

Pennine Care NHS Foundation Trust

Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.






This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust

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 

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Pennine Care NHS Foundation Trust was formed in 2002 as a mental health trust. The trust has an income of approximately £280 million, and employs more than 5,500 staff.

Community services for the boroughs of Bury, Rochdale and Oldham were added in 2011. This was followed by Trafford services in 2013. Pennine Care NHS Foundation Trust provides mental health, community and specialist services across the areas of Bury, Heywood, Middleton, Rochdale, Oldham, Tameside, Stockport, Glossop and Trafford in Greater Manchester to a population of 1.3 million people.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement 



What this trust does

The trust provides services from 263 sites

It provides the following services:

- Acute mental health wards for adults of working age
- Community based mental health services for adults of working age
- Long stay/rehabilitation mental health wards
- Child and adolescent mental health wards
- Child and adolescent mental health community services
- Forensic/low secure mental health wards, in the trust these wards are called Rehabilitation and High Support Directorate (RHSD) Wards
- Mental health wards for older people
- Community based mental health services for older people
- Mental health crisis services and health-based places of safety
- Community based mental health services for people with a learning disability
- Community based health services for adults
- Community based health services for children, young people and families
- Community health inpatient services
- Substance misuse service
- Adult social care - respite services at Cambeck Close
- End of Life service
- Community Dental
- Urgent Care

Summary of findings

The trust also provides mental health services for military veterans across the whole of Greater Manchester, working in partnership with other trusts which cover Lancashire, Cheshire and Merseyside.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Our last comprehensive inspection was 13 to 16 June 2016, at that inspection;

We rated as outstanding:

Child and adolescent mental health wards.

We rated as good:

Community health inpatient services.

Community health services for children, young people and families.

Substance misuse services.

Community-based mental health services for older people.

Specialist community mental health services for children and young people.

Forensic inpatient / secure wards.

Long stay/rehabilitation mental health wards for working age adults.

Community mental health services for people with learning disabilities.

We rated as requires improvement:

Acute wards for adults of working age and psychiatric intensive care units (PICU's).

Wards for older people with mental health problems, Community-based mental health services for adults of working age, Mental health crisis services and health based places of safety, Community health services for adults and End of life care.

Following the inspection the trust was issued 7 requirement notices:

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulation 10 HSCA (RA) Regulations 2014 Dignity and Respect

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Summary of findings

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Additionally, we undertook focussed inspections on 12 to 14 June 2017 for Acute wards for adults of working age and psychiatric intensive care units and 19 to 21 June 2017 and 27 June 2017 Wards for older people with mental health problems. Aggregation principles did not apply, so the trust ratings remained as required improvement overall.

As part of our continual checks on the safety and quality of healthcare services we inspected the following services during September and October 2018 at this trust: Acute wards for adults of working age, Wards for older people with mental health problems and Mental health crisis services and health-based places of safety. We also inspected two core services previously not inspected or rated; Community dental and Community urgent care. The trust had requested and anticipated that we would inspect community end of life care. This core service was not inspected at this inspection.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed is this organisation well-led?

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe, effective and well led as requires improvement, caring and responsive as good. In rating the trust, we considered the previous ratings of the services we did not inspect this time in the overall rating.
- Of the five services reviewed at this inspection we rated two as good, wards for older people with mental health problems and community dental services. We rated three as requires improvement community urgent care, mental health crisis services and health based places of safety and Acute wards for adults of working age and psychiatric intensive care units (PICU's).
- Overall considering previously rated services and those undertaken at the inspection we rated one of the trust's 17 services as outstanding, 10 as good and six as requires improvement.
- Although several practice areas within the trust and service delivery had demonstrated improvement many of these quality improvements had not been in place for a sufficient time to demonstrate sustainability and assure the trust of the success of their implementation.
- There was a risk of patients being harmed as there was limited assurance about safety measures in place to meet patient's needs. There was an inconsistent practice throughout the organisation with lessons learnt not reliably shared with staff to support improvements in practice.
- Staff did not consistently feel equality and diversity were promoted in their day to day work and when looking at opportunities for career progression. There had been a deterioration in the previous 12 months for black, minority ethnic staff (BME) staff in recruitment, experience of bullying and opportunity within the trust.
- The leadership, governance and culture did not consistently support the delivery of high-quality person-centred care. There was a variety of practice throughout the trust with limited sharing of best practice when identified.

Summary of findings

- Whilst there were clear systems in relation to the implementation of the of the Mental Health Act 1983 and its amendments 2007 (MHA) and the Mental Capacity Act 2005 (MCA); these were inconsistently understood and adhered to throughout the trust.
- There were four breaches identified in relation to the fundamental standards.

However:

- The rating of effective, caring and well led in wards for older people with mental health problems improved from requires improvement to good.
- There was a clear commitment from the trust that the priority was its service to the local population and a drive to improve the quality of services. There was evidence of a significant positive change in the culture within the trust led by the senior leadership team.
- Patients were supported by staff, treated with dignity and respect and were involved as partners in their care.
- Overall most patients' needs were met through the way care was organised and delivered.
- There had been an increase in support to the divisions to develop their own communication and engagement strategies and encouraged staff to get involved with projects affecting the future of the trust.

Are services safe?

- Our rating of safe stayed the same. We rated it as requires improvement because:
- We rated four of the five services reviewed at this inspection as requires improvement for safe. We considered the previous ratings of services that we did not inspect this time within the overall rating for this key question.
- Whilst systems and process had been implemented to bring about improvements; there remained a risk of harm as there was limited assurance about safety.
- Staff on acute wards for older persons and adults of working age including psychiatric intensive care units did not always monitor patients following the use of rapid tranquilisation. Records relating to medicines were not all fully completed and there were inconsistencies in medicine management arrangements across the trust.
- There was inconsistent practice in relation to blanket restrictions on some wards. The use of blanket restrictions had been considered with the aim of reducing restrictive practices but blanket restrictions remained on some wards without a clear rationale.
- There was a lack of monitoring in place to make sure that staff received appropriate training deemed as mandatory by the trust.
- Some patient records were held on paper. An electronic patient record system had not been fully implemented. This meant that staff were not fully aware of patient's history or risks on admission to the wards and prevented the trust from having full assurance that care and treatment was delivered appropriately.
- There was a lack of oversight in ensuring that all staff knew what incidents to report and how to report them. Lessons learnt were not consistently shared with the whole team and the wider service preventing good practice from being implemented consistently.
- Although there had been an improvement in staff availability. This was not consistent with some areas of the trust. Urgent care reported that there remained insufficient staff to meet the levels determined by the trust.

However,

Summary of findings

- There had been improvements in how the trust managed mixed sex accommodation. A consultation was on going to assist the trust in making future decisions about managing mixed sex wards.
- When things went wrong, staff apologised and gave patients honest information and suitable support. Records reviewed confirmed patients and families were invited to contribute to serious incident investigations.
- Overall the trust ensured that staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The ward areas were safe, clean and well-maintained environments.
- There were enough staff on each ward to provide clinical care to patients. The wards received additional agency and bank staff guided by the safer staffing model.
- The trust had an up to date duty of candour policy and procedure. Records we reviewed confirmed that duty of candour was reflected in the trust's duty of candour guidance, policies. There had been some inconsistent practice in relation to the trust duty of candour response that was addressed at the time of inspection.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- We rated three of the five services reviewed at this inspection as requires improvement for effective. We considered the previous ratings of services that we did not inspect this time within the overall rating for this key question.
- Whilst systems and process had been implemented to bring about improvements and several improvements were noted. Patients were at risk of not receiving effective care or treatment. There was a lack of consistency in the effectiveness of the care, treatment and support that patients received.
- In most services, staff said they felt supported and that clinical supervision took place. However, there was no trust target and reported rates of clinical supervision were low.
- Clear systems were in place for the trust for the provisions of the Mental Health Act and its Code of Practice (MHA). However, these systems were not consistently followed at ward level.
- There was variable knowledge and practice of staff in relation to the implementation of the Mental Capacity Act 2005 and its codes of practice (MCA). There were no arrangements in place to audit the implementation of the MCA in relation to covert medicines.
- Staff were not always supported to participate in training and development. There were gaps in management and support arrangements for staff, such as supervision and professional development.
- There was inconsistent practice in the development of person centred care planning throughout the trust. The quality and depth of care planning arrangements varied across all wards and areas.

However:

- There was good multi-disciplinary working taking place within services and care was provided in line with national guidance.
- Staff undertook assessments of patient's needs on admission. This included mental health and physical health assessments.
- Most patients were involved in decisions about their care and treatment.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

Summary of findings

- We rated all of the five services reviewed at this inspection as good for caring. We considered the previous ratings of services that we did not inspect this time within the overall rating for this key question.
- Patients and carers were supported, treated with dignity and respect. Where applicable and appropriate to individual circumstance patients and carers were involved as partners in their care.
- Staff supported patients with compassion and respect. Feedback from patients was positive.
- Staff engaged with patients, families and carers, and people could feedback about the service.
- Staff communicated with patients and provided information in a way that would assist their understanding. Patients were supported to understand their care and treatment.
- Overall patients and staff worked together to plan care and there was shared decision-making about care and treatment.
- Patients had free access to their family, friends and community. Any restrictions to this were determined in the patients' best interests.

However:

- Although patients personal, cultural, social and religious needs were understood. Arrangements to support these individual needs were not consistently available.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- We rated four of the five services reviewed at this inspection as good for responsive. We considered the previous ratings of services that we did not inspect this time within the overall rating for this key question.
- The trust planned and provided services in a way that was designed to meet the needs of patients. Some reasonable adjustments had been made to enable patients with disabilities to access treatment.
- Services were delivered in a manner that focused on patients' needs. Discharge planning included liaison with relevant stakeholders to meet the needs of patients.
- Patients could access the right care at the right time. Access to care was managed to take account of patients' needs, including those with urgent care needs.
- Waiting times from treatment were generally good. Arrangements to admit, treat and discharge patients were in line with good practice.
- The trust has systems in place for patients to obtain information on treatment and local services.
- The trust ensured that patients who use the service, their family, friends and other carers could be confident that if they complained, they will be taken seriously and treated compassionately.
- The trust took active steps to engage with patients who found it difficult or were reluctant to engage with mental health services.
- Facilities and premises were appropriately adapted to meet the individual needs of patients
- The trust developed working relationships with other services. Care and treatment was coordinated with other services, families and carers and other providers to ensure the needs of patients were met.

However:

Summary of findings

- Information leaflets regarding the services, patient rights and self- help resources were only displayed in English and one size print format.
- Sufficient beds for patients in their local areas was not always available. Patients were not always able to return to the same ward they left before they had leave. Female patients were unable to access a psychiatric intensive care unit bed within the trust.
- Patients had limited access to outside space and leisure facilities. On some wards the outside space was either not accessible or patients had to be accompanied by staff.
- Staff reported they did not always receive feedback from complaint investigations.

Are services well-led?

Our rating of well-led stayed the same. We rated it as requires improvement because:

- We rated three of the five services reviewed at this inspection as requires improvement for well led. We considered the previous ratings of services that we did not inspect this time within the overall rating for this key question.
- Although staff were aware of the trusts vision, the trust had recently determined the need to revise the values. The trust strategy was directly linked to the vision and values. However, following a well led review it was recognised that the values and visions needed to be amended. The strategy in place no longer matched the values and visions that the trust was intending to implement.
- Board members, governors and senior management recognised that they had work to do to improve diversity and equality across the trust. There were no clear plans in place as to how the trust would address the areas identified in relation to hard to reach communities.
- The trust board had undergone and continued to undergo changes in its representation of directors. Leadership changes whilst, recognised by the board and staff as bringing about cultural improvements plans and means to improve the quality of the service delivery were not yet fully embedded.
- The leadership recognised the need and gaps in training including themselves, and worked to provide development opportunities for the future of the organisation. Recent board development days had been implemented to assist in this resolution. However, there were no plans in place to recognise training needs and develop managers within the trust. Systems at local levels were not sufficient or consistent to ensure that staff were appropriately supervised or supported to meet training needs.
- Whilst there was a governance structure in place, we found that the arrangements did not consistently operate effectively across trust services and locations we inspected. Quality auditing arrangements were inconsistent. Some areas of service delivery did not have arrangements in place. Whilst other audits were not sufficient to provide assurance that quality of performance and regulatory requirements were consistently met.
- Whilst the trust demonstrated a commitment to improving services by learning from when things go wrong or well, the learning was inconsistently communicated and adhered to.
- There was a limited structure within the trust to obtaining the views of patients and utilising the opinions of the diverse local population to influence the quality of the service.
- There were inconsistencies throughout the trust at the application of the Mental Health Act requirements. Mental Health Act (MHA) reviewer reports were not routinely reviewed.
- Staff morale was variable with some staff reporting quite low morale due to the demands of the service.

However:

Summary of findings

- There was a clear commitment from the trust that the priority was its service to the local population and a drive to improve the quality of services.
- At all levels within the trust it was recognised that there had been a significant improvement in the culture which was now more open, transparent and responsive to challenge. Examples included the recruitment of an external candidate as a Speak Up Guardian who was empowered to provide appropriate challenge to leaders and support to staff.
- Statistical information on the MHA was monitored and compared with national data to influence change
- The trust board of executives and non-executives were open and inclusive. They demonstrated a clear understanding of the challenges and risks facing the trust in their agenda to improve the quality of the services provided for the local communities. The board had considered the risk to the sustainability of the trust in delivering the trust strategy.
- Senior leaders made sure they visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced.
- The board reviewed performance reports that included data about the services, which divisional leads could challenge. Board members were represented across the divisions.
- Patient safety and the investigation of incidents and deaths had been given a priority to increase learning. There had been an increase in the impartiality of internal investigations and a collaborative approach with other stakeholders in undertaking appropriate investigations.
- Staff and managers were positive and proud about their work. They were confident about the support they received within their immediate teams.
- There had been an increase in the arrangements to promote candour, openness, honesty, transparency and challenge. Concerns were investigated sensitively and confidentially. When something went wrong, patients and carers were kept informed.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service type, and for the whole trust. They also show the ratings for services inspected at this inspection and parts of them previously inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings

Outstanding practice

We found examples of outstanding practice in acute wards for adults of working age and psychiatric intensive care units.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement, including four breaches of legal requirements across four core services. We found areas that the trust should improve to comply with a breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report

Summary of findings

Action we have taken

We issued four requirement notices to the trust. Our action related to four breaches of legal requirements in four core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

We found the following areas of outstanding practice.

In acute wards for adults of working age and psychiatric intensive care units.

- North and South wards had access to a physical health check, drop in clinic additional to the physical health checks on the wards.
- Clinical staff had co-produced a handbook, to act as a quick reference guide to staff on inpatient wards.

In Wards for older people with mental health problems.

Saffron ward did not admit patients with mental illness but provided care for patients experiencing delirium, such as post-operatively or because of infection. This was provided through a partnership between the mental health trust, the acute NHS trust and local GPs. This type of service is usually provided within acute trusts and is innovative within mental health services.

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust **MUST** take to improve:

Acute wards for adults of working age and psychiatric intensive care units:

- Ensure checks are in place to consistently review the effects of medication on patients' physical health regularly, especially when the patient is prescribed a high dose of antipsychotic medication and rapid tranquilisation.

Mental health crisis services and health-based places of safety:

- Ensure there are enough staff to provide the services safely, including managers for teams and staff to support patients in the health based places of safety.
- Ensure managers provide staff with management supervision in line with the trust's policy.

Summary of findings

- Ensure that medicines are managed safely, including the completion of medication administration records, recording of fridge temperatures and taking action if a reading is out of the recommended range.
- Ensure that staff comply with the requirements of the Mental Health Act, including the completion of the Mental Health Act documentation fully and ensuring patients have their rights explained to them. Patients should be assessed by an approved mental health professional when they are detained under section 136.

Wards for older people with mental health problems:

- Ensure details of best interests' meetings and the rationale for administering medicines covertly is recorded consistently on all wards.
- Ensure the monitoring of medicines prescribed for use as required and the rationale for administering these is recorded consistently on all wards.
- Ensure the details of best interests' meetings and rationale for decisions such as 'do not attempt cardiopulmonary resuscitation' are recorded consistently on all wards.
- Ensure all patients have individual care plans that fully detail how to administer medicines covertly in a safe manner.

Community Urgent Care:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

Action the trust SHOULD take to improve:

Acute wards for adults of working age and psychiatric intensive care units:

- Ensure patients are kept safe and their privacy and dignity is maintained. That consultations with patients, carers and staff are reflected in decisions the trust makes about eliminating mixed sex wards. A policy is implemented for patients being admitted to the acute and psychiatric intensive care unit with protected characteristics under the Equality Act.
- Ensure that blanket restrictions on all wards are only applied in line with guidance under the Mental Health Act unless they can be justified and are proportionate.
- Ensure care plans are completed to meet individual needs and take into consideration of the communication needs of patients with learning disabilities.
- Ensure applicable staff on Hollingworth ward have completed their intermediate life support mandatory training and staff complete their mandatory child safeguarding level three training.
- Ensure psychological therapies are provided to all the inpatient wards and a full range of specialist are available to all inpatient wards.
- Ensure non-medical staff receive an appraisal as per the trusts target rate.
- Consider that where escorted leave and one to one time with patients is cancelled there are clear reporting mechanisms to report and document the reasons for this.
- Consider the full implementation of electronic recording for patient records.

Summary of findings

- Consider advocacy services are readily accessible to all patients.
- Consider beds are available to patients living in their own catchment area and that psychiatric intensive care unit beds are available to female patients within the trust.
- Consider alternatives to ward admissions across the trust due to the capacity of beds and the overoccupancy of the wards.
- Consider an appropriate audit tool, to provide assurance that the collaborative care planning is fully implemented and that care plans are produced to meet individual assessed need.

Mental health crisis services and health-based places of safety

- Explore the possibility of providing information in relation to patient rights and self- help resources in other languages to meet the needs of all patients.
- Ensure that patients are aware of how to complain and give feedback regarding the service.
- Ensure there is a notice displayed in all health based places of safety to inform patients CCTV is in operation.
- Consider how managers can share good practice and learning with their counterparts in other boroughs.

Community dental services

- Ensure recommendations made from the testing of X-ray machines are identified and actioned appropriately.
- Improve the process for carrying out the X-ray audit.
- Improve the overall communication between the dental directorate and other teams within the trust.

Wards for older people with mental health problems

- Ensure only relevant, up to date information is displayed on wards and in clinic rooms.
- Ensure all staff have a clear understanding of blanket restrictions as defined in the Mental Health Act Code of Practice.
- Ensure all staff receive supervision at an appropriate frequency.
- Review arrangements for managing records so that information is easily accessible.
- Ensure that practice in medicines management in line with national guidance is consistent across the service.
- Consider providing information in formats that meets the accessible standard in relation to patients' needs, including care plans.
- Ensure all staff are aware of opportunities to contribute to discussions about service strategy.
- Ensure there is a system for sharing of good practice across the service.

Community Urgent Care

- The medicines fridge should have a thermometer which ensures the temperature is within the recommended range for safe storage.
- A programme of ongoing mandatory training should be in place to support staff with their development.
- Hard copies of the standard operating procedures should be available to support agency nursing staff in their role.
- Information and health care leaflets should be provided in other languages.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as requires improvement because:

- Although staff were aware of the trusts vision, the trust had recently determined the need to revise the values. The trust strategy was directly linked to the vision and values. However, following a well led review it was recognised that the values and visions needed to be amended. The strategy in place no longer matched the values and visions that the trust was intending to implement.
- Board members, governors and senior management recognised that they had work to do to improve diversity and equality across the trust. There were no clear plans in place as to how the trust would address the areas identified in relation to hard to reach communities.
- The trust board had undergone and continued to undergo changes in its representation of directors. Leadership changes whilst, recognised by the board and staff as bringing about cultural improvements plans and means to improve the quality of the service delivery were not yet fully embedded.
- The leadership recognised the need and gaps in training including themselves, and worked to provide development opportunities for the future of the organisation. Recent board development days had been implemented to assist in this resolution. However, there were no plans in place to recognise training needs and develop managers within the trust. Systems at local levels were not sufficient or consistent to ensure that staff were appropriately supervised or supported to meet training needs.
- Whilst there was a governance structure in place, we found that the arrangements did not consistently operate effectively across trust services and locations we inspected. Quality auditing arrangements were inconsistent. Some areas of service delivery did not have arrangements in place. whilst other audits were not sufficient to provide assurance that quality of performance and regulatory requirements were consistently met.
- Whilst the trust demonstrated a commitment to improving services by learning from when things go wrong or well the learning was inconsistently communicated and changes not consistently adhered to.
- There was a limited structure within the trust to obtaining the views of patients and utilising the opinions of the diverse local population to influence the quality of the service.
- There were inconsistencies throughout the trust at the application of the Mental Health Act requirements. Mental Health Act (MHA) reviewer reports were not routinely reviewed.
- Staff morale was variable with some staff reporting quite low morale due to the demands of the service.

However:

- There was a clear commitment from the trust that the priority was its service to the local population and a drive to improve the quality of services.

Summary of findings

- At all levels within the trust it was recognised that there had been a significant improvement in the culture which was now more open, transparent and responsive to challenge. Examples included the recruitment of an external candidate as a Speak Up Guardian who was empowered to provide appropriate challenge to leaders and support to staff.
- Statistical information on the MHA was monitored and compared with national data to influence change
- The trust board of executives and non-executives were open and inclusive. They demonstrated a clear understanding of the challenges and risks facing the trust in their agenda to improve the quality of the services provided for the local communities.
- Senior leaders made sure they visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced.
- The board reviewed performance reports that included data about the services, which divisional leads could challenge. Board members were represented across the divisions.
- Patient safety and the investigation of incidents and deaths had been given a priority to increase learning. There had been an increase in the impartiality of internal investigations and a collaborative approach with other stakeholders in undertaking appropriate investigations.
- Staff and managers were positive and proud about their work. They were confident about the support they received within their immediate teams.
- There had been an increase in the arrangements to promote candour, openness, honesty, transparency and challenge. Concerns were investigated sensitively and confidentially. When something went wrong, patients and carers were kept informed.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Requires improvement ↔ Jan 2019	Requires improvement ↓ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019
Mental health	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Requires improvement ↔ Jan 2019

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Requires improvement Dec 2016	Requires improvement Dec 2016
Community health services for children and young people	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016
Community health inpatient services	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016
Community end of life care	Requires improvement Dec 2016	Requires improvement Dec 2016	Not rated	Requires improvement Dec 2016	Requires improvement Dec 2016	Requires improvement Dec 2016
Community dental services	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Urgent care	Requires improvement Jan 2019	Requires improvement Jan 2019	Good Jan 2019	Good Jan 2019	Requires improvement Jan 2019	Requires improvement Jan 2019

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019	Good ↔ Jan 2019	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019
Long-stay or rehabilitation mental health wards for working age adults	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016
Forensic inpatient or secure wards	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016
Child and adolescent mental health wards	Outstanding Dec 2016	Good Dec 2016	Outstanding Dec 2016	Outstanding Dec 2016	Outstanding Dec 2016	Outstanding Dec 2016
Wards for older people with mental health problems	Requires improvement ↔ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019	Good ↔ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019
Community-based mental health services for adults of working age	Requires improvement Dec 2016	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016
Mental health crisis services and health-based places of safety	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019
Specialist community mental health services for children and young people	Good Dec 2016	Good Dec 2016	Good Dec 2016	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016
Community-based mental health services for older people	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016
Community mental health services for people with a learning disability or autism	Requires improvement Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016
Substance misuse services	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016	Good Dec 2016

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for adult social care services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Cambeck Close	Good Dec 2016	Good Dec 2016	Good Dec 2016	Outstanding Dec 2016	Good Dec 2016	Good Dec 2016

Community health services

Background to community health services

The trust provides the following community health services:

- Community based health services for adults.
- Community based health services for children, young people and families.
- Community health inpatient services.
- End of Life service.
- Community Dental.
- Urgent Care.

We inspected community dental and urgent care at this inspection.

Summary of community health services

Requires improvement   

Our rating of these services stayed the same. We rated community health services as requires improvement because:

- We inspected two core services for the first time.
- Our overall ratings of three of six services were requires improvement. We took into account ratings for services not inspected this time. This made the overall rating for community health services requires improvement.

See individual service sections below and the ratings table above for more details.

Community dental services

Good 

Key facts and figures

The dental service delivers community and urgent dental services across Bury, Oldham and Heywood, Middleton and Rochdale.

The Community Dental Service (CDS) provides treatment and care for individuals who have special requirements that cannot be met by a general dentist. The service offers sedation and general anaesthetic services. The general anaesthetic services are provided at Fairfield hospital and Alder Hey hospital. We also offer home visits and services are fully accessible for disabled users. Urgent or emergency dental care is available in Bury, Heywood, Middleton and Rochdale, and Oldham. These services provide urgent treatment for people who are unable to access a dentist for an emergency appointment in-hours.

A Minor Oral Surgery service is also available in Bury. The service provides dental treatment in HMP Buckley Hall and epidemiology in Bury, Oldham, HMR and Lancashire. Patients are referred to the Community Dental Service by letter from their own dentist, or by another healthcare professional such as a GP, health visitor or school nurse. Urgent care appointments are allocated on a daily basis. Patients are advised to contact their local centre at the earliest opportunity on the day they require treatment. Patients are referred for the Minor Oral Surgery service by their own dentist. When the referral is received the next available appointment will be allocated over the telephone.

We received feedback from 53 patients and spoke with 22 members of staff. We looked at dental care records for 25 people.

Our inspections between 28 and 30 August then 11 and 13 September 2018 were short-announced, which means that staff knew we were coming a few days beforehand.

Summary of this service

This service has not been inspected before. We rated it as good because:

- Staff had the qualifications, skills and experience to keep patients safe. They had access to training to support their roles.
- Systems and processes were in place to deal with patients becoming acutely unwell.
- Staff reported incidents and accidents, these were investigated and acted upon to reduce the chance of re-occurrence.
- Infection control procedures were in line with nationally recognised guidance.
- Staff were aware about issues relating to safeguarding and there were systems in place to refer children and vulnerable adults.
- Staff provided care and treatment based on nationally recognised guidance.
- There was an effective skill mix at the service to assist with the ever-increasing complexity of patient. Staff worked together as a team and with other healthcare professionals in the best interest of patients.
- The service was proactive to improve the oral health of the local community.
- Staff understood their responsibilities under the Mental Capacity Act 2005 and with regards to Gillick competence.

Community dental services

- Staff cared for patients with compassion. We observed staff treating patients with dignity and respect.
- Feedback from patients was positive. They told us staff were friendly, caring, informative and helpful.
- The service considered patients' individual needs. Clinics had been adapted to ensure they were accessible for all patients.
- The appointment system met patients' needs.
- The service dealt with complaints positively and efficiently.
- There was a clearly defined management structure. Managers had the right skills and abilities to provide high quality sustainable care.
- There were systems and processes in place for identifying risks and planning to reduce them.
- Staff engaged with patients and other healthcare professionals to continually improve the service.

However:

- Recommendations from the routine test of an X-ray machine had not been identified or actioned.
- Audits of X-rays did not reflect nationally recognised guidance and was not dentist specific.
- Communication between teams was not consistent. Managers did not always know about risks relevant to the dental service.

Is the service safe?

Good 

This service has not been inspected before. We rated it as good because:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Effective systems were in place to assess and respond to patient risk. Patients' medical histories were taken before any treatment was carried out. Staff provided patients and carers with adequate pre- and post-operative information.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.
- The service prescribed, gave, recorded and stored medicines well. Prescription pads were stored securely, and medical gasses and medicines used in the provision of sedation were stored appropriately.
- Staff kept appropriate records of patients' care and treatment. Dental care records were clear, up-to-date and available to all staff providing care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise signs of abuse, how to report upon it and they knew how to apply it.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training included basic life support (BLS), immediate life support (ILS), information governance, infection prevention and control, equality and diversity and fire safety.

However:

- Recommendations made in the routine test of an X-ray machine had not been identified or actioned .

Community dental services

Is the service effective?

Good ●

This service has not been inspected before. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. The dentists followed national guidelines to ensure patients received the most appropriate care.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. Audits of X-rays, dental care records, antibiotic prescribing and infection prevention control were carried out. Results of audits were discussed during team meetings.
- The service made sure staff were competent for their roles. Staff were appropriately qualified and competent to carry out their roles. Staff had annual appraisals to help them develop professionally.
- Staff of different kinds worked together as a team to benefit patients. Multidisciplinary team meetings were held for patients with complex needs and as part of best interest decision making.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

However:

- The X-ray audit did not reflect nationally recognised guidance and was not broken down to individual dentists.

Is the service caring?

Good ●

This service has not been inspected before. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients was positive. They told us staff were friendly, caring, informative and helpful. We observed staff treating patients with dignity and respect.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients and their families were appropriately involved in and central to making decisions about care options and the support needed.
- Staff provided emotional support to patients to minimise their distress. Staff made patients feel at ease prior to and during treatment. Parents commented that staff were particularly good at providing support for nervous children.

Is the service responsive?

Good ●

This service has not been inspected before. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people. Reasonable adjustments had been made to enable patients with various disabilities to access treatment.

Community dental services

- People could access the service when they needed it. Waiting times from treatment were generally good. Arrangements to admit, treat and discharge patients were in line with good practice.
- The service took account of patients' individual needs. The service was configured to reflect the needs of vulnerable people. Domiciliary visits were available for patients who could not access the clinics.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Is the service well-led?

Good ●

This service has not been inspected before. We rated it as good because:

- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were passionate about their work and were proud to work for the service.
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. A comprehensive risk register was maintained, reviewed and shared with staff on a regular basis.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

However:

- There was a lack of communication between other teams within the organisation and the dental directorate. Managers did not always know about matters which were considered relevant to the dental service.

Outstanding practice

Areas for improvement

- Improvements could be made to the process for ensuring recommendations made from the testing of X-ray machines are identified and actioned appropriately.
- Improvements could be made to the process for carrying out the X-ray audit.
- Improvements could be made to the overall communication between the dental directorate and other teams within the trust.

Urgent care

Requires improvement   

Key facts and figures

We carried out a short notice announced core service inspection on 8 October 2018 and 9 October 2018. The core service of Urgent care consists of Prestwich walk-in centre and Bury walk-in centre.

At the time of the inspection Prestwich walk-in centre was registered for the trust but was operated by another service. Following this inspection, the trust applied to remove the Prestwich location.

Whilst this report also reports on the Prestwich walk-in Centre where there are common themes between the walk-in centres most of this report reflects the findings of the inspection at the Bury walk-in centre.

We visited both locations. The walk-in centres provide services for patients needing urgent care for minor injuries and illnesses. The walk-in centres are a drop-in service, there are no appointments or referrals into this service.

The service is not for treatment of ongoing, routine or 'managed care'. Patients will be signposted to the alternative appropriate services if they do not have an urgent minor injury or illness.

The walk-in centre is for patients who are unable to get an appointment with their own GP where they need to be seen same day or as an alternative to going to A and E for urgent minor injuries or illness.

Our inspection team was led by two CQC inspectors. The team also included a nurse specialist adviser.

We carried out this inspection as part of a wider inspection of the trust and inspected all the five key questions at both locations.

During the inspection, the inspection team:

- Visited both walk-in centres looked at the quality of the environment.
- Checked five clinic rooms
- Interviewed six registered nurses and health care support staff
- Interviewed five members of the management team
- Interviewed two administrative staff
- Looked at records relating to the management of the service including audits, minutes of meetings and policies.

This was the first inspection of Urgent Care undertaken for the trust.

Following this inspection, we issued the trust with two requirement notices for regulatory breaches that related to:

Regulation 17 Good Governance

Regulation 18 Staffing

Summary of this service

This was the first rating inspection of the Urgent care services.

We rated it as requires improvement because:

Urgent care

The service had put some systems to manage risk so that safety incidents were less likely to happen. However, these were recently developed and were not yet embedded sufficiently to provide the service with assurance that can recognise risks and take appropriate action in a timely manner.

The leadership, management and governance of the walk-in centre did not always assure the delivery of high-quality and person-centred care. There had been a recent review of the governance arrangements which had brought about strengthening of the vision and strategy for the future development of the service.

Systems and processes to ensure staff learned from the incidents and complaints to improve their practice were not consistent to provide appropriate learning for staff. This issue was being addressed as part of an improvement plan.

Staff did not consistently receive suitable supervision or mandatory training to meet their job roles. There was inconsistency noted from staff in their involvement in meetings and awareness of support from senior managers.

Systems were in place to ensure patients were safeguarded from abuse and harm.

Staff involved and treated patients with compassion, kindness, dignity and respect.

Patients could access care and treatment from the service within an appropriate timescale for their needs.

The facilities and premises were appropriate for the services that were delivered.

The service took account of patients' needs and choices.

There was now a focus on improvement and learning in the team.

Is the service safe?

Requires improvement



We rated it as requires improvement because:

The service did not provide and monitor their mandatory training in order that staff were kept up to date and maintain patient safety.

The service did not manage patient safety incidents well. Staff did not recognise incidents and appropriately report patient safety incidents. Additionally, investigated incidents and shared lessons learning was inconsistent.

The service did not have enough staff with the right qualifications, skills, training and experience deployed in accordance with their own policy to provide the right care and treatment.

The service did not use safety monitoring results well. Staff did not collect safety information or shared it with staff, patients and visitors.

However,

The shortfalls in the service had been identified and plans had been commenced to address these shortfalls. Staff were aware of the actions taken to improve safety.

When things went wrong, staff apologised and gave patients honest information and suitable support

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The service had suitable premises and equipment and looked after them well.

Urgent care

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

There was an appropriate system in place to keep records of patients' care and treatment. Records were available to all staff providing care in order that they could appropriately monitor the care delivered.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service followed best practice when prescribing, giving and recording medicines

Is the service effective?

Requires improvement ●

We rated it as requires improvement because:

Evidence based care and treatment was not consistently available.

There were inconsistent systems to keep clinicians up to date with current evidence based practice. As a result, the service did not consistently provide care and treatment based on national guidance.

The service did not have a comprehensive programme of quality improvement activity to monitor the effectiveness and appropriateness of the care delivered.

Managers did not have a system in place to monitor the effectiveness of care and treatment and used the findings to improve them.

Clinical supervision to ensure staff members were supported to maintain, further develop their skills, experience and their competency to undertake their job role was monitored was not in place

However,

Patients had comprehensive assessments and plans to meet their needs. The expected outcomes were identified and care and treatment was reviewed and updated as needed.

Staff of different kinds worked together as a team to benefit patients. Nurses and other healthcare professionals supported each other to provide care.

Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff supported patients to manage their own health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Is the service caring?

Good ●

We rated it as good because:

Staff responded compassionately when patients needed help. Support was given by caring staff as and when required by patients to meet their individual needs.

Urgent care

Patients' personal, cultural, social and religious needs were understood and arrangements were in place to meet their individual needs.

Staff involved patients and those close to them in decisions about their care and treatment.

Staff developed trusting relationships with patient maintaining their confidentiality at all times.

Patients' privacy and dignity was maintained at all times.

Is the service responsive?

Good ●

We rated it as good because:

Patients could access the service when they needed it. Waiting times from assessment to treatment were in line with good practice.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

Patients' needs and preferences were considered and acted on to ensure that services were delivered in a way that met their individual needs.

Facilities and premises were appropriately adapted to meet the individual needs of patients

Information was easily available to assist patients to give feedback about their experiences, including how to raise any concerns or issues. All complaints were monitored and addressed in a timely manner.

Staff members were aware of how to support patients to make a complaint or raise a concern. All complaints were taken seriously and treated compassionately.

However,

Staff reported they did not always receive feedback from complaint investigations.

Is the service well-led?

Requires improvement ●

We rated it as requires improvement because:

The leadership, senior management and governance of the walk-in centre did not consistently assure the delivery of high-quality and person-centred care.

The trust had a vision for what it wanted to achieve. However, the shortfalls identified by the trust did not support the implementation of the strategy.

The trust did not have a systematic approach to continually improving the quality of its services and safeguarding high standards of care.

The service did not have a comprehensive process to identify, understand, monitor and address risks. Risks were inconsistently monitored and reviewed.

Urgent care

However,

Recent improvements had been made to the governance arrangements at the walk-in centre. Structures, processes and systems to support good governance and management were in the process of being introduced.

Staff reported that morale at the walk-in centre had now improved.

Outstanding practice

Areas for improvement

We found areas for improvement in this service.

The provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties

The provider should:

- The medicines fridge should have a thermometer which monitors the minimum and maximum temperature to ensure medicines are stored safely.
- A programme of ongoing mandatory training should be in place to support staff with their development.
- Hard copies of the standard operating procedures should be available to support agency nursing staff in their role.
- Information and health care leaflets should be provided in other languages.

Requirement notices

Action we have told the provider to take The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements. For more information on things the provider must improve, see the Areas for improvement section above. **Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
. Treatment of disease, disorder or injury	Regulation 17, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 –Good governance
Treatment of disease, disorder or injury	Regulation 18, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 –Staffing

Mental health services

Background to mental health services

The trust provides a range of community and inpatient mental health services.

The trust also provides mental health services for military veterans across the whole of Greater Manchester, working in partnership with other trusts which cover Lancashire, Cheshire and Merseyside.

Summary of mental health services

Requires improvement ● → ←

Our rating of these services stayed the same. We rated mental health services as requires improvement because:

- Our overall ratings of three of eleven services were requires improvement. We took into account ratings for services not inspected this time. This made the overall rating for mental health services requires improvement.

See individual service sections below and the ratings table above for more details.

Wards for older people with mental health problems

Good  

Key facts and figures

We inspected this core service provided by Pennine Care NHS Foundation Trust. The service is provided to people aged 65 and over. There were nine wards over five locations. All wards were mixed sex and provided care to people with organic and functional mental health issues.

Bury Mental Health Services	Ramsbottom Ward	12 beds	Mixed organic and functional
Oldham Mental Health Services	Rowan Ward	12 beds	Functional
Oldham Mental Health Services	Cedars Ward	10 beds	Organic
Rochdale Mental Health Services	Beech Ward	14 beds	Mixed organic and functional
Tameside Mental Health Services	Summers ward	11 beds	Organic
Tameside Mental Health Services	Hague ward	14 beds	Functional
The Meadows	Saffron Ward	23 beds	Delirium
The Meadows	Davenport Ward	20 beds	Functional
The Meadows	Rosewood Ward	10 beds	Organic

Wards for older people with mental health problems

The inspection was announced at short notice. Staff did not know we were coming until the first day of the inspection and we were able to observe routine activity.

The inspection team consisted of four CQC inspectors, an inspection manager, two assistant inspectors and two specialist advisers, a doctor and a nurse with experience of nursing older people.

During the inspection, the inspection team:

- Visited all nine wards and looked at the quality of the environment
- Checked seven clinic rooms
- Observed how staff provided care and treatment. We used a formal observation tool called a short observation framework for inspection
- Spoke with 28 patients and 13 carers
- Interviewed the managers of all nine wards, one matron, one service manager and one divisional director
- Interviewed 15 registered nurses and nine health care support staff
- Interviewed three allied professionals including two occupational therapy staff and one physiotherapist
- Interviewed two ward administrative staff
- Observed one ward round
- Observed four doctor/patient interactions
- Observed two ward handover meetings
- Observed one community meeting
- Reviewed 43 sets of care records including Mental Health Act records
- Reviewed 14 staff supervision records
- Reviewed 71 prescription charts
- Spoke with two pharmacists
- Reviewed four staffing rotas
- Looked at records relating to the management of the service including audits, minutes of meetings and policies.

We also left comment cards on all wards for feedback. Only three were completed but all three were positive.

We carried out a comprehensive inspection of older people's wards in June 2016. We rated the service as requires improvement for safe, effective, caring and well led. We rated responsive as good. Following this inspection, we issued the trust with two requirement notices for regulatory breaches that related to:

Regulation 10 Dignity and respect

Regulation 18 Staffing

We carried out a focused inspection of the safe domain for older people's wards in June 2017 but we did not rate the service. At this inspection, we found the issues from the previous inspection had been addressed. However, we issued the trust with three further requirement notices for regulatory breaches that related to:

Regulation 12 Safe care and treatment

Wards for older people with mental health problems

Regulation 17 Good governance

Regulation 18 Staffing

At this inspection, we found the issues from the previous inspection had been addressed. However, we have issued two further requirement notices for regulatory breaches that relate to:

Regulation 12 Safe care and treatment

Regulation 17 Good governance

Summary of this service

Our rating of this service improved. We rated it as good because:

- The wards were safe and clean. Staff ensured people were safe and their privacy and dignity maintained and provided support that was appropriate to their needs.
- Managers were able to bring in extra staff when they needed to so that there were enough staff on each shift.
- The multi-disciplinary team that cared for patients included a range of disciplines and specialists.
- Overall, staff followed National Institute for Health and Care Excellence guidance. There was a range of psychological interventions available. The service had introduced topical sessions to promote healthy lifestyles.
- Staff ensured care planning was holistic and patient centred and they undertook regular reviews of risks.
- Staff encouraged relevant outside agencies and carers to attend multi-disciplinary meetings.
- We saw many positive interactions between staff and patients, their relatives and carers. Staff respected patients' personal and cultural preferences. They made efforts to involve patients, their relatives and carers in care planning as much as possible. They explained patients' rights under the Mental Health Act in a way that they could understand. They gave carers information about the carer's assessment.
- Patients, their relatives and carers had opportunities to give feedback about the service. Staff reviewed complaints and compliments regularly and used the learning from this to help improve the quality of care.
- The ward was accessible to older people with disabilities including those with a mobility impairment.
- Staff understood the trust ethos and explained how they applied the vision and values in their work.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity.
- Effective governance systems and audits provided assurance.
- There were examples of innovative practice and staff felt supported to take opportunities to make changes.

However:

- Not all staff had a clear understanding of blanket restrictions as defined in the Mental Health Act Code of Practice.
- Not all staff followed national guidance in relation to medicines management consistently.
- Frequency of staff supervision did not follow the trust policy.
- There were no formal arrangements to monitor adherence to the Mental Capacity Act. Staff did not record best interest decisions in a consistent way.
- Information was not always available in a format that was accessible by different patient groups.

Wards for older people with mental health problems

- Staff used a combination of paper and electronic records and they were expected to record information in more than one system. They said this did not cause them any difficulty in entering or accessing information on the ward. However, the records were not easy to navigate and information was held in different places. Staff said that using different recording methods meant sharing information was difficult.
- Some staff said they did not have opportunity to be involved in discussing service strategy.
- There was no forum for discussion or sharing good practice across the service.

Is the service safe?

Requires improvement ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- Practice in medicines management in line with national guidance was not consistent across the service. Staff were mostly following policy; however, there were inconsistencies in relation to the safe administration of medicines. For example, records were not always complete, and staff were not consistent in reviewing the effects of medication on patients' physical health regularly.
- There were breaches of guidance on eliminating mixed-sex accommodation. The trust was unable to provide the reasons for the breaches. However, the number of breaches was reducing and staff were making efforts to ensure patients were safe and their privacy and dignity maintained.
- Care plans did not always describe clearly how care should be delivered to avoid use of restrictive interventions.
- Not all staff had a clear understanding of blanket restrictions as defined in the Mental Health Act Code of Practice.
- Records were not easy to navigate and information was held in different places.

However:

- The ward environment was safe, clean and well maintained.
- There were enough staff on each shift and ward managers were able to bring in extra staff when they needed to.
- Most staff were up to date with appropriate mandatory training and others were booked onto courses.
- Staff carried out risk assessments of every patient within 48 hours of admission. They updated records at least weekly and whenever clinically indicated.
- Staff understood when they might need to make a safeguarding alert and what action to take.
- Mostly, staff knew what incidents to report and how to report them. They discussed feedback and made changes to improve safety.

Is the service effective?

Good ● ↑

Our rating of effective improved. We rated it as good because:

- The multi-disciplinary team that cared for patients included a range of disciplines and specialists.
- Staff undertook physical health monitoring on a weekly basis. Patients had access to specialists when needed.

Wards for older people with mental health problems

- Staff provided care and treatment in line with National Institute for Health and Care Excellence guidance on psychosis and schizophrenia in adults and use of clozapine. A range of psychological interventions, including cognitive behavioural therapy, were available for older people.
- Saffron ward provided care for patients experiencing delirium, through a partnership between the mental health trust, the acute NHS trust and local GPs. This type of service is usually provided within acute trusts and is innovative within mental health services.
- Staff ensured care planning was holistic and patient centred. They undertook regular reviews of risks and all patients underwent an assessment of need.
- Staff made patient referrals to other services when this was required including diabetes and tissue viability services.
- The service held regular multidisciplinary meetings and encouraged attendance by outside agencies and carers.
- Staff explained patients' rights under the Mental Health Act to them in a way that they could understand, repeated it as required and recorded that they had done it.
- Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards

However:

- Frequency of staff supervision did not follow the trust guidance of taking place every 8 weeks but occurred every 4-12 weeks on average, depending on location, ward and role.
- Staff did not record best interest decisions in a consistent way that reflected the individual or captured the details about the rationale for the interventions considered.
- There were no formal arrangements to monitor adherence to the Mental Capacity Act.

Is the service caring?

Good  

Our rating of caring improved. We rated it as good because:

- Staff respected patients' personal and cultural preferences. They used 'life story' work to learn more about their patients with dementia and their personal interests.
- Staff ensured they maintained people's privacy, dignity and confidentiality and provided support that was appropriate to their needs.
- We saw many positive interactions between staff and patients, their relatives and carers.
- Staff knew what resources were available to support carers and gave them relevant information.
- Staff made efforts to involve patients in care planning as much as possible.
- The service was using the triangle of care to involve patients' relatives and carers.
- The service had introduced topical sessions to promote healthy lifestyles.
- Patients, their relatives and carers were able to give feedback about the service.
- Staff gave carers information about the carer's assessment.

Wards for older people with mental health problems

Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- Staff respected patients' dignity and confidentiality.
- The ward was accessible to older people with disabilities including those with a mobility impairment.
- The ward had clear admission criteria. Staff monitored referrals, waiting times, delayed discharges and lengths of stay.
- Patients had access to snacks and cold and warm drinks.
- Staff supported patients' identified spiritual needs and cultural requirements
- Carers were aware of the complaints process. Staff reviewed complaints and compliments regularly and acted upon any learning to improve the quality of care.

However:

- Information was not always available in a format that was accessible by different patient groups.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- Leaders had a good understanding of the service. They knew how the teams were working to provide high quality care and they were visible and approachable for patients and staff.
- Staff understood the trust ethos and explained how they applied the vision and values in their work
- Staff felt respected, supported and valued. They were optimistic about the new management structure.
- Staff reported that the trust provider promoted equality and diversity.
- Effective governance systems and audits provided assurance.
- All the wards had made improvements in safety.
- Staff, patients and carers had access to up-to-date information about the service.
- There were examples of good practice and staff felt supported to take opportunities to make changes.

However:

- Staff said that using different methods of recording meant sharing information was difficult.
- Some staff said they did not have opportunity to be involved in discussing service strategy.
- There was no forum for discussion or sharing good practice across the service.

Wards for older people with mental health problems

Outstanding practice

We found an example of outstanding practice in this service.

Saffron ward did not admit patients with mental illness but provided care for patients experiencing delirium, such as post-operatively or because of infection. This was provided through a partnership between the mental health trust, the acute NHS trust and local GPs. This type of service is usually provided within acute trusts and is innovative within mental health services.

Areas for improvement

We found areas for improvement in this service.

The provider must:

- Ensure details of best interests meetings and the rationale for administering medicines covertly is recorded consistently on all wards.
- Ensure the monitoring of medicines prescribed for use as required and the rationale for administering these is recorded consistently on all wards.
- Ensure the details of best interests' meetings and rationale for decisions such as 'do not attempt cardiopulmonary resuscitation' are recorded consistently on all wards.
- Ensure all patients have individual care plans that fully detail how to administer medicines covertly in a safe manner.

The provider should:

- Ensure that all wards are compliant with guidance on eliminating mixed-sex accommodation.
- Ensure that all care plans describe clearly how care should be delivered to avoid use of restrictive interventions.
- Ensure all staff have a clear understanding of blanket restrictions as defined in the Mental Health Act Code of Practice.
- Ensure all staff receive supervision at an appropriate frequency.
- Review arrangements for managing records so that information is easily accessible.
- Ensure that practice in medicines management in line with national guidance is consistent across the service.
- Consider providing information in formats that meets the accessible standard in relation to patients' needs, including care plans.
- Ensure only relevant, up to date information is displayed on wards and in clinic rooms.
- Ensure all staff are aware of opportunities to contribute to discussions about service strategy.
- Ensure there is a system for sharing of good practice across the service.

Requirement notices

Action we have told the provider to take The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements. For more information on things the provider must improve, see the Areas for improvement section

Wards for older people with mental health problems

above. **Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and Treatment This was a breach of regulation 12 (1) and 12 (2) (g)
Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance This was a breach of regulation 17 (1) and 17 (2) (c)

Mental health crisis services and health-based places of safety

Requires improvement   

Key facts and figures

Pennine Care NHS Foundation Trust provide crisis and health based places of safety in five boroughs:

- Oldham
- Rochdale
- Bury
- Tameside
- Stockport.

The trusts provision of crisis services is made up of three different teams in all five boroughs. The home-based treatment teams offer intensive support to patients in mental health distress and deterioration as an alternative to a hospital admission. They operate from 9am to 9pm and offer support in patient's own homes.

Rapid access interface and discharge (RAID) teams provide support 24 hours a day, seven days a week. The team provide mental health assessment, brief intervention and signposting in accident and emergency departments and medical wards at the following acute hospitals:

- Stepping Hill Hospital, Stockport.
- Royal Oldham hospital
- Tameside general hospital
- Fairfield general hospital, Bury
- Rochdale urgent care centre.

The RAID teams also coordinate the support and care for patients brought in by the police on a section 136 of the Mental Health Act to a place of safety.

There were access teams in Stockport, Oldham and Tameside who triage and assess all referrals into mental health services to determine level of risk and if referrals meet the criteria for mental health services. In Rochdale and Bury, they offer access and crisis teams who provide the same provision as the access teams with the additional short-term intervention for patients in mental health crisis.

At this inspection we inspected the following teams:

Health based places of safety, RAID teams and home-based treatment teams in the following boroughs:

- Oldham
- Rochdale
- Bury
- Tameside
- Stockport.

The access team in Stockport.

Mental health crisis services and health-based places of safety

The access and crisis teams in the following boroughs:

- Bury
- Rochdale

Our inspection was short-notice announced (staff did not know we were coming) to enable us to observe routine activity.

We chose to inspect these teams because they were either teams that we had not inspected before or they had actions from the last inspection that we wanted to review if they had achieved.

At the last inspection in June 2016, the service was rated as requires improvement overall and had four requirement notices issued; Regulation 9 Person centred care, Regulation 12 Safe care and treatment, Regulation 17 Good governance and Regulation 18 Staffing.

At this inspection, the service had met the requirement notices in relation to Regulations 9, 12 and 18. The health based places of safety had been refurbished in all boroughs, were clean and had systems in place to ensure the ongoing maintenance of the facilities. However, information regarding patients' rights and that CCTV cameras were on operation were not displayed in each health based place of safety.

Improvements had been made in relation to record keeping. Care plans and crisis management plans were in place and physical health monitoring was taking place. Allergies were also recorded in most of records. Risk assessments were detailed and comprehensive.

Training levels had improved and the team managers had access to dashboards to monitor team compliance.

However, medicine recording was still inconsistent and will be discussed further in the report.

Some improvements had been made in relation to governance of the teams in relation to access to training, appraisals and the quality of the documentation. However, concerns remained in relation to staff accessing supervision.

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

- Toured the health based places of safety in each borough.
- Spoke with 19 staff including doctors, nurses, occupational therapists and support time and recovery workers.
- Spoke with members of Greater Manchester Police in relation to their experiences of bringing patients to the health based places of safety.
- Spoke with 12 managers and acting managers.
- Observed two home visits with the home- based treatment teams in Stockport and Tameside.
- Spoke with two patients and a carer in person.
- Spoke with 20 patients via the telephone.
- Received one completed comment card.
- Reviewed 62 care records and detention paperwork in relation to the Mental Health Act for patients brought in on a section 136.
- Observed a handover meeting and a zoning meeting.

Mental health crisis services and health-based places of safety

- Toured the community bases for the home-based treatment teams including interview rooms where patients were seen.
- Reviewed the medicines management arrangements in each of the home-based treatment teams.
- Reviewed a variety of documentation including incident data, meeting minutes and environmental records.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not manage medicines safely. There were different arrangements and processes for storing and administering medicines across the teams. Records were incomplete and staff were not aware of how to act on concerns.
- Staffing levels meant that managers were providing clinical work, this had a detrimental impact on their managerial tasks including providing regular supervision to staff.
- The service was not following the requirements of the Mental Health Act. Patients in the health based places of safety did not routinely have their rights explained to them or have an assessment from an approved mental health practitioner.
- Oversight was not sufficient to ensure staff received regular supervision, the Mental Health Act was adhered to, learning and good practice was shared with managers in other boroughs.
- The services did not meet the needs of all patients. Information for patients was only available in English. Patients we spoke with were not aware of any opportunities that they could feedback about the service or any examples of where their feedback had been requested. Not all patients were aware of how to complain about the service.

However:

- Improvements had been made to the facilities since the last inspection. The health based places of safety had all been refurbished and regular maintenance checks took place including legionella checks.
- Safety had improved with detailed risk assessments in place for patients and staff followed lone working arrangements. Staff were aware of the duty of candour and were open and honest when an incident occurred, learning was shared with staff at team meetings.
- Records contained assessments completed in a timely manner with evidence of patient involvement.
- Feedback from patients and our observations showed staff were caring, supportive and responsive to the needs of patients.

Is the service safe?

Requires improvement ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- Medicines were not managed safely. Records were incomplete and there were inconsistencies in medicine management arrangements across the trust.

Mental health crisis services and health-based places of safety

- The service did not have enough staff with the right skills and training to keep people safe. All teams except the Stockport home based treatment team had vacancies at the time of the inspection. Staff were taken from neighbouring wards and community teams to staff the health based places of safety leaving their teams short. We observed managers being included in the numbers and providing clinical interventions due to staffing challenges and the pressures of the service.

However:

- The health based places of safety had all been refurbished since the last inspection. They were clean and well maintained.
- There were good lone working arrangements in place which staff were aware of and followed.
- Staff undertook a risk assessment of every patient at initial triage/ assessment and updated this regularly. Risk assessments were detailed and comprehensive.
- The teams created and made good use of crisis plans which included strategies for keeping patients safe and contact details for organisations for support.
- Staff understood and followed the duty of candour regulation. Staff were open and transparent and explained to patients when something went wrong.

Is the service effective?

Requires improvement ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- Mental Health Act documentation in relation to patients detained under a section 136 was not completed fully. This included if patients had had their rights under section 132 of the Mental Health Act explained to them.
- Staff were not receiving regular management supervision in line with the trust policy.

However:

- There had been progress made in record keeping and documentation since the last inspection. Records reviewed included a comprehensive assessment completed in a timely manner.
- Staff had received an appraisal and team meetings took place.

Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with kindness, respect and dignity. Most patients felt that the teams involved them in their care and considered their feelings and wishes.
- Patients explained that the teams involved family, friends and carers as per their wishes.
- Staff spoke about patients in a respectful and caring manner.
- Interactions we observed were positive, supportive and empowering.

Mental health crisis services and health-based places of safety

- Patients gave examples of the home- based treatment teams linking them in to groups and services in the local area that would suit their needs.
- Patients told us the health based places of safety facilities were clean, safe and staff explained to them why they were there. Staff were caring towards patients and understood their needs.

However:

- Patients we spoke with were not aware of any opportunities that they could feedback about the service or any examples of where their feedback had been requested.

Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- Teams were responsive. They were available to respond to patients in crisis 24 hours a day, seven days a week. Teams could increase their support to patients if their mental state deteriorated, this was agreed at daily handover meetings.
- Teams had information leaflets providing information to both patients and carers which included what to do in a crisis and local contact details for organisations that could offer support.
- The teams took active steps to engage with patients who found it difficult or were reluctant to engage with mental health services. The home- based treatment teams supported patients at home, RAID teams saw people in accident and emergency departments and on medical wards and access teams could provide home visits where needed.
- Staff understood the complaints process and managers shared learning from complaints investigations with staff.

However:

- The trust was not providing information that was accessible to all patients.
- Eight of the 22 patients we spoke with did not know how to complain.

Is the service well-led?

Requires improvement ● → ←

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Systems were not effective in ensuring that staff were supervised and Mental Health Act requirements were followed in relation to the documentation, explaining rights to patients and ensuring they were assessed by an approved mental health professional.
- Managers reported difficulties with recruitment. The service used bank staff to fill gaps but the service required managers to provide clinical interventions due to staffing challenges and the pressures of the service. We concluded that this affected the managers' ability to manage the services effectively.
- There was no opportunity for managers to meet with their counterparts in other boroughs.
- Staff morale was quite low due to the demands of the service, increases in referrals, the nature of the work, staff supporting patients in crisis and heightened distress and vacancies within the teams.

Mental health crisis services and health-based places of safety

- There were vacancies for team managers at Tameside home based treatment team and Rochdale access and crisis team. Acting managers were in post at Bury RAID and Rochdale home based treatment team.

However:

- Staff told us team and service managers were supportive. Staff reported enjoying their roles and a number had worked for the trust for many years.
- Acting managers reported the trust were supportive in their leadership development.
- Managers had access to an electronic dashboard to monitor staff and team compliance.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Action the trust **MUST** take to improve:

- The trust must ensure there are enough staff to provide the services safely, including managers for teams and staff to support patients in the health based places of safety.
- The trust must ensure managers provide staff with management supervision in line with the trust's policy.
- The trust must ensure that medicines are managed safely, including the completion of medication administration records, recording of fridge temperatures and taking action if a reading is out of the recommended range.
- The trust must ensure that staff comply with the requirements of the Mental Health Act, including the completion of the Mental Health Act documentation fully and ensuring patients have their rights explained to them. Patients should be assessed by an approved mental health professional when they are detained under section 136.

Action the trust **SHOULD** take to improve:

- The trust should explore the possibility of providing information in relation to patient rights and self- help resources in other languages to meet the needs of all patients.
- The trust should ensure that patients are aware of how to complain and give feedback regarding the service.
- The trust should ensure there is a notice displayed in all health based places of safety to inform patients CCTV is in operation.
- The trust should consider how managers can share good practice and learning with their counterparts in other boroughs.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement   

See guidance note ICS 1 – then delete this text when you have finished with it.

Key facts and figures

We inspected the whole core service to check whether improvements had been made following our last inspections.

When we last undertook a comprehensive inspection of the trust in June 2016, we rated acute wards for adults of working age and psychiatric intensive care units as **requires improvement** overall and rated the core service as requires improvement for safe, effective, responsive and well-led and good for caring. We asked the provider to take action to meet the following essential standards of quality and safety;

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 18 HSCA (RA) Regulations 2014 Staffing

We completed a focused inspection in June 2017 for the safe domain and found the provider was not meeting the essential standard of quality in safety;

Regulation 17 HSCA (RA) Regulations 2014 Good Governance.

During this inspection in September 2018 we found the above regulations had been met. However, we have issued one requirement notice for Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

The inspection was announced at short notice. Staff did not know we were coming until the first day of the inspection to enable us to observe routine activity.

The inspection team consisted of six CQC inspectors, a CQC pharmacist inspector, one assistant inspector and two specialist advisers, a psychiatrist and a nurse with experience of nursing on acute adult wards.

Pennine Care NHS Foundation Trust provides 10 acute wards for adults of working age, and one psychiatric intensive care unit, across five sites.

Irwell Unit is in the grounds of Fairfield General Hospital in Bury, and has two acute admission wards for working age men and women:

- North ward - 24 beds, for both males and females.
- South ward - 24 beds, for both males and females.

Tameside General Hospital –has two acute admission wards for working age men and women, the mental health units are in the grounds of the general hospital:

- Saxon suite - 23 beds, for both males and females.
- Taylor ward - 22 beds, for both males and females.

Parklands House is in the grounds of the Royal Oldham Hospital in Oldham, and has two acute admission wards for working age men and women:

- Aspen ward - 22 beds for females.

Acute wards for adults of working age and psychiatric intensive care units

- Oak ward - 22 beds for males.

Rochdale, Heywood and Middleton Mental Health Services – the John Elliot Unit is in the grounds of Birchill Hospital in Rochdale, and has two acute admission wards for working age

men and women:

- Hollingworth ward – 18 beds, for both males and females.
- Moorside ward – 24 beds, for both males and females.

Stepping Hill Hospital – the mental health unit is in the grounds of the general hospital in Stockport, and has two acute admission wards for working age men and women and a

psychiatric intensive care unit:

- Arden ward – 24 beds, for both males and females.
- Cobden ward – 10 bed psychiatric intensive care unit for men only.
- Norbury ward – 23 beds, for both males and females.

During the inspection, the inspection team;

- Toured all 11 wards
- Checked all 11 clinic rooms
- Checked one seclusion room
- Spoke with 40 patients
- Spoke with 22 health care support staff
- Spoke with two advanced practitioners
- Spoke with 17 nursing staff
- Spoke with 11 managers on the wards
- Spoke briefly with three service managers
- Spoke with two carers
- Spoke with six occupational therapists including recovery and inclusion workers
- Spoke with four psychologists
- Spoke with two house keepers
- Spoke with one general practitioner in practice and an associate physician
- Spoke to one chaplain
- Spoke to one bed manager
- Observed six ward rounds
- Observed one patients meeting
- Observed one qualified nurses' supervision meeting

Acute wards for adults of working age and psychiatric intensive care units

- Reviewed 134 prescription charts
- Reviewed 50 patient care records
- Reviewed three rapid tranquilisation records
- Spoke with five pharmacists
- Observed three ward handover meetings
- We received 22 comment cards

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

Staff did not consistently monitor or document the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence guidance, especially when the patient was prescribed a high dose of antipsychotic medication and rapid tranquilisation.

The trust had not fully implemented the schedule 5 recommendations to prevent future deaths, for example providing psychological input as a critical treatment to all inpatient wards and to introduce one information technology system.

Staffing levels were insufficient to fully facilitate patients accessing their planned leave, one to one time and access to outside recreational activities. Blanket restrictions were also in place on all the wards we visited.

Staff did not always complete care plans that were personalised, holistic and recovery orientated. They did not always meet the needs for patients with protected characteristics. Psychological therapies were not available across all wards. The trust electronic record system was not fully accessible across all teams.

The information provided for patients with a learning disability was not always in a form accessible to them. The service did not always make adjustments for disabled patients.

Psychiatric intensive care unit beds were not always available within the trust when a patient required more intensive care. Female patients were unable to access a psychiatric intensive care unit bed within the trust.

Patients had access to outside space. However, on most of the wards the outside space was either locked or patients had to be accompanied by staff apart from Norbury ward where patients had access to a small garden freely. Patients and staff reported access to leisure facilities on all sites were restricted due to staff availability to accompany patients.

Although the trust had implemented audits throughout the adult inpatient wards the documentation audit was not effective to provide assurance that the collaborative care planning had been fully implemented and that care plans were produced to meet individual needs.

However:

The wards were safe and clean and the trust had implemented appropriate systems for managing the risks to patients belonging to the opposite gender. Risk assessments were in place for all the patient records we looked at apart from one on Taylor ward where specific risks had not considered nor assessed.

There were skilled staff able to deliver care and multidisciplinary and interagency team work was well established.

Acute wards for adults of working age and psychiatric intensive care units

Patients were given a full physical health check on admission and at regular intervals thereafter. Physical health needs including referral to specialist services were completed in a timely manner and advice given to promote healthier lifestyles.

Feedback from patients and comments cards we received about the care and treatment they received were mostly positive. Our observations of staff confirmed staff treated patients with compassion, dignity and respect and involved them in making decisions about their individual care and treatment.

Staff planned for patients' discharge, including good liaison with care managers/co-ordinators.

Consultation with patients, carers and staff had taken place to assist the trust in making future decisions about eliminating mixed sex wards.

There was a clear statement of vision and values displayed throughout the wards we visited. Staff were positive about the new management and proud about their work. Staff felt able to raise concerns without retribution.

Is the service safe?

Requires improvement ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- Staff did not consistently review the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence guidance, especially when the patient was prescribed a high dose of antipsychotic medication and rapid tranquilisation.
- Taylor ward did not always ensure that patients were kept safe and their privacy and dignity was maintained. Staff had not considered nor assessed the risks of a patient being admitted to mixed sex accommodation as part of the admission process, nor were there any alerts to inform the ward of previous history regarding disinhibited behaviour. There was no reference to this in their risk assessment and no reference to the use of the trust algorithm.
- Ward managers, staff and patients reported that escorted leave off the ward and one to one time with patients was sometimes cancelled due to too few staff to facilitate this.
- Staff applied blanket restrictions on all wards we visited. Examples of these included freedom to access garden areas, two hourly smoking breaks, takeaways allowed on certain days and times. Televisions were turned off at certain times during the week and at weekends.
- The trust did not have a policy, for patients with protected characteristics under the Equality Act, for example patients who are gender reassigned.
- The trust reported that only 70% of applicable staff had completed their mandatory intermediate life support on Hollingworth ward and safeguarding children level three was only 50% compliant across the service.
- The trust reported 87 mixed sex accommodation breaches for this core service over a 12-month period.
- The trust had not fully implemented the schedule 5 recommendations for example providing psychological input as a critical treatment to all inpatient wards and to introduce one information technology system which is currently not in place.

However:

- The ward areas were safe, clean and well-maintained environments. The seclusion room allowed clear observation and two-way communication, and had toilet facilities and a clock.

Acute wards for adults of working age and psychiatric intensive care units

- There were enough staff on each ward to provide clinical care to patients. The wards were to receive additional staff, to increase the number of staff on each ward under the safer staffing model.
- There was adequate medical cover day and night with arrangements in place for a doctor to attend in an emergency.
- Staff completed a risk assessment for every patient on admission and updated them regularly whenever clinically indicated.
- All the wards had been involved in identifying and reducing restrictive practices and this was being reviewed by the trust.
- Staff were safeguarding patients and knew how to identify and report safeguarding concerns.
- All staff knew what incidents to report and how to report them.
- Consultation with patients, carers and staff had taken place to assist the trust in making future decisions about eliminating mixed sex wards.

Is the service effective?

Requires improvement   

Our rating of effective stayed the same. We rated it as requires improvement because:

- Care plans across the wards were not always completed, personalised, holistic and recovery orientated.
- Psychological therapies were not available across all wards.
- Staff did not use recognised rating scales such as Health of the Nation Outcome Scales to assess and record severity and outcomes across all wards.
- On Hollingworth ward a patient was prescribed a combined dose of anti-psychotic medicines that were more than twice the does recommended by the British National Formulary. Staff had not followed trust guidance by recording the rationale or the additional monitoring required.
- Not all core service staff had received or updated their Mental Health Act and Mental Capacity Act training.
- The trust electronic record system was not fully accessible across all teams.
- Patients with section 17 escorted leave were not always able to take it because staffing levels on the ward were not sufficient to allow this.

However:

- Comprehensive assessments and risk assessments were completed on patient admission and were regularly updated.
- Patients were given a full physical health check on admission and at regular intervals thereafter. Physical health needs including referral to specialist services were completed in a timely manner.
- Patients were offered support to live healthier lives such as smoking cessation, referral to substance misuse services and healthier eating advice.
- Patients detained under the Mental Health Act had their rights explained regularly and the original detention papers were placed in patient records.
- Risk assessments and care plans were easily identifiable in patients' records.

Acute wards for adults of working age and psychiatric intensive care units

Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with kindness and support and respected their privacy and dignity.
- Staff helped patients to settle onto the ward and provided useful information to help patients feel comfortable and know what to expect during their stay.
- Staff communicated with patients and involved patients in planning for their ward rounds and multidisciplinary meetings.
- Staff responded to patients cultural and spiritual needs. Patients had access to chaplaincy services, and meals were available to meet religious needs. Staff used translation services to help patients needing an interpreter.
- Patients had the opportunity to give feedback to staff through regular community meetings. Patients felt able to complain to staff if they needed to.
- Families and friends and were given opportunities to be involved in patient care if the patient wished it.
- Patients received support with housing, bills and accommodation and staff worked with external agencies to help prepare patients for discharge.

However:

- Advocacy was not available to all patients on all wards.
- Care plans showed that the communication needs of patients with learning disabilities were not always taken into consideration.

Is the service responsive?

Requires improvement ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Beds were not always available to patients living in their own catchment area and beds were not always available to patients to return to the same ward they left before they had leave.
- A bed was not always available in a psychiatric intensive care unit when a patient required more intensive care. Female patients were unable to access a psychiatric intensive care unit bed within the trust.
- Although there were bed vacancies on some of the wards we visited, between 1 May 2017 and 30 April 2018 apart from the Cobden Unit, the average bed occupancy rate for each ward was over 100%.
- The information provided for patients with a learning disability was not always in a form accessible to them. The service did not always make adjustments for disabled patients – for example patients with specific communication needs were not care planned for.
- Patients had limited access to outside space and leisure facilities. However, on most of the wards the outside space was either locked or patients had to be accompanied by staff apart from Norbury ward where patients had access to a small garden freely.

Acute wards for adults of working age and psychiatric intensive care units

However:

- Staff planned for patients' discharge, including good liaison with care managers/co-ordinators. Recovery and inclusion workers were attached to most wards.
- The food was of a good quality and snack boxes were made available if patients missed their meals. Hot and cold drinks were accessible to patients.
- The wards provided a choice of foods to meet dietary requirements of religious and ethnic groups.
- Staff ensured patients could obtain information on treatment, local services, patients' rights and how to complain.
- Staff and patients had easy access to interpreters and signers as well as spiritual support.
- Patients could make a phone call in private and had access to their own mobile phones unless this had been risk assessed.

Is the service well-led?

Requires improvement ● → ←

Our rating of well-led stayed the same. We rated it as requires improvement because:

- There were networks and forums available to staff and the trust had altered the way these were managed. There were new quality assurance leads within the trust but these were not fully embedded at the time of inspection.
- The trust had implemented an adult inpatient documentation audit. We found this was not sufficient to provide assurance that the collaborative care planning had been fully implemented and that care plans were produced to meet individual needs.
- Some staff reported there were sometimes delays in accessing the computerised system used to store current risk assessments. Not all staff had access to the information technology infrastructure.
- There were still restrictive and blanket restrictions on the wards we inspected.
- The wards did not participate in accreditation schemes relevant to the service.
- There were lapses in the management of medicines practice and managers had not ensured there was consistent practice.
- Bed management practice meant that patients could not always access a bed in their catchment area. Psychiatric intensive care beds were not always available and the trust had no facility for female patients to access a bed within their trust.

However:

- Leaders had the right skills and abilities to perform their roles and leadership development opportunities were available and encouraged.
- Staff were aware of the providers vision and values and implemented these within the wards they worked.
- Staff and leaders were positive and proud about their work. Staff felt able to raise concerns without retribution.
- There were innovative practices accessible at North and South wards where patients could access a physical health check drop in clinic. Clinical staff had co-produced a survival guide handbook, to act as a quick reference guide to staff on inpatient wards.

Acute wards for adults of working age and psychiatric intensive care units

- The governance arrangements were mostly effective with audits, systems and procedures in place to ensure the wards were safe and clean.
- The management of risk issues and staff performance were monitored. The corporate risk register matched some of the concerns we found on this inspection.

Outstanding practice

- North and South wards had access to a physical health check, drop in clinic additional to the physical health checks on the wards.
- Clinical staff had co-produced a survival guide handbook, to act as a quick reference guide to staff on inpatient wards.

Areas for improvement

We found areas for improvement in this service.

The trust must:

- Ensure checks are in place to consistently review the effects of medication on patients' physical health regularly, especially when the patient is prescribed a high dose of antipsychotic medication and rapid tranquilisation. (Regulation 12)

The provider should:

- Ensure patients are kept safe and their privacy and dignity is maintained. That consultations with patients, carers and staff are reflected in decisions the trust makes about eliminating mixed sex wards. A policy is implemented for patients being admitted to the acute and psychiatric intensive care unit with protected characteristics under the Equality Act. (Regulation 10)
- Ensure that blanket restrictions on all wards are only applied in line with guidance under the Mental Health Act unless they can be justified and are proportionate. (Regulation 13)
- Ensure care plans are completed to meet individual needs and take into consideration of the communication needs of patients with learning disabilities. (Regulation 9)
- Ensure applicable staff on Hollingworth ward have completed their intermediate life support mandatory training and staff complete their mandatory child safeguarding level three training.
- Ensure they continue to monitor and implement the schedule 5 recommendations.
- Ensure psychological therapies are provided to all the inpatient wards and a full range of specialist are available to all inpatient wards.
- Ensure non medical staff receive an appraisal as per the trusts target rate.
- Consider that where escorted leave and one to one time with patients is cancelled there are clear reporting mechanisms to report and document the reasons for this.
- Consider the full implementation of electronic recording for patient records.
- Consider advocacy services are readily accessible to all patients.
- Consider beds are available to patients living in their own catchment area and that psychiatric intensive care unit beds are available to female patients within the trust.

Acute wards for adults of working age and psychiatric intensive care units

- Consider alternatives to ward admissions across the trust due to the capacity of beds and the overoccupancy of the wards.
- Consider an appropriate audit tool, to provide assurance that the collaborative care planning is fully implemented and that care plans are produced to meet individual assessed need.

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Action we have told the provider to take

Regulated activity	Regulation
Treatment of disease, disorder or injury.	Regulation 12, 2 (a), (b) and (c), Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe Care and Treatment

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Our inspection team

The team included a Head of Hospitals Inspection, 15 inspectors, 2 executive reviewers and 8 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.