formal and informal supervision at regular intervals.

Medical staff

The service did not have enough medical staff. Although there were no vacancies in the medical team, patients could wait a considerable time to have an outpatient appointment with a doctor or non-medical prescriber. There were variable waits within the teams. For patients in the Central East team, routine outpatient appointments could be arranged for approximately two months' time, and two weeks' time for urgent cases. On the day of our inspection, the next available appointment to see a consultant psychiatrist in the Central East team was four weeks. The next available appointment to see a consultant psychiatrist in the Central West team was seven weeks. Therefore, it is unlikely that urgent cases were seen promptly. We reviewed one patient who had been waiting 20 weeks from being referred into the service. The patient had not attended an outpatient appointment in March 2022, the next outpatient appointment offered to them was August 2022. This meant another five months of waiting for this patient.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

The service could get limited support from a psychiatrist quickly when they needed to. Staff told us medical staff were available for informal advice about patient's care and medications. There was noted to be a delay in accessing psychiatrist appointments.

In a response to staffing pressures in July 2020 an extra section 12 approved doctor was employed to support the service.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients and themselves well. Patients did not receive a risk assessment in a timely manner. Staff found it difficult to respond promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff were unable to monitor patients on waiting lists to detect and respond to increases in level of risk.

Assessment of patient risk

Our findings

Staff did not complete risk assessments for each patient on admission, or reviewed this regularly, including after any incident. In the central east team, there were 238 patients without a risk assessment. Staff and managers explained that many of the patients were newly allocated to care coordinators and therefore did not have a risk assessment in place. Care coordinators felt they did not have the time to fully complete risk assessments promptly.

We reviewed 12 care records and found that 11 patients had a risk assessment and one patient did not. Six of these risk assessments were not up to date.

For example, one patient had behaved violently in April 2022 during an appointment at the service. The patients risk assessment had not been updated to reflect this incident and it had not been reviewed since June 2021.

Another patient had not had their risk assessment reviewed or updated since September 2020.

Staff used a recognised risk assessment tool. The strategic tool for assessing risks (STAR) assessment was used.

Staff could not always recognise when to develop and use crisis plans according to patient need. We reviewed 12 care plans and found that seven were not up to date and did not reflect current issues for patients. For one patient, their plan referred to being an inpatient, despite being discharged three months ago. Another patient's care plan referred to difficulties in 2017 and not any current concerns. Another patient's care plan did not contain any emergency or crisis numbers.

Management of patient risk

Staff were not always able to respond promptly to any sudden deterioration in a patient's health. Staff were often unaware of patients decline in mental health. Not all patients were seen or contacted as frequently as required. For example, in the central east team there were 262 patients who had not had any contact in the last 28 days, although 25 of these were in long term placement or prison. There were 83 patients who were overdue a care programme approach review.

Patients and carers spoke of their difficulty contacting the service to raise awareness of any deterioration in mental health. This was partly due to telephone calls being unanswered and staff not being available. This led to patients and carers becoming frustrated and upset. Staff also described feeling distressed following emotional telephone calls from upset patients and carers.

The teams received ten formal complaints in relation to poor communication. Six in the central east team and four in the central west team.

Staff were unable to monitor patients on waiting lists for changes in their level of risk and respond when risk increased. The service had a high number of patients on waiting lists to access the service which was not being managed well. Between triage, initial assessment and then treatment, there were long waits with little or no contact. In the Central East team there were 162 patients waiting for an initial assessment. Included within these figures were 45 safeguarding referrals. The trust informed us 40 patients had been referred in the last four weeks and were therefore within the trust target. There were 117 patients waiting for an initial assessment but had received a basic triage risk screening. There were 169 patients waiting for treatment. Of these 137 required a care coordinator. 117 of these patients did not have a full up to date risk assessment in place.

Our findings

In the central west team, there were 320 patients waiting for an initial assessment. Included within these figures were nine safeguarding referrals. Patients waiting for an initial assessment had received a basic triage risk screening. There were 136 people waiting to be allocated to a care coordinator, 104 of these patients did not have a full up to date risk assessment in place.

In total there were 428 patients waiting for assessment and 221 patients waiting for treatment across the two teams. The longest wait for an initial assessment was in central east which was 114 weeks. The trust have since informed us this person was in prison and will be offered an appointment on their release. Many of these patients were not contacted or reviewed during this time. The service was not aware of potential changes in the level of risk for these patients as this was not assessed and monitored effectively. This meant that some patients could deteriorate significantly, and reach crisis point before they were able to access the support they needed. Opportunities for staff to deliver interventions to reduce the risk of some patients relapsing were therefore missed.

Referrals were not seen promptly. Routine referrals that required to be seen within 21 days were not being achieved. The 21 day target was set by Manchester Health and Care Commissioning. In the last 12 months, this was only being achieved on average 55% of the time. In the Central East team this was 62% and in the Central West team this was 47%. In particular, in March 2022 routine referrals being seen within 21 days was only being achieved in 34% of cases (Central East 38% and Central West 30%)

Urgent referrals were also not always seen promptly. The trust target was to see urgent referrals within five days. However, this was not being met. Over the last 12 months the central east team saw urgent referrals within five days in 84% of cases. In the central west, urgent referrals were seen within five days in 90% of cases. The trust target was 95%.

Patients discharged from inpatient wards were mostly followed up within 72 hours. The trust target was 80%. In the last 12 months, 82% of patients discharged were seen within 72 hours.

We sampled the care records of 13 patients who were waiting for assessment or treatment. We found patients had received little or no contact during this time.

For example, one patient who was referred in January 2020 had their case closed permanently in October 2021 and then re-opened in February 2022 following the patient requesting an outpatient appointment. The referral was backdated to the original referral date. An outpatient appointment was offered to the patient and they attended this in March 2022. However, there was no record on the system of the appointment or a letter to the GP. This patient had received no other contact from the team in the last 12 months.

Another patient was referred in October 2021 and it was agreed an outpatient appointment would be offered on 3 November 2021. However, the patient did not attend this appointment. There was no record of any further action following this. The patient had no risk assessment.

Another patient was referred by their GP on 22 October 2021 due to urgent concerns that the patient was suffering a psychotic relapse. An appointment was offered on 2 November 2021 which the patient did not attend. A discharge letter was sent to the GP following this, but the case remained open to the team with no action planned. The patient did not have a risk assessment or any other contact from staff members since their referral.

Our findings

The trust told us they were reviewing elements of the community mental health teams to improve the quality of patient care. This included reviewing the management of waiting lists, the referral process and the quality of the safeguarding process. This is due to be completed by 31 May 2022. However, staff and team managers were unaware of this work being undertaken.

The teams were managing high risk patients who required hospital admission. Due to problems within the mental health pathway, staff told us that inpatient bed availability was scarce and crisis teams were often overstretched. In the last six months, three patients had their community treatment orders recalled and there was no bed available. Patients waited between five and ten weeks for inpatient admissions. During this time, intensive community support from the teams was provided to the patients. This added to the pressures within the service and the team's ability to function.

Team managers had access to a dashboard that supported their management of the teams. However, the quality of the data being used by team managers was unreliable. Data reports often included unnecessary data making operational oversight and monitoring difficult both locally and at trust level. For example, safeguarding referrals were included in waiting list reports.

Safeguarding

Staff did not have enough time to address any safeguarding referrals that came into the team. The trust did not have an effective system to ensure that safeguarding referrals were addressed quickly.

The service had responsibility to address and investigate all safeguarding alerts that were related to patients under their care and also safeguarding alerts involving any other member of the public with a mental health concern. This responsibility had been delegated to them from the local authority.

Safeguarding concerns referred to the trust had been increasing considerably since 2015. The trust received 3315 safeguarding concerns in 2020/21 compared to only 1680 in 2015/16. Of these, approximately 17% required section 42 enquiries to be initiated, which was 603 in 2020/21. Managers informed us this increase has continued into 2021/2022.

There was a backlog of safeguarding referrals that required attention in both teams. In the Central East team, there were 36 safeguarding cases that either had not been addressed initially or actions still remained outstanding. One case was 13 months old. Two weeks prior to the inspection, the team had 128 safeguarding alerts that required attention.

In the Central West team, there were 82 safeguarding referrals open to the team with the longest being 13 months.

One patient was referred by the local authority in September 2021 due to being at risk of financial abuse and threatening to take their own life. There were no records to demonstrate that this patient had been safeguarded in any way and they had not received any contact from the service.

As an interim measure in the Central East team, three staff members had been assigned to address the safeguarding referral backlog as a temporary measure.

There was no robust plan in place to manage the current backlog of safeguarding referrals or to prevent further backlogs of safeguarding referrals developing in the future. The trust was meeting with the local authority to review the section 75 agreement, however plans were in their infancy.

Our findings

The trust told us they were reviewing the quality of the safeguarding process. However, this was also in its infancy. During our onsite inspection staff and team managers were not aware.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff received training on safeguarding adults level three and safeguarding section 42 enquiry training.

Our findings

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Requirement notices:

- The trust must ensure that patients can contact the service with ease via telephone or other method. Patients and carers must be able to liaise with staff when needed regarding care and treatment.

Enforcement Action:

- The trust must ensure that there are systems and processes in place to effectively monitor patients who are waiting for assessment and treatment. The risk management of patients waiting for assessment and treatment should be robust to ensure all patients are safe.
- The must ensure that all patients have an up to date risk assessment and that risks within the teams are managed effectively.
- The trust must ensure that systems and processes are in place to ensure that all safeguarding alerts are acted upon promptly.

Action the trust should take to improve:

- The trust should consider a staffing establishment review to ensure that demand meets capacity.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and two specialist advisors. The inspection team was overseen by Brian Cranna, Head of Hospital Inspection.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment