Greater Manchester Mental Health NHS Foundation Trust

Community-based mental health services of adults of working age

Inspection report

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Date of inspection visit: 04 - 06 October 2022
Date of publication: 10/03/2023

Ratings

Overall rating for this service	Not inspected
Are services safe?	**Inadequate**
Are services responsive to people's needs?	**Requires Improvement**

Our findings

Community-based mental health services of adults of working age

Not inspected

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

We inspected the trust's community based mental health services for adults of working age in the Central West, Central East and South Mersey teams.

We carried out this unannounced focused inspection as a follow up to the previous inspection carried out in April 2022 where we rated safe as inadequate. We also received information giving us concerns about the safety and quality of the services.

We focused our inspection on specific key lines of enquiry within the domains of safe and responsive.

Our ratings of safe and responsive stayed the same. We rated safe as inadequate and responsive as requires improvement.

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

- The service had mitigated waiting lists by creating a manager's caseload for those waiting allocation of a care co-ordinator. However, we found patients on these caseloads with significant risks that had not been escalated.
- There was no oversight for how long people remained on these caseloads.
- The nature of the contacts made to those who were unallocated was not sufficient to identify risk.
- Not all patients had up to date care plans and risk assessments. This meant that any new issues were not being identified or monitored.
- The assessment of risk for those who were unallocated was not adequate to identify areas of concern or issues that required monitoring. This was because it mainly relied on patients volunteering the information themselves.
- The services had high levels of non-permanent staff and often did not have enough staff to deliver care safely.
- The service did not have effective alarm systems in the patient consultation rooms
- Due to staff shortages, staff without the required skills were carrying out more specialised work. The teams were not compliant for most of their mandatory training modules.
- There was no system in place for the storage and administration of medication. We found out of date medication. Patients did not always receive their medication in time.
- The service did not have systems in place to provide oversight of the management of medicines. There were no audits in place to appraise the ordering, storage and safe administration of medicines.

Our findings

- Not all areas were clean and there was no system or audit in place to oversee this.
- Not all teams were adequately equipped to safely deliver physical health care. Some of the equipment in the emergency grab bags were out of date.
- The telephone system was not designed in a way that made it easy for people to get through to the service.

However:

- Staff were passionate about the work they carried out and showed a caring attitude towards people that used the service.
- Staff felt respected and supported in their teams.

How we carried out the inspection

During the inspection visit the team:

- Toured the environments at Central East, Central West and South Mersey CMHT's
- Spoke with 11 patients
- Spoke with 2 carers
- Took part in 2 home visits
- Observed 2 zoning meetings
- Observed a safeguarding strategic meeting
- Looked at 21 care records, this included patients who were allocated as well as unallocated
- Looked at 20 depot prescription cards
- Spoke with medical secretaries, safeguarding leads, 7 nurses (3 of whom were agency), 3 administration workers, a receptionist, 5 social workers, an occupational therapist, 2 managers and a deputy manager
- Reviewed a range of policies, procedures and other documents.

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

What people who use the service say

The parent of an autistic person told us they were keen to be involved in their care but had not been given the opportunity. Some had also complained about the difficulty in getting through when they called seeking support. However, most of the people who used the service told us staff were respectful, polite and interested in their well-being.

Is the service safe?

Inadequate 

Our rating of safe stayed the same. We rated it as inadequate.

Our findings

Safe and clean environment

Not all clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Not all interview rooms had alarms and staff available to respond. The interview rooms at the Central West and Central East community mental health teams (CMHT's) were not fitted with alarms. The interview rooms at the South Mersey team had them but these were behind a desk and on the far wall of the room which meant that staff would have to turn away from the patient and the door to reach them.

Not all clinic rooms had the necessary equipment for patients to have thorough physical examinations. The clinic room at the Central West team did not have an examination couch. This meant that there was no option for people to lie down for examinations and administration of injections. Staff told us a couch had been ordered but had not yet arrived.

Not all areas were clean, well maintained, well-furnished and fit for purpose. Some of the chairs at Central West and South Mersey teams were ripped. The floor at Central West did not look clean and was stained.

Staff did not make sure cleaning records were up-to-date and the premises were clean. The teams did not have any cleaning records. There was also no audit process in place to monitor cleaning. The room temperature at the Central West team was not recorded.

Staff did not ensure equipment was well maintained, clean and in working order. The emergency grab checklist at the Central East CMHT had not been completed since November 2020. The single use resuscitator had expired in January 2021. The adult Pacing/Defibrillation/ECG electrodes had been out of date from July 2022. However, the emergency medicines and grab bags were equipped and up to date at Central West and South Mersey CMHT's.

Safe staffing

The service did not have enough staff who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high but they were quite complex which prevented staff from giving each patient the time they needed.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. All 3 teams did not have enough staff. The managers told us they always had agency to cover staff shortages. Staff told us they at times cancelled visits in order to cover the duty system. Nine of the clinical staff we spoke with told us they were not able to fulfil their roles due to their workload. Of these, 7 felt they were operating at unsafe levels. Managers also told us their biggest challenge was the lack of staff. This had an adverse effect on patients that were awaiting allocation for a care co-ordinator. Routine appointments were often postponed as staff prioritised crisis interventions. A carer we spoke with complained that there was not enough staff, as well as a lack of continuity as staff frequently changed. A patient we spoke with received monthly telephone contact. Although happy with the service, they had not received any other therapeutic support.

The service had high vacancy rates. The Central East and Central West teams had 8 vacancies each at the time of inspection. The Central West CMHT had 3 posts for nurses that had been vacant for 12 months. The Central East CMHT had 5 vacancies that included nurses, social workers and occupational therapists that had been vacant for more than 6 months. Over the 12 month period from October 2021, Central East had 9 staff leavers, Central West 13 and South Mersey 19, a total of 41 staff. Staff told us the high vacancy rates made it difficult for them to be responsive to patient's needs.

Our findings

The teams also sent out agency staff to help other teams' shortages. We found three staff members that had been brought in from other services to help out in the community teams.

The teams were unable to run their physical health clinics as the staff had left. All 3 CMHT's had a physical health nurse vacancy. This had an impact on patient care. For example, an electrocardiogram was requested in January 2022 for a patient but was only carried out in May that year. Other patients were being redirected to their GP's for some of the routine checks and investigations that would normally be done in the physical health clinics.

The service had high rates of bank and agency nurses. The managers told us they had high use of agency staff. The 3 teams had issued 570 shifts to bank and 2027 shifts to agency in the past 12 months.

Managers made arrangements to cover staff sickness and absence. Managers booked some of the agency staff to cover periods of time rather than individual days.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Managers told us all agency staff received the same local induction as substantive staff. They were also given access to an online learning hub for mandatory training. Of the agency staff we spoke with, one had received 2 days induction and the other had received a verbal induction.

The teams had different turnover rates. These covered the period from October 2021 to September 2022. The Central East team had reducing turnover rates from 39% to 19%. The Central West team had relatively equal rates but an overall reduction from 27% to 20%. However, the South Mersey had an increase from 7% to 25%. The remaining staff found their workload made it difficult to provide effective care co-ordination. The managers also told us they were struggling to recruit and retain staff.

Sickness levels varied across the 3 teams. Covering the period from October 2021 to September 2022 the average sickness rate for Central East was 14%, Central West 6% and 12% for South Mersey team.

Mandatory training

Most of the staff were not up-to-date with their mandatory training. The trust's target for mandatory training was 85%. The Central East and Central West teams were compliant in 24% of the modules. The South Mersey team were 35% compliant.

The mandatory training programme was comprehensive and met the needs of patients and staff. However, compliance for modules such as the Mental Health Act Code of Practice, Mental Capacity act and Safeguarding level 3 was low. Some of this was reflected in the ability of staff to identify and address concerns in these areas. There was a patient with cognitive impairment that did not have a capacity assessment or informed consent documented in their care records. In another record a patient was not taking their medication all the time. Their carer was expressing concern over paranoid behaviour and lack of sleep. When seen by a nurse, there was no record of a capacity assessment that would inform what actions to take.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients and themselves well. They did not respond promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans however, this was not consistent. Staff did not adequately monitor patients on waiting lists to detect and respond to increases in level of risk.

Our findings

Assessment of patient risk

Assessment of risk was not consistent, and staff did not always complete risk assessments for each patient following referral to the teams. They also did not always review risk regularly, including after any incident. The South Mersey team told us risk was assessed at the point of triage but was recorded as a progress note. The Central East team told us assessment of risk depended on information in the referral and if accepted for allocation, patients would have a risk assessment done. The Central West Team told us the duty assessor completed the initial risk assessment and if high risks were identified the patient would be prioritised for allocation. In one of the teams the computer system did not date stamp each entry and some risk assessments were kept open from the time they were initially done. We found risk issues that were not acted on such as a patient not taking their medication who had also smashed their phone and yet they were given an appointment for 4 months time. In another care record, it was recorded that a patient had thoughts of taking an overdose but there was no further information provided.

Out of 17 relevant care records, 9 of them did not have an up to date risk assessment.

Patients who were unallocated received a well-being check every 28 days. Managers told us there was a standard template for calls. However, this did not assess for any risk factors unless the patient volunteered the information themselves. Staff we spoke with were not aware of this template and did not therefore have standard questions to ask regarding risk. Phone calls were mainly done by Band 3 workers who escalated concerns to the Band 6 workers or their zoning meetings (meetings to discuss people with risks where they were zoned as either red, amber or green). The 3 records we saw for people who were zoned showed that one of them who was graded as red had been zoned for two weeks. They had not been seen by their care co-ordinator and one of the plans was for the police to do a welfare check. The other patient who was also zoned red had been receiving welfare checks and awaiting allocation of a care co-ordinator since March 2022. Contact 6 months later showed they had been relapsing over a 3-4 week period. For both patients there were gaps in their follow-up contacts.

The teams did not complete crisis plans for those who were unallocated. These patients were instead given crisis lines to call out of hours and the office number for normal working hours. This limited the interventions available to people and their carers to mitigate escalation of risk.

Junior staff told us they had to signpost patients to A&E as they were not able to assess risk adequately when senior staff members were not available and patients called in a state of distress.

We also found 2 records for those that were unallocated who had recent in-patient admissions followed by support from the home based-treatment. There was no record indicating their escalation for care co-ordination. Staff told us that due to a lack of care co-ordinators some patients who were unallocated had to wait several months following in-patient admissions in order to be allocated a care co-ordinator.

Staff used a recognised risk assessment tool. The teams used the STAR risk assessment tool

Management of patient risk

Staff did not always respond promptly to any sudden deterioration in a patient's health. Staff told us there was no consistency in care co-ordinators which meant some concerns were not actioned in a timely manner. One of the care records had a plan made the previous year to book an audiology appointment that had not been actioned. In another care record of a patient who experienced auditory hallucinations, there were many gaps in the notes including some where information was not completed leading to an in-patient admission for their mental health. This meant there was no information to show staff identified or responded promptly to the deterioration in mental health. Their care plan was out of date and was not updated following the admission.

Our findings

Staff did not always continually monitor patients on waiting lists for changes in their level of risk and did not always respond when risk increased. Patients that were waiting for a care co-ordinator or whose care co-ordinator had left or were on long-term sick were placed on the team manager's caseload. From there they were managed by a team called the Unallocated Hub. At the Central East team, we looked as six patient records for those that were unallocated and found five of them were unwell with high risks. For example, one of the patients had become underweight and reported they were urinating blood, but this was not escalated. There was another patient whose protective factors and warning signs entries were abandoned mid-sentence and not completed. The patient also did not have a management plan.

We observed two virtual zoning meetings. A patient was discussed who was experiencing command hallucinations. They were not allocated but staff continued with welfare checks. There was no clear documentation explaining the rationale for not escalating them. The person subsequently committed an offence which resulted in them being sent to prison.

Staff had also told us that if a patient did not have their depot this would be raised in zoning meetings. However, we found records of patients who had not had their depot for months with no record of actions taken.

Junior staff told us that they did not feel safe a lot of the time. Staff felt uncomfortable asking people who required an urgent assessment to wait 2 weeks as this was outside the recommended response time of 5 days. Another example they gave was a patient calling in the morning in a state of distress and having no one call them back by the afternoon. Staff told us they would have to signpost some of these patients to the emergency department or call ambulances when they had taken overdoses.

Three staff members told us they were concerned that if a GP sent through a written referral as an urgent request, unless they called through, the team administrators were expected to down-grade the referral to routine. Administrators were then expected to inform the person doing triage. They were not happy with this process as they felt it potentially risked urgent referrals being missed.

The service did not have a system in place to assess the effectiveness of interventions. They did not have any audit process for their physical health record or a system that audited the quality of the care plans and risk assessments.

Staff followed clear personal safety protocols, including for lone working. Staff told us they used electronic diaries for their whereabouts. At the end of the day staff were required to ring in safe.

Safeguarding

Safeguarding was not consistent for all the patients open to the service. There was no process to support those waiting for allocation. Not all staff had completed training on how to recognise and report abuse.

Staff had not completed training on how to recognise and report abuse, appropriate for their role. They had not kept up to date with all their safeguarding training. The mandatory training record showed staff were on the whole compliant with level 2 safeguarding adults and children. Compliance was low for level 3 training for both modules at mostly less than 70%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act however, they did not always act on the concerns. Staff told us they held daily safeguarding meetings. We observed a safeguarding strategic meeting. This was also attended by external agencies. The concerns were looked at holistically. The views of the patient were taken into account and the plan made was centred on this.

Our findings

We also observed 2 zoning meetings. Safeguarding was on the agenda. Staff were able to identify safeguarding concerns. These included gender, pregnancy, and religion. One of the patients discussed under safeguarding required an interpreter. The patient had required an urgent mental state examination and risk assessment. Staff were meant to have made contact with them the previous day however this had not been actioned.

Staff were not always able to identify safeguarding in patients that were unallocated. Those that were unallocated received check in calls from mainly a Band 3 staff member every 28 days. They did not actively assess safeguarding when they made the calls. Of the 4 case notes for people that were unallocated, 3 of them showed safeguarding risks that had not been raised as a concern or added in the risk assessment. A patient with a diagnosis of psychosis had safeguarding concerns around neglect and rough sleeping in an unsafe environment. There were gaps in contact with the patient despite the risks. In another care record a patient had money taken off them and also had undiagnosed learning difficulties. The concerns raised were not followed up.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All the clinicians we spoke with were aware of how to make safeguarding referrals and were also aware of their safeguarding clinical leads.

Staff access to essential information

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up-to-date to all staff providing care.

Patient notes were not always comprehensive. However staff could access them easily. The service had one computer system that staff used to access patient records. It was easy to navigate. We looked at 23 care records. Eighteen of them had risk assessments that were either out of date going as far back as 2018 or missing, incomplete assessments as well as missing or out of date care plans. Four of the notes showed gaps where there was no contact and inconsistencies in actions from the previous plans.

Records were stored securely. This was on a password protected electronic system. The service told us that any paper records were scanned onto this system. We however found medication charts that went back as far as 2017 that were mixed in with current ones in a folder. There was no evidence of use of a filing system.

Medicines management

The teams did not use systems and processes to safely prescribe, administer, record and store medicines. Staff did not regularly review the effects of medicines on each patient's mental and physical health.

Staff did not always follow systems and processes to prescribe and administer medicines safely. At the Central West team there were 40 cards that had queries. At both the Central West and Central East team a large number of prescription cards showed that patients' depot injections were not administered on time. They were overdue ranging from 2 days to 5 weeks. On one of the prescription cards there were 11 incidents where the depot injection had not been administered on the due date. On another card out of 6 records, only 2 had been administered on time.

Whilst we were inspecting, the clinical team was contacted by a pharmacist who had identified a patient's depot was overdue. If it was not given that week it would fall outside of the 6 week window and would require retitration. Staff had not been aware of this.

Staff told us that often patients did not receive their depots on time due to staff capacity. However, when we looked at the care records there was no evidence explaining why medicine wasn't administered on the due date, or discussions with patients where they were informed of this.

Our findings

Staff did not always review each patient's medicines regularly and provide advice to patients and carers about their medicines. Three out of 7 patients told us they had not received information or did not understand the medicine they were taking. They also told us they did not receive regular medicines reviews.

Staff did not always store and manage all medicines and prescribing documents safely. There was no clear filing system for the medication cards. We found old and current cards filed together randomly. Staff told us prescription cards were regularly missing. The service did not have a medicines audit system in place.

The depot medicines Paliperidone and Zuclopenthixol were out of date at the Central West team. The emergency medication to treat allergic reactions Adrenaline was also out of date as well as water for injections. When this was pointed out during the inspection the staff member disposed of expired vials in the sharps box. NICE guidance recommends that expired or unused medicine is returned to a pharmacy. There was no audit system for the medicine in stock. There were also no pharmacist visits in place at the Central East and Central West CMHT's.

The fridge temperatures at Central West were completed on a blank piece of paper. There was no action for out of range readings. There were no precautions to prevent accidental switch off of the fridges.

Track record on safety

The service did not have a good track record on safety.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers investigated incidents thoroughly. However, they did not always share lessons learned with the whole team and the wider service.

Staff did not always know what incidents to report and how to report them. Staff did not always raise concerns and report incidents and near misses in line with trust policy. A patient was given a depot injection meant for another patient. The incident had occurred 13 days prior to our inspection date but had not been reported on the trust's incident reporting system. We also identified an error in their records where the person's name entered as having been given a depot was different to the name held in the record itself. There was no evidence to show the service had identified this or taken any action.

Staff reported serious incidents clearly and in line with trust policy. The Central West had received 2 adverse events within the last 2 weeks prior to our visit. In one of the incidents a patient had missed their appointment. When the consultant looked up their record they found the patient had died in July. The cause of death was not known.

Managers debriefed and supported staff after a serious incident. At one of the community teams a patient had jumped out of a window a day prior to our inspection, resulting in hospitalisation. Staff had received a debrief and support from their managers.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The trust's facilitated learning event had a section where they expressed the views and concerns from a family member and incorporated these into their learning as well as the changes they made for future practice.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Of the 5 staff members we spoke with about this, 3 of them reported not receiving feedback from investigations.

Our findings

The managers were not aware of a risk register.

Is the service responsive?

Requires Improvement 

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

Access and waiting times

The service was easy to access. However, staff did not always assess and treat patients who required urgent care promptly, and patients who did not require urgent care sometimes waited too long to start treatment.

The service had criteria to describe which patients they would offer services to. However, anyone could refer via their Gateway Service. To mitigate waiting lists the service placed accepted patients into manager's caseloads which they named Unallocated Hub. At the time of our inspection the Central West had 124 patients and Central East had 249 patients in the Unallocated Hub. One of the managers explained that this caseload also included people whose care co-ordinator had left or was on long-term sick leave.

The service did not always meet trust target times for seeing patients from referral to assessment and assessment to treatment. The target for referral to triage was 24 hours. One of the triage workers told us they had 58 patients to triage and there was a backlog due to demand. The service did not have targets for triage to assessment as some people would be placed in the Unallocated Hub. The trust target was to have contact with those who were unallocated every 28 days.

Staff did not always see urgent referrals quickly and non-urgent referrals within the trust target time. Staff told us that urgent referrals were meant to be responded to in five days but their current response time was two weeks due to staff shortages. They also told us they were rarely able to offer an emergency appointment on the same day and would often have to send people to the emergency department. On 2 occasions during inspection we observed administration staff struggling to find a duty worker to respond to urgent calls.

The teams had internal waiting lists for psychology input. Central East had 2 people on the list. The longest wait was 8 weeks and the shortest was 4 weeks. Central West had 7 people on their waiting list. The longest wait was 51 weeks and the shortest was 19 weeks. South Mersey did not have a psychologist in post.

The trust told us their system for managing occupational therapy, support, treatment and recovery workers varied across the teams. This was because they did not have a facility on the clinical database to manage referrals and any associated waiting list. Due to the sizes of workload as well as the complexities patients, we were not assured that people who required this type of support were receiving it in a timely manner. Of the 11 staff members we spoke to regarding caseloads and capacity to carry out their work effectively, 8 of them felt they were unable to carry out any therapeutic work, in part as they had to take on a number of different roles in order to support the service.

Staff did not always engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff told us patients that did not actively seek support were not getting as much time or attention because they were usually responding to high risk or urgent interventions.

Our findings

Patients were not always able to get through when they contacted the services. Staff told us it was quite often that no one was available to answer the phone on duty as they would be away from their desk.

Whilst on inspection we observed administration staff take calls from patients in the initial instance. When we spoke to the staff they told us they often take calls from patients when they require advice or just want to talk. At other times when clinicians were not available they would advise people to attend the emergency department.

A group of 4 staff members told us that if staff were on the phone, it would not show as engaged. The telephone line had been set up to ring 28 times which meant people would hang up and not leave messages. It had recently been changed to 10 rings before a person could leave a message. Two patients commented on the difficulty in communication, getting messages passed to the relevant person as well as getting through to the service. Communication was one of the issues highlighted in the trust's facilitated learning event following a serious incident (death). Communication also featured in the services' service user and carer concerns and complaints although this was not the most significant theme.

Staff tried to contact people who did not attend appointments and offer support. People that did not attend appointment or failed to contact the service for 2 weeks were placed in zoning.

When staff cancelled appointments they did not give patients clear explanations. Data provided by the trust showed that over the past 12 months the number of cancelled appointments were 747, 807 and 1377 for the Central East, Central West and South Mersey teams respectively. The trust explained they may have been due to staff absences at short notice or operational changes. 17% of the cancellations were for new appointments/assessments.

The service did not have a robust system to help them monitor waiting lists. The managers told us they did not have a tool that showed them how long a person had been on their caseload. We noted that a patient had been on there for 12 months however, they were able to monitor the frequency of contacts and were able to flag up to clinicians if an unallocated person had not been seen within their recommended 28 days.

Staff did not always support patients when they were transferred between services, or needed physical health care. Data provided by the trust showed that for the people on their unallocated list, the person with the longest wait for allocation, of 74 weeks had been transferred from another team. This was the same for the longest wait in the South Mersey team, of 65 weeks. Whilst unallocated they continued to be seen by the transferring team. The 3 teams did not have a physical health team in place to deliver physical health care. The Central West and Central East community teams did not have any physical health nurses.

Meeting the needs of all people who use the service

The service did not always meet the needs of all patients – including those with a protected characteristic. However the service provided help to patients with communication, advocacy, cultural and spiritual support.

The service did not always support and make adjustments for people with disabilities, communication needs or other specific needs. In one of the care records a female patient attended for their depot injection and had requested it to be administered by female staff. She was asked to return a week later as there were no female staff available.

During a home visit a patient from an ethnic minority background told us the team had never spoken to them about their culture. We also viewed three care records of people from ethnic minority backgrounds. Only one of them had evidence of a holistic care plan that covered multiple areas of support and interagency working. The other two showed high risk factors that included vulnerability and poor self-care but had no involvement from other services.

Our findings

The service had information leaflets available in languages spoken by the patients and local community. The Central East had a board in the waiting area with information leaflets in different languages. This included how to access services such as housing, consumer rights, racial discrimination, education and council services.

Managers made sure staff and patients could get hold of interpreters or signers when needed.

Our findings

Areas for improvement

Following this inspection we served the provider with three Warning Notices under Section 29A of the Health and Social Care Act (2008). The first warning notice was in relation to Regulation 12: Safe Care and Treatment. The trust was asked to ensure that people who were unallocated were monitored in a way that ensured their safety and wellbeing was monitored. The second was in relation to Regulation 18: Staffing. The service was asked to ensure staff were allocated work that was appropriate to their roles, and arrange a staffing structure that managed caseloads and risks effectively. The third was in relation to Regulation 17: Governance where we asked the trust to ensure it had adequate governance systems and processes to monitor the quality of care provided.

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

Action the trust MUST take to improve:

- The trust must ensure it has enough staff in order to deliver care safely and effectively.
- The trust must ensure effective alarm systems are in place in the patient consultation rooms.
- The trust must ensure that all emergency equipment is checked, maintained and calibrated.
- The trust must ensure that all emergency medications are checked, in date and disposed of appropriately if expired.
- The trust must ensure that staff report all incidents and that staff are clear about what incidents they must be reporting.
- The trust must ensure that staff are informed of any feedback or learning following the investigation of incidents.
- The trust must ensure that staff compliance with mandatory training is improved.

Action the trust Should take to improve:

- The trust should ensure it keeps care plans and risk assessments up to date.
- The trust should ensure it develops a telephone system that takes less rings to leave a message, and if on hold where they can be alerted of their position in the queue or how long they are likely to wait.
- The trust should ensure safeguarding is considered for those who are unallocated.
- The trust should ensure that crisis plans are completed for patients.
- The trust should ensure that patients are informed about and understand any medication that they are prescribed.
- The trust should ensure that fridge temperatures are monitored and recorded appropriately. The trust should ensure that actions are taken if any issues are identified.
- The trust should ensure that staff consider patient's culture, background and preferences within care plans. The trust should ensure that staff liaise with appropriate agencies to provide to support to patients when issues are identified.
- The trust should ensure that the cleanliness of the environment is monitored and actions are taken to address any identified issues.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a support CQC inspector and 2 Specialist Advisors.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing