Manchester Mental Health and Social Care Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community based mental health services for adults of working age	Laureate House Park House Edale House	TAE02 TAE03 TAE01
Mental health crisis services and health based places of safety	Laureate House Park House Edale House	TAE02 TAE03 TAE01
Acute wards for adults of working age and PICUs	Laureate House Park House	TAE02 TAE03
Long stay/rehabilitation mental health wards for working age adults	Park House Anson Road	TAE03 TAE17
Wards for older people with mental health problems.	Laureate House Park House	TAE02 TAE03
Community-based mental health services for older people.	Laureate House Park House Edale House	TAE02 TAE03 TAE01
Perinatal services - Specialist inpatient services for mothers and babies	Laureate House	TAE02
Substance misuse treatment services	Laureate House Park House	TAE02 TAE03

Summary of findings

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

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Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for mental health services at this provider	Requires improvement 
Are mental health services safe?	**Requires improvement** 
Are mental health services effective?	**Requires improvement** 
Are mental health services caring?	**Good** 
Are mental health services responsive?	**Requires improvement** 
Are mental health services well-led?	**Requires improvement** 

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We found that the provider was performing at a level which led to a rating of Requires Improvement.

Manchester Mental Health and Social Care NHS Trust provided mental health services and substance misuse services to adults and older people across the city of Manchester. We found that the trust was providing services that required improvements to ensure it better met the needs of the people that it served.

The trust was not always providing a safe service for people across some of the services it provided. This included the older people's wards, acute wards and PICU, community based services for older people and the crisis services for adults of working age.

Environmental risks on the SAFIRE unit had not been fully assessed or mitigated. Due to several serious untoward incidents, risks were mitigated with an overly restrictive approach with restrictions not reviewed periodically to ensure they were appropriate to individual patients. There were medicine management issues on the community older people's services and in the rehabilitation service which amounted to regulatory breaches.

The trust was a low reporter of incidents; there were delays in notifications of incidents and delays in investigating incidents through the national incident reporting and learning system. The trust had been escalated to NHS England's risk summit for a significant number of months due to several issues relating to patient safety including incident reporting, commissioner assurances and safeguarding arrangements. Whilst some recent improvements were noted in some of these areas, for example, in the safeguarding arrangements; NHS England continued to oversee the trust until sustained improvements were seen.

Risks were not always fully assessed or reviewed by staff. We have issued requirement actions in relation to the safety issues and management of risks and have asked for an action plan to receive assurances that these risks would be addressed.

The trust was not always providing an effective service for people across some of the services it provided. This included the older peoples' wards, acute wards and PICU; community based services for adults, and long stay rehabilitation wards.

Care plans were not always holistic and person centred especially on the acute wards. There was limited evidence of coherent and consistent care pathways, outcome measures and performance data in community adult teams. This meant that there was not a strong recovery focus evident in community mental health teams and patients were being retained on the caseload of teams longer than was clinically required.

Staff within certain services had not received recent clinical or management supervision and the take up of appraisals remained an issue in some services despite efforts by the trust to address this issue. We saw limited evidence of best practice, except within perinatal services

There was no or limited psychological input for patients especially within in-patient areas. There was inconsistent medical cover at Anson Road which was impacting on patient care. Roles and responsibilities between the acute and mental health trust staff were not clearly defined to ensure effective care when patients received care jointly, such as within the health based place of safety and psychiatric liaison services.

We found systemic issues with the Mental Health Act (MHA) documentation. MHA documentation was not always completed correctly for patients on some wards to assure us that people were being supported to understand their rights. Patients' medication for treatment for mental disorder was not always properly authorized. Appropriate checks were not always taking place to ensure that patients' detention was legally supported by the appropriate documentation, for example medical scrutiny checks were not routinely taking place. Action was not always taken to ensure that renewals of detention occurred within appropriate

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timescales. The operation of the Act was particularly poor on the older people's service. We saw that appropriate action had not been taken or embedded following our previous Mental Health Act monitoring visits across the trust as we found the same issues being repeated or not resolved.

Where patients were subject to a deprivation of liberty safeguards (DoLS) authorisations pending agreement from the local authority were not kept under review or updated as needed and decisions about time limitations were not communicated. We weren't routinely being notified of deprivation of liberty safeguards (DoLS) applications once an outcome was known.

We saw that overall the trust was providing a caring service for people across all core locations. Throughout the inspection we saw examples of staff treating people with kindness, dignity and compassion. The feedback received from people who used services and their visitors was generally positive about their experiences of the care and treatment provided by the trust.

The trust was not always responsive to people's needs across some of the services it provided, in particular the community based services for adults and the long stay rehabilitation services. There were a number of blocks within the system so that people were not always receiving the right care at the right time, for example crisis teams could not pass people through to community mental health teams (CMHTs), there were delays in receiving CMHT support and there were significant delayed discharge arrangements. There were a number of waits in the psychiatric liaison service and assessing people brought in on a section 136 at the health based place of safety emergency department. Some of these involved waits of beyond 12 hours as they related to patients under 18 or with a learning disability. Whilst some of the waits were beyond the full control of the trust, staff had failed to follow agreed escalation procedures to limit the delays in at least one case. The links between the acute and community adult teams needed strengthening to ensure improved communication and better patient flows. Patient activities were cancelled on the acute wards. There was good management of patient complaints.

Overall the trust was not as well led as it could be. Lines of communication from the board and senior managers to frontline services were not always effective. Staff morale was low. Staff felt well supported by local managers but did not feel that the trust senior managers were proactively addressing the current and future challenges of the trust. We saw some recent examples where board members spent time within services to understand the challenges faced and were aiming to engage with front line staff including through initiatives such as commissioning an external review into culture and initiatives such as 'listening into action'. However these initiatives had limited reach into front line services.

The trust had a research and academic function with research and teaching clinicians also involved in the operational delivery of clinical services. However we did not see evidence of the research and academic function being fully utilised or fully embedded into the work and practices across the trust to proactively improve services and work towards best practice.

The future of the trust was uncertain at the time of the inspection. A process was underway to determine the longer term position of the trust with support from the trust development authority (TDA). This was continuing to cause difficulties for the front line staff. The trust had utilised a number of engagement methods to try and manage this uncertainty. However a number of staff across services told us that they did not feel that these methods provided meaningful engagement to assure them that this uncertainty was being managed well.

Representatives from the local clinical commissioning groups told us that the trust did not engage positively with them and did not involve the local communities or other organisations in how services were planned or designed. The trust also told us that the relationship between them and the commissioning groups was, at times, a difficult one. Despite the efforts of the trust development authority to improve the professional relations between the trust and the local clinical commissioning groups, there continued to be engagement issues between these organisations. We were concerned that this might adversely affect the provision of high quality patient care but recognised that both parties worked to ensure there was no detriment to quality care.

The trust was in the process of an option appraisal for its future direction and strategic intention following its removal from the foundation trust process and future commissioning decisions. The chair of the trust board

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acknowledged that there were gaps within the non-executive director experience, including managing complex healthcare organisations and mental health experience capability. On occasions, the board had received reassurances from the executive team rather than seeking full assurances themselves when significant decisions were made, for example when changes to older people's services were made. Staff understood the vision and values but did not always understand how that related to them at a more local level or in terms of the future challenges the trust faced.

The trust needs to take steps to improve the quality of their services and we found that they were currently in breach of regulations. We have issued requirement notices in relation to several areas and have asked for an action plan to receive assurances that these risks would be addressed. We will be working with the trust to agree an action plan to assist them in improving the standards of care and treatment.

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The trust has been escalated to regular risk summits with NHS England for a significant number of months due to several issues relating to patient safety including incident reporting, commissioner assurances and safeguarding arrangements. Whilst some recent improvements were noted in some of these areas, for example, in the safeguarding arrangements; NHS England continued to oversee the trust until sustained improvements were seen.
- There were medicine management issues on the community older people's services and in the rehabilitation service at Anson Road which amounted to regulatory breaches.
- The fridge used to store food on the older people's wards at Park House was not maintained so food was stored in equipment with temperatures above the maximum safe storage.
- Environmental risks on Safire unit had not been fully assessed or mitigated.
- Staff reported incidents internally in a timely manner initially. However the processing of incident reports internally including signing off incidents caused delays in reporting incidents externally and investigating incidents.
- The trust was a low reporter of incidents; there were delays in notifications of incidents externally and delays in investigating incidents through the national reporting and learning system.
- Due to several serious untoward incidents, there was an overly restrictive approach to managing risks with restrictions not reviewed periodically to ensure they were appropriate to current patients' individualised needs.
- We saw an operational breach of the same sex guidance rules on the older people's ward at Laureate House. We received assurances that the trust would attend to this.
- Security measures in the Brian Hore Unit did not fully afford safety to staff and visitors.
- There was no working operational protocol for people staying overnight on the perinatal unit which meant it was not clear that appropriate risks had been considered.

However there were sufficient staff on duty to keep people safe. Patient risk assessments were in place. Risk management plans were updated regularly in most core services with the exception of

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older people's community mental health services and substance misuse services. Following regular audits and effort to improve safeguarding action, the trust had recently improved its safeguarding arrangements.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- There was not a strong recovery focus evident in community mental health teams and patients were being retained on the caseload of teams longer than was clinically required.
- There was limited evidence of coherent and consistent care pathways, outcome measures and performance data in community teams.
- Staff within certain services had not received recent clinical or management supervision and many staff had not had a recent appraisal despite efforts by the trust to address this issue.
- There was inconsistent medical cover at Anson Road which was impacting on patient care.
- Roles and responsibilities between the acute and mental health trust staff were not clearly defined to ensure effective care when patients received care jointly.
- Care plans were not always holistic and person centred in some services.
- We continued to find systemic issues with the operation of the Mental Health Act (MHA). Documentation was not completed correctly in line with the requirements of the MHA and MHA Code of Practice. We found issues across in-patient services in the MHA records relating to detained patients' rights, medication authorisations, leave, appropriate checks to ensure lawful detention and timely renewals of detention. The operation of the Act was particularly poor on the wards for older people.
- Where patients were subject to a deprivation of liberty safeguards (DoLS), the authorisations pending agreement from the local authority were not kept under review or updated as needed and decisions about time limitations were not properly communicated.

However, peoples' needs were generally assessed and care planned using appropriate tools. The perinatal, memory service and ECT service were accredited.

Are services caring?

Good

We rated caring as good because:

- Overall the trust was providing a caring service for people across all core locations.

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- Throughout the inspection we saw examples of staff treating people with kindness, dignity and compassion.
- The feedback received from people who used services and their visitors was generally positive about their experiences of the care and treatment provided by staff within the trust.
- Where people could not speak with us, for example in older people's services, we saw positive and warm interactions.
- Most people stated that they felt that they were involved in their care.
- Most staff were knowledgeable about people's needs.
- People had access to advocacy when they were in-patients, including specialist advocacy for people detained under the MHA to facilitate effective participation.
- Staff were also aware of the emotional aspects of caring for people and made sure that specialist support was provided for people where needed.
- The trust board heard a patient story at every board meeting to remind the officers of the primary purpose of the trust to ensure people get good quality care that meets their needs and aids their recovery from mental ill health.

However patients' full participation was not always evidenced in care planning documents to reflect their involvement. It was therefore not always clear that patients had been fully involved in drawing up their written plans of care in meaningful ways and as active partners, for example patients identifying their own recovery goals. The local service user group felt that their concerns were not always listened to and the trust did not respond appropriately to the issues they raised.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- There were a number of blocks within the system so that people were not always receiving the right care at the right time, for example crisis teams could not pass people through to community mental health teams (CMHTs), there were delays in receiving CMHT support and there were significant delayed discharge arrangements.
- Two detained patients in long stay rehabilitation could not be discharged in a timely manner due to the lack of a responsible clinician at Anson ward.
- There were a number of incidents of waits in assessing people presenting with mental health problems within the emergency department some of which involved waits of beyond 12 hours. Despite efforts to reduce these incidents, they continued to occur.

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- Patients receiving longer term rehabilitation services on Acacia ward were cared for within 4 bedded bays which compromised privacy and dignity and did not aid recovery. The dignity of patients on the acute wards was not always being maintained.
- The links between the acute and community adult teams needed strengthening to ensure improved communication and better patient flows.
- Patient activities were cancelled on the acute wards.

However staff had access to interpreting services for patient whose first language was not English. Services we visited had disability access and disabled facilities such as toilets and bathrooms. Where there was no wheelchair access in community based services, alternative appointments were made either at the person's home or a venue close to where they lived. Information about raising concerns and complaints was available to all patients in the wards, and community mental health services. There were good systems for managing complaints.

Are services well-led?

Are services well-led?

Requires improvement 

We rated well led as requires improvement because:

- The trust had stated vision and values. The vision did not fully articulate or reflect this current situation and future uncertainty of the trust.
- The trust board was not proactive in formally considering the options appraisal processes to address the uncertainty of the trust's future position.
- The trust had withdrawn from foundation trust status due to financial viability issues requiring intervention by the NHS trust development authority.
- The commissioners of the trust had concerns about its performance and whilst staff were working to address these concerns, continued issues arose, for example continued 12 hour breaches for people in mental health crisis waiting in the emergency department, without staff following the agreed escalation process on at least one occasion.
- There were acknowledged gaps within the non-executive director experience, including managing complex healthcare organisations and mental health experience capability.
- On occasions, the board had received reassurances from the executive team rather than seeking full assurances themselves when significant decisions were made.

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- Staff morale was poor. The trust had commissioned an external review but the action to address the morale was limited in scope.
- The audits that the trust carried out picked up issues which we identified but often the action plan was not properly implemented to support systemic change and improved practice.
- There was limited best practice identified.
- The trust had a significant research and development function but this was not fully utilised within operational services.

However staff in many core services were supported by good local managers.

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Our inspection team

Our inspection team was led by:

Chair: Steve Shrubb, Chief Executive Officer, West London Mental Health NHS Trust

Team Leader: Brian Burke, Care Quality Commission

Head of Inspection: Nicholas Smith, Care Quality Commission

The team included 12 CQC inspectors and a variety of specialists including:

- Consultant psychiatrists in adult and older age psychiatry
- Director of nursing
- Experts by experience both users of services and family carers
- Governance leads
- Mental health nurse, perinatal nurse, substance misuse nurse
- Nurse managers
- Community psychiatric nurses
- Rehabilitation and recovery manager
- Mental health social workers
- Mental Health Act reviewers
- Occupational therapists
- Pharmacist inspector
- Clinical psychologists
- Psychologists and
- Student nurses

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of the experiences of people who use services, we always ask the following five questions of every service and provider:

•Is it safe?

•Is it effective?

•Is it caring?

•Is it responsive to people's needs?

•Is it well-led?

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We also arranged a service user focus groups prior to the inspection, facilitated by Turning Point, which is a voluntary organisation. We also held some staff and detained patient focus groups before the inspection. We carried out announced visits to all core services on 24, 25 and 26 March 2015. We carried out an unannounced visit to Laureate House on 9 April 2015 to return to Cavendish ward, which was one of the wards for older people with mental health problems.

During the visit, we:

- spoke with 100 people who use services who shared their views and experiences of the services we visited.
- observed how patients were being cared for.
- attended a range of clinical meetings including multi-disciplinary meetings on the wards, home visits in the community and handover meetings.
- met with representatives of the trust's user involvement forum and representatives of Manchester User Network.
- spoke with 237 members of staff. We also held focus groups with members of staff who worked within the service, including nurses, doctors, psychologists, allied health professionals, and administrative staff.

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- met with representatives from other organisations including commissioners of health services and local authority personnel.
- reviewed care or treatment records of 186 patients who use services.
- looked at a range of documents including clinical and management records, policies and procedures.
- met with members of the senior executive team and board.
- interviewed the senior management team within the trust.
- observed a trust board meeting.
- completed three scheduled Mental Health Act monitoring visits during the inspection.

Information about the provider

Manchester Mental Health and Social Care Trust provides mental health, public health, wellbeing, and social care services to the people of Manchester. The trust is located within Greater Manchester. The trust works within the boundaries of Manchester City Council and most services are commissioned by Central Manchester, North Manchester and South Manchester clinical commissioning groups. Manchester has a population of 503,000 people.

Manchester Mental Health and Social Care Trust was formed in 2002. The trust is contracted to provide services to people aged 18 and over. The trust does not provide any learning disability or children's mental health services. The organisation has an income of £104.6 million, and employs more than 1500 staff.

The trust provides the following core services:

Community-based mental health and crisis response services:

- Community based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Community based mental health services for older people

Mental health wards:

- Acute wards for adults of working age and PICUs
- Rehabilitation wards for working age adults
- Wards for older people with mental health problems

We also inspected the following services that the trust provides:

- Substance Misuse services
- Perinatal services

Manchester Mental Health and Social Care Trust have a total of five registered locations serving people with mental health needs, including three hospitals sites: Park House, Laureate House and Anson Road. It also provides community mental health services which are provided from the following registered locations: Park House, Laureate House and Edale House. The trust also provides health services for Her Majesty's Prison Manchester and specialist regional services for perinatal care. In addition the trust also provides improving access to psychological therapies (IAPT) services.

Manchester Mental Health and Social Care Trust have been inspected ten times since registration. These inspections have been across all five locations which are registered for mental health conditions. In 2011 we issued compliance actions against two of the locations to ensure that concerns we had relating to the patients' consent to care and treatment were addressed. Follow up visits identified that the trust had taken steps to address these concerns.

At the time of the inspection Laureate House was non-compliant following an inspection in December 2013. We found that the location did not meet the required standard in regard to the care and welfare of people who use services. Care and treatment was not always delivered in a way that was intended to ensure people's safety principally due to the lack of observations following the use of rapid tranquilisation. We determined that this had a moderate impact on people who use the service and asked that the trust took action to address this. At this inspection, we found that the trust had improved in this area with improved recording of incidents relating to rapid tranquilisation.

We have also carried out regular Mental Health Act monitoring visits across locations with all of the wards having had a MHA monitoring visit within the last 18

months of this inspection. Where we found issues relating to the MHA on these monitoring visits, the trust has provided an action statement telling us how they would improve adherence to the MHA and MHA Code of Practice. However we would often see the same issues reoccurring or elsewhere when we returned for a further MHA visit.

In June 2013, the trust board decided to withdraw from the foundation trust pipeline. The reason for this was the financial viability of the trust as a smaller mental health NHS trust without a significant portfolio of services and funding streams. The health commissioners were also at this time preparing a long-term commissioning strategy for a new system of health care across the city of Manchester.

What people who use the provider's services say

We spoke with 100 patients during the inspection. Nearly all of the patients we spoke with were happy with the quality of the care and treatment they were receiving.

They were happy with the approach of the staff and they felt involved in the decisions about their care. We include their comments in the core service reports.

Community Mental Health Patient Experience survey

The Care Quality Commission Community Mental Health survey is sent annually to people who received community mental health services from the trust. This survey is conducted to find out about the experiences of people who receive care and treatment. Those who were eligible for the survey were people receiving specialist care or treatment for a mental health condition, aged 18 or over who received community mental health services from the trust.

At the start of 2014, a questionnaire was sent to 850 people who received community mental health services. Responses were received from 227 people at Manchester Mental Health and Social Care Trust.

Similar surveys of community mental health services were carried out in 2010 to 2013. However, the 2014 survey was substantially redeveloped and updated in order to reflect changes in policy, best practice and patterns of service. This means that the results from the 2014 survey are not comparable with the results from the 2010-2013 surveys.

The trust scored about the same as other trusts in most questions. The trust scored better than most trusts in four of the questions. This included a score of 8.5 which meant it was one of the 'best performing trusts' for the question 'Were you involved as much as you wanted to be in discussing how your care is working?'.

Community Focus Groups

Before the inspection, we held a focus group in Manchester. The focus group was hosted by Turning Point, which is a mental health charity. We did this so that people who use, or have used, the services provided by the trust, could share their experiences of care. It was a small group, with nine attendees.

The group provided responses to the five questions we always ask about services. Participants on the whole were mostly negative about their experiences.

The majority of the group felt that care plans were not up-to-date and their involvement was 'tokenistic.' The majority of the group commented that side-effects of medication were not always shared or fully explained to patients. There was a view held by the majority that service users were not fully informed about care reviews and therefore could not invite other people such as relatives or advocates. A majority of individuals said that there was a lack of beds and a need to place service users at a considerable distance to their friends and family.

People felt that the views of service users were not taken into account and their views were not used in making policy and service decisions. They felt that they were consulted after decisions had been made. Half of the group stated that they felt that service users were being inappropriately stepped down from secondary mental health services back to primary care based on financial

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constraints rather than clinical decisions. There was a general feeling that the trust was not well-led, did not listen to service users and was making decisions based on finances rather than patient need.

Patient Opinion

Patient Opinion offers people who use services a forum for honest and meaningful conversations between patients and providers as people can post their experiences on the website. There were not a significant number of posts on Patient Opinion relating to recent experiences of people using the services of Manchester Mental Health and Social Care NHS Trust. Overall the comments were largely positive with people scoring the trust three out of five stars for 'listening' and 'respect' posted by four people.

Comment cards

Before and during the inspection, we left comment cards in all in patient wards and areas where patients might spend time. This was so that they could write their comments down about their experiences of care within the trust services. People posted their comments in sealed boxes which we opened and looked at as part of the inspection. We received 238 comment cards in relation to 33 locations.

o 66% were positive

o 23% were negative

o 11% were mixed

Top ranking wards with the most comment cards were:

- The Brian Hore Unit, which is a substance misuse service, where we received 22 comment cards all of which were positive.
- Studio 1 where we received 32 comment card; all of which were positive. Studio 1 is a visual art service based in Wythenshawe, Manchester which works with people to improve mental wellbeing through creative art practice.

We received 21 comment cards from Acacia ward, which is a rehabilitation ward, all of which were negative. Nine of the ten comment cards we received from Redwood ward, which is an adult acute ward, were also negative. When we spoke with patients on both these wards, we did not receive particularly negative comments from patients we spoke with.

Good practice

- The perinatal ward had a self-contained flat that could be utilised to support a graded discharge if appropriate.
- The perinatal ward maintained contact with patients seven days post discharge to ensure continuity of care into the community.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

Community-based mental health services for adults of working age

- The trust must ensure that there are effective recovery focussed care plans and discharge planning in place for each patient to make sure patients do not remain in services longer than is clinically appropriate.
- The trust must ensure that care and treatment is delivered in line with CPA best practice guidance. This includes medical representation at patients' CPA reviews.
- The trust must ensure that incidents are investigated in line with trust policy and there are robust systems in place to make sure learning or good practice is shared within and across the service.
- The trust must ensure that all staff receive mandatory training and appraisals in line with trust policy.

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- The trust must ensure there are systems in place to effectively monitor, improve and evaluate the quality of service provision across the service.
- The trust must ensure that patients are discharged from hospital in line with the CPA guidance and with their community care coordinator and consultant's knowledge and involvement.

Mental health crisis services and health-based places of safety

- The trust must ensure that environmental risk assessments for ligature points of SAFIRE unit are updated to include the grab rails in the bathroom and the use of plastic bags in the patients' bins.
- The trust must ensure that it provides care in line with the same sex accommodation guidance.

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

- The trust must ensure that where environmental risks have been identified, action is taken to ensure the safety and well-being of patients.
- The trust must ensure privacy and dignity is promoted.
- The trust must ensure that there is an effective system in place to monitor and analyse incidents.
- The trust must ensure there is sufficient staff with appropriate skills and competence to meet the needs of patients at all times.
- The trust must ensure patients have access to activities to meet their needs effectively
- The trust must ensure that care plans are holistic, personalised and patient focused.
- The trust must ensure staff are suitably qualified, competent and skilled.
- The trust must ensure that patents' have access to psychological intervention and therapies in accordance with published research and guidance.
- The trust must ensure they work effectively with other professionals.
- The trust must have an effective governance system to ensure improvements are made.

Long stay/rehabilitation mental health wards for working age adults

- The trust must ensure that medication records and the agreed medication limits of patients detained under the MHA are correct at Anson ward. Also, that patients are informed about the purpose or side effects of their medications.
- The trust must ensure all qualified nursing staff have appropriate clinical supervision.
- The trust must provide a plan of how bed bays can be replaced with single rooms. The plan should include the interim measures that will be put in place to ensure the privacy and dignity of the patients using shared accommodation is improved.

Community based mental health services for older people

- The trust must ensure that appropriate arrangements are in place for the storage and recording of medication in community older peoples' services.

Wards for older people with mental health problems

- The trust must ensure that Cedar and Maple wards have the kitchen fridges safety tested and door seals replaced to ensure the fridges are operating at safe temperatures, operating temperatures monitored, recorded and kept in a clean state.
- The trust must ensure that Mental Health Act documentation is completed correctly for patients on Cedar, Cavendish and Maple wards to ensure people are being supported to understand their rights, their medication is authorized, their leave is approved and their detention is legally supported by the appropriate documentation being in place.

Action the provider SHOULD take to improve

Community-based mental health services for adults of working age

- The trust should ensure that the recording of information to support risk management is consistently recorded in patients' care records.

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- The trust should ensure consistent use of caseload weighting tools in the allocation of caseloads. There was limited evidence that acuity and numbers within each area had been considered. This impacted on the equity of caseload distribution.
- The trust should ensure that access to psychological therapies is equitable across all services.

Mental health crisis services and health-based places of safety

- The trust should ensure that information is provided at the ward door of SAFIRE ward as to how patients who are informal can leave the ward.
- The trust should ensure that blanket restrictions placed on the use of the outside space for patients on SAFIRE unit are reviewed based upon an individual risk assessment.
- The trust should ensure that staff are provided with equipment which will enable them to summon assistance if required.
- The trust should ensure that all staff complete the mandatory training.
- The trust should ensure that copies of paperwork for detained patients are made before the original paper work leaves the ward. The trust should ensure that a copy of the AMHP report is available in the patients file.
- The trust should ensure that roles and responsibilities regarding patient care are clear between the acute and mental health trust.
- The trust should develop an audit system that monitors patients who receive treatment from the home treatment teams for longer than six weeks to ensure patients are receiving the most appropriate service and are not being disabled by service provision when it is not needed.
- The trust should ensure that the daily handover of information is done without interruption.

Long stay/rehabilitation mental health wards for working age adults

- The trust should make sure that patients at Anson ward have a consistent approach to their medical treatment.
- The trust should make sure that patients are involved with the development of their care plans on Anson ward.
- The trust should ensure that staff at Anson ward are able to find all the patient information.
- The trust should ensure that patients have access to psychological therapies, to help them recover from their mental health problems and regain the skills and confidence to enable them to live successfully in the community.
- The trust should ensure that a local rehabilitation care pathway for patients with complex mental health needs is agreed and implemented at Anson ward.
- The trust should ensure that patients who are risk assessed and safe to do so have access to the internet on the wards.
- The trust should ensure that staff have access to MHA and MCA training.

Community based mental health services for older people

- The trust should ensure there are clear processes in place to ensure that risk is monitored and reviewed regularly.
- The trust should ensure there are clear processes in place to ensure that care needs are monitored and reviewed regularly.
- The trust should work with its partner agencies to ensure information stored is not duplicated or at risk of being missed.
- The trust should take steps to address the amount of staff time lost due to computer systems and time spent travelling.
- The trust should ensure staff are consistent in using the system provided to maintain their personal safety.

Wards for older people with mental health problems

- The trust should ensure fridges used for storing medicines are maintained and cleaned regularly.
- The trust should ensure food left in fridges is correctly labelled to show a date opened and a use by date.

Summary of findings

- The trust should ensure prescribed medicines of the same type but with different batch numbers and expiry date are not stored in one box, when a new supply had been received from the pharmacy.
- The trust should ensure staff working on wards for older people can clearly articulate through patient centred care planning how they are supporting patients to keep safe in terms of the ligature risks on the ward.
- The trust should ensure patients in the services have regular access to and input from clinical psychologists as part of their assessment, treatment and recovery as recommended by the national institute for health and care excellence (NICE).
- The trust should ensure that where patients are subject to a deprivation of liberty safeguards that the authorisations pending agreement from the local authority are kept under review, updated as needed and decisions about time limitations are communicated to the relevant managers.
- The trust should follow guidance on dementia friendly environments. Research from Bradford and Stirling universities could be more widely used to promote dementia friendly environments.

Substance misuse services

- The trust should increase the security and accountability for all people entering the Brian Hore unit.
- The trust should ensure staffing levels are adequate to accommodate unexpected sickness or ensure contingency plans are developed so prevent lone working.
- The trust should ensure all groups of people using the service have up to date recorded risk assessments and management plans.
- The trust should ensure individual prescription numbers are recorded in a central location to enable an effective audit trail.
- The trust should ensure all groups of people using the service have individual, up to date and recovery focused care plans.

Perinatal services

- The trust should ensure that there is a comprehensive visiting policy in place with thorough risk assessments where special considerations are required. In particular relating to fathers remaining on the ward through the night.
- The trust should ensure that fridge temperatures on the ward are checked daily and temperatures recorded.
- The trust should ensure there is a robust system for monitoring the availability of mobile alarms for staff use.
- The trust should ensure there is provision to review the reduction of levels of observations every day including the weekend period.
- The ward should ensure that care plans are individualised to meet the needs of patients.
- Patients should always be offered a copy of their care plan and this should be clearly recorded.
- Mandatory training should be undertaken to the standard set by the trust.
- Clinical and managerial supervision should be undertaken, structured and recorded in accordance with the trust policy.
- The ward should consider how the administration of medication is improved, monitored and audited for accuracy.
- The ward should consider an appropriate space for clinical examinations of mothers and their babies other than the mother's bedrooms by providing an examination couch in the clinical room.

Manchester Mental Health and Social Care Trust

Detailed findings

Mental Health Act responsibilities

We found that where the Mental Health Act (MHA) was used that people were detained with a full set of corresponding legal paperwork which was kept in the MHA department. However, we found in several cases that copies of the documents weren't kept on the wards. This meant that ward staff could not always assure themselves that patients were lawfully detained. A copy of the outline report prepared by the approved mental health act professional (AMHP) was not always present in the records as recommended by the MHA Code of Practice (CoP). There was currently no consistent process in place for medical scrutiny of all detention documents to ensure that the medical reasons for detention were properly evidenced and checked.

We also found blanket policies in place with regard to patients opening mail in front of staff. No patients were permitted to refuse and no individual risk assessments had taken place around this issue.

Across the wards there was variable evidence that people had their rights explained to them on admission to hospital. In some cases it was documented that patients had been given their rights but there was no record of the level of patient understanding. There was an independent mental health advocacy service (IMHA) service available and most qualifying patients spoken with were aware of this. The IMHA service was well advertised on the wards.

We had concerns about adherence to section 58 rules around consent to treatment for treatment for mental disorder to detained patients across the core services.

We highlighted the following concerns:

- some medications were being administered which were not authorised by a T2 or T3 certificate. This meant that some patients received medication which not lawfully authorised according to the rules of the MHA.
- There was no evidence that the responsible clinician (RC) had discussed the reasons for treatment or the effects and side effects of medication on many files despite the development of a trust form specifically for recording discussions with patients.
- Legal certificates were not always held with prescription cards and/or not present on the ward at all. Therefore it was not clear that staff administering medication were checking that they had the legal authority to give medication to detained patients.

While we saw that the conditions of the patient's leave had been clearly specified and signed by the patient's responsible clinician, there was no record that the patient had been given a copy of the leave form in line with the CoP. This meant that patients were not fully supported to understand the conditions of their leave to promote adherence to these conditions. Detained patients on Anson Road were without a designated responsible clinician for a short period which delayed leave and discharge decisions.

Detailed findings

It was not clear that the governance of the trust and board oversight of the operation of the MHA were fully effective as we continued to find systemic issues with Mental Health Act adherence. For example, the operation of the Act was particularly poor on the older people's service.

At recent MHA monitoring visits we carried out before the inspection, we continued to raise significant issues with adherence to the MHA. On this inspection, we continued to find poor adherence to the MHA and the promised changes from the trust not being fully actioned or embedded. This was despite the fact that the trust had appropriate flagging systems in place to remind staff of their duties.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had Deprivation of Liberty Safeguards (DoLS) policy and an associated procedure for staff to follow. The policy took into account the most recent supreme court judgements following the Cheshire West case.

We saw some good examples of facilitation of capacity assessments that ensured patients were supported to make specific decisions. Staff we spoke with understood that capacity fluctuated and were clear about their responsibilities in undertaking capacity assessments and continuous monitoring of patients' consent. This meant decisions were made which ensured people were able to understand and agree or that they were made in the best interest of the person.

Most staff understood the issues relating to mental capacity, consent and DoLS, with the exception of staff on the older people's wards who weren't fully clear about the rules regarding DoLS. Mental Capacity Act and DoLS training were mandatory with a trust target of 90%. However compliance was varied. Most notably within services where mental capacity and consent issues were likely to come to the fore, we found that uptake on staff training on the Mental Capacity Act

(MCA) as 44% on the older people's inpatient wards and 42% for staff in older people's community services.

The trust had only submitted one Deprivation of Liberty Safeguards notification to us. However the trust reported that they had submitted ten Deprivation of Liberty Safeguarding applications to the supervisory body (the local authority). The trust did not have a proper process to ensure that we were notified but agreed to ensure that appropriate notifications were made in future.

There were several issues around the use of deprivation of liberty safeguards (DOLS) authorisations on the older people's service.

- Urgent DOLS were requested without a standard authorisation meaning that the urgent DOLS could not be extended.
- The supervisory body had made the decision that urgent DOLS authorisations were not time limited. This information had not been passed to clinical staff.
- It was unclear how the outcome of DOLS authorisation requests were communicated to staff.

Within crisis services, a patient who was seen by the liaison team had been placed on restrictions on the general hospital wards. Staff were not sure of whose responsibility it was to provide a mental capacity assessment and apply for a deprivation of liberty safeguard, or whether the restrictions put in place were necessary.

Requires improvement

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Detailed findings

Summary of findings

We rated safe as requires improvement because:

- The trust has been escalated to regular risk summits with NHS England for a significant number of months due to several issues relating to patient safety including incident reporting, commissioner assurances and safeguarding arrangements. Whilst some recent improvements were noted in some of these areas, for example, in the safeguarding arrangements; NHS England continued to oversee the trust until sustained improvements were seen.
- There were medicine management issues on the community older people's services and in the rehabilitation service at Anson Road which amounted to regulatory breaches.
- The fridge used to store food on the older people's wards at Park House was not maintained so food was stored in equipment with temperatures above the maximum safe storage.
- Environmental risks on Safire unit had not been fully assessed or mitigated.
- Staff reported incidents internally in a timely manner initially. However the processing of incident reports internally including signing off incidents caused delays in reporting incidents externally and investigating incidents.
- The trust was a low reporter of incidents; there were delays in notifications of incidents externally and delays in investigating incidents through the national reporting and learning system.
- Due to several serious untoward incidents, there was an overly restrictive approach to managing risks with restrictions not reviewed periodically to ensure they were appropriate to current patients' individualised needs.
- We saw an operational breach of the same sex guidance rules on the older people's ward at Laureate House. We received assurances that the trust would attend to this.
- Security measures in the Brian Hore Unit did not fully afford safety to staff and visitors.
- There was no working operational protocol for people staying overnight on the perinatal unit which meant it was not clear that appropriate risks had been considered.

However there were sufficient staff on duty to keep people safe. Patient risk assessments were in place. Risk management plans were updated regularly in most core services with the exception of older people's community mental health services and substance misuse services. Following regular audits and effort to improve safeguarding action, the trust had recently improved its safeguarding arrangements.

Our findings

Track record on safety

The Strategic Executive Information System (STEIS) records serious incidents and never events. A never event is classified as such because they are so serious that they should never happen. Trusts have been required to report any never events through STEIS since April 2011. Between the 1 January 2014 and the 31 December 2014, the trust reported no never events in this time.

Serious incidents are those that require an investigation. A total of 64 incidents were reported by the trust between 1 January 2014 and the 31 December 2014. Of those incidents 45 related to the death of a patient; 25 of the deaths related to the unexpected death of community patients who were in receipt of care and treatment at the time of their death. The highest number of serious incidents (21) occurred within the patient's home.

The most common location by clinical area where serious incidents occurred was the emergency department of the acute trusts where Manchester Mental Health and Social Care NHS Trust provide liaison psychiatry services. These incidents involved significant waits within the accident and emergency department (AED) for mental health or Mental Health Act assessments, including people waiting over 12 hours within the AED. There was one incident of one person waiting 5 days in police custody for a mental health bed. The commissioners led a stakeholders meeting to prevent and reduce these incidents in Autumn 2014. Despite clear escalation and reporting mechanisms for such incidents, there continued to be a small number of long waits in AED.

Of the incidents reported, 64 were categorised as Grade 1 with a 45 day investigation deadline. Only 5% of the serious incidents between 1 January and 31 December 2014 were

investigated and closed on STEIS. 82% of the serious incident investigations were overdue on 20 January 2015. A further 17 incidents were closed in February 2014, leaving 74% of serious incidents still on-going.

Between 1 January 2014 and 31 December 2014, 1,951 incidents were reported to the National Reporting and Learning System (NRLS). The reporting rate to NRLS was 17.4 incidents per 1000 bed days. The median reporting rate for this timeframe was 26.7 incidents per 1,000 bed days and compared to 56 similar trusts, the trust was in the lowest 25% of reporters. Trusts with lower reporting rates to similar trusts are known to be at elevated risk.

Of the reported incidents, the most common speciality was 'adult mental health' 1,215 (62.3%) followed by 'older adult mental health' 346 (17.7%) and 'mental health rehabilitation' 343 (17.6%).The incident category that was most frequently reported was self-harming behaviour with 433 incidents (22.2%) followed by access, admission, transfer, discharge (including missing patient) with 385 incidents (19.7%). Ten of these incidents were categorised as 'death' accounting for 0.05% of incidents. There were 258 incidents of aggression reported which includes patient to patient aggression. The trust had categorised 95% of incidents as no or low harm with only 11 incidents being categorised as moderate harm. Nationally, 69 % of incidents are reported as no harm, and just less than 1% as severe harm or death.

From the information uploaded to NRLS between 1 January 2014 and 31 December 2014, the Trust took an average 84 days to report incidents to NRLS. When we inspected the core services, in most services we saw that staff were usually aware of and reporting incidents within reasonable timescales within the trust's incident management system known as DATIX. We met with the head of patient safety and case tracked some incidents. We saw that there was frequently a delay in quality checking, signing off and uploading incident reports from DATIX to the NRLS system. We judged that the resource within the trust to manage the function of incident management was insufficient to meet the demands placed on the service. This meant there was frequently a delay in incidents being signed off and reported and delays in the safety data we receive as a regulator in terms of patient safety incidents.

Every six months, the courts and tribunals judiciary publish a summary of recommendations which had been made by the local coroners with the intention of learning lessons from the cause of death and preventing future deaths.

There were no concerns regarding the trust in the most recent report (April 2013 and September 2013). The trust told us about four subsequent coroners' rulings (regulation 28 rulings) which had come out of inquests which occurred about the trust relating to incidents from 2012 to 2013. The issues and themes from these rulings included:

- issues relating to the trust's serious incidents investigation
- communication including clerking in and handover processes
- communication protocols between NHS and the private sector in respect of transfers of adolescents
- bed availability problems
- supervision and prescribing of medication by junior doctors
- performing and recording of observations
- staff training
- physical harm arising from illicit substances
- transitional protocol from children and adolescent mental health services (CAMHS) to adult mental health services and
- access to clinical psychology in crisis teams

Learning from incidents

Incidents were reported through datix which was the electronic risk management system used by the trust. The trust aimed to ensure that learning from serious incidents was part of effective risk management processes and had a range of mechanisms to integrate this learning. There was evidence that opportunities for embedding learning from incidents, for example the trust ran effectiveness days to consider improvements and themes from incidents.

The trust board reviewed incident management and action through the trust escalation framework principally through the reportable incidents log. A summary of completed serious incidents by theme and learning with the relevant recommendations went to the monthly integrated risk and clinical governance committee. All completed serious incident requiring investigation SIRIs went to the local quality governance groups for further discussion and dissemination. Full reports and action plans were available

centrally and accessed via the trust's intranet. Panel chairs were advised to give direct feedback to teams and individuals following publication of their report and any lessons learnt.

However, whilst there was evidence of changes to practice there was also evidence to suggest that repeated themes in serious incidents remained and practice development issues continued.

There were also a number of delays in incident reports being signed off and escalated and a number of delays in SIRI investigations being closed. This meant that there may be risks that there was a delay in learning lessons from key events to prevent similar incidents reoccurring.

The non-executive trust board members challenged the effectiveness of the learning from incidents at trust board meetings where they felt actions plans were meaningful in the context of learning and asked where staff received the learning points.

There was variable evidence of staff learning lessons within the core services we inspected with some teams able to articulate changes made following incidents; whilst other teams could not describe learning from incidents or recall receiving data or details of themes and learning arising from incidents. Where learning arose, there was evidence that risk mitigation became overly restrictive rather than based on individualised approaches. For example following a death within the in-patient wards involving substance misuse, blanket practices were in operation rather than determining individual risks.

Safeguarding

The trust had policies and systems in place to ensure safeguarding incidents were reported and investigated.

The trust related to one local authority in relation to safeguarding procedures (Manchester City Council) and two safeguarding boards - the Manchester safeguarding adults board and the Manchester safeguarding children's board. These meetings were held on a monthly basis and the trust was represented on these safeguarding boards.

The trust's deputy chief nurse and director of quality assurance supported by the professional head of social work took the lead for safeguarding responsibilities within the trust. The trust completed adult safeguarding investigations on behalf of Manchester City Council for adults with mental health issues. The trust also has a named nurse for child safeguarding. The Trust also had safeguarding children link practitioners who provided additional support, advice and expertise to colleagues to help the quality assurance of referrals to children's social services. The trust also had named leads for the trust for domestic abuse, forced marriage, honour-based violence and female genital mutilation

In 2012/13, the local authority identified a number of concerns about the management of adult safeguarding incidents within the trust. At the time, the local authority undertook audits of information recorded on the trust's systems to consider the robustness of the safeguarding processes, including:

- Investigation and safeguarding work being completed but recorded in clinical notes rather than centrally or within an investigation form, reducing available evidence within qualitative audits.
- Lack of multi-disciplinary and multi-agency representation at safeguarding strategy meetings.
- Lack of clear minute–taking at strategy meetings.
- Difficulties in reconciling safeguarding incidents between the systems used between AMIGOS (the trust's patient information system) and MiCare (Manchester City Council's client information system) electronic referrals and records.
- Managers not having a full oversight of investigations within their teams and safeguarding forms not being signed off

In the safeguarding compliance assignment report 2014/15 audit dated September 2014 found:

- Themes from audits of safeguarding issues within the trust identified the following issues:
- Instances of non-compliance with the Trust's safeguarding procedures:
- Timescales for actions from strategy meetings not being documented
- Insufficient oversight and challenge on referral, investigation and outcome forms.
- Two cases identified where there was insufficient recording of multi-agency working.

There were six extreme risks identified on the trust's corporate risk register in October 2014; one of which was the local authority concerns regarding safeguarding.

In terms of action to address these concerns, the chief nurse was overseeing the safeguarding improvement

process; the head of social work was leading the monthly audit process, team managers were supporting local improvements in their teams and internal safeguarding governance groups received audit results, monitored the implementation of the action plans, and reported through risk committee.

The recent audit had recently shown ongoing improvements. The trust's performance in relation to safeguarding continued to be monitored by NHS England via risk summit meetings to ensure that these improvements made were sustained.

Assessing and monitoring safety and risk

The trust had an integrated assurance framework and corporate risk register in place. The risk register document identified the responsible owner and the timescales for completion of identified actions. There were six extreme risks identified on the trust' s corporate risk register dated October 2014 relating to the following issues:-

- out of area bed funding,
- staff engagement,
- local authority concerns regarding safeguarding,
- staff sickness,
- lack of pharmacist advice in community settings and
- capacity demands due to the new Care Act 2014.

Minutes of board meetings confirmed full discussions taking place every two months. We observed a board meeting during our inspection and the integrated assurance framework and risk register were discussed and actions reviewed. Many of these risks had been on the risk register for a significant period of time so it was not clear that the mitigating action was robust enough to address and mitigate the risk fully. The trust's overall financial position, the viability of the trust and commissioner relations were included within the extreme risks identified by the trust board or the actions to mitigate these risks.

The trust had a small pharmacy team that provided a clinical and advisory service to in-patient wards and had oversight of medicines use in the trust. The supply of medicines was externally sourced. The trust had a small on-site research pharmacy to support clinical trials. Each pharmacist covered two to three wards each day and over 80% of in-patients had their medicines reconciled within 24 hours of admission (exceeding the trust's own performance target).

The pharmacy team organised a 'medicines week' annually to raise medicines awareness amongst trust staff, with a different theme each year. The pharmacy team included a nurse who led on medicines optimisation from a nursing perspective aiming for improved outcomes for patients. This helped to ensure that medicines optimisation had a higher profile within the trust.

The pharmacy team was well-led and there were clear reporting arrangements for medicines governance. The chief pharmacist met regularly with the medical director and provided input into the senior management team, the quality board and the transformation programme board. The chief pharmacist, as the trust's accountable officer for controlled drugs, participated in the activities of the local intelligence network (LIN). There had been no incidents involving controlled drugs at the trust.

The pharmacy promoted evidence based prescribing; for example in the choice of medicines for treating schizophrenia. We found that learning occurred from medicine safety incidents and appropriate action was taken. For example, e learning about insulin was made mandatory for medical and nursing staff following an error involving this medicine.

The trust subscribed to the 'choice and medication' website which means that information on prescribed medicines was available to all patients and relatives with access to the internet.

Whilst the management of medicines was largely good across most core services, we identified issues in relation to medicines management at some core services. Most notably these were storage of medicines at a community outreach centre in older people's community services, problems with equipment used for medicines storage on the older people's wards and the prescribing of treatment for mental disorder for patients on Anson Road. The issues have been noted in the reports for these core services. The chief pharmacist confirmed that there were not enough pharmacists for visits to the trust's community services. The lack of pharmacy advice into community settings was listed as an extreme risk on the trust's corporate risk register. We also saw problems with adherence to treatment rules of the Mental Health Act (section 58) which we report on in the section of this report relating to the Mental Health Act.

The seclusion rooms were situated on the psychiatric intensive care units (PICU). The seclusion rooms were used

by other wards which meant that patients requiring seclusion had to be brought down a flight of stairs in restrictive holds. The occupancy of the PICU was then increased by one patient. Due to the pressure on beds if the patient no longer required seclusion they may not return to the same ward and/or their bed may not be available leading to potential delays in patients coming out of seclusion.

The trust reported 67 incidents of use of seclusion across eight wards for the period 13th May 2014 and 13th November 2014. Juniper ward had the highest number of seclusion incidents at 32, followed by Blake ward at 26 (both being PICUs).

The trust reported 386 incidents where restraint was used for the same period over 22 patient wards, units or teams. The trust reported 69 service users were restrained in the prone position. Juniper ward had the highest number of restraints using the prone position with 24 incidents and the highest number of rapid tranquilisations with 18 incidents.

We saw, during our inspection, that the use of rapid tranquilisation followed NICE guidance. Rapid tranquilisation was not regularly used on the wards with 44 incidents resulting in rapid tranquilisation for the period 13th May 2014 and 13th November 2014. Staff completed appropriate records if rapid tranquilisation was used. Improvements in the recording of rapid tranquilisation were particularly noted at Laureate House This showed that, following our last visit to Laureate House, the trust had made progress on recording physical health checks following rapid tranquilisation.

The trust had a compulsory training procedure which detailed all statutory and compulsory training. Training included safeguarding, clinical risk management, customer care, health and safety, infection control, medicines management and managing violence and aggression. We saw that the trust had set a target of 90% of staff to have completed up to date compulsory training between November 2013 and October 2014. The trust did not achieve these targets. Trust records showed that the compulsory training compliance stood at between 53% and 81%.

Potential risks

The bed occupancy rate for Manchester Mental Health & Social Care NHS Trust had been consistently higher than the national average. In the 12 months prior to this inspection bed occupancy rates across the trust were between 90% and 97% across the in-patient wards. This compared to an England average for mental health bed occupancy as 89%. In the first quarter of 2014, bed occupancy overall for the trust was recorded as 97% falling slightly to 94% in the subsequent quarter. It was generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.

Emergency equipment, including automated external defibrillators and oxygen, was in place in clinical areas. Staff checked the emergency equipment in line with the trust policy to ensure it was fit for purpose and could be used effectively in an emergency. The trust used the same emergency equipment used which was used in the general hospitals co-located at the same site. This helped to ensure the effectiveness and efficiency of any emergency response because staff were familiar with the equipment.

Systems were in place to maintain staff safety. The trust had good lone working policies and arrangements for its' community services.

The acute wards had undertaken ligature risk assessments (identifying places to which patients might tie something to strangle themselves) and identified window locks, bed posts and door hinges as potential ligature risks. The action for replacing or reducing these these fixtures with ligature risk free alternatives were outlined in the capital programme. All furniture on Juniper ward was fixed, except sofas and heavy weight chairs, in line with PICU standards; however on Blake ward, the furniture was not fixed which meant that the service was not operating in line with PICU standards. On Safire unit, the ligature audits did not cover risks such as plastic bags in waste bins and grab rails in bathrooms.

The trust adhered to national guidance on same sex accommodation (SSA) on adult wards. The older people's wards were mixed gender and whilst there was appropriate segregation of facilities. On the inspection we witnessed an operational breach of the same sex guidance on the older people's ward at Laureate House although we received assurances that the trust would attend to this. There were also issues with same sex accommodation on Safire unit due to the configuration of the ward. Safire ward was an assessment ward as part of the crisis service pathway.

Detailed findings

Cedar ward, one of the older people's inpatient wards, had the highest number of vacancies for registered nurses and Cavendish ward, another older people's inpatient ward, had the highest number of vacancies for nursing assistants as seen by the safer staffing reports dated October – December 2014. Staff sickness rates have been about the same as the national average for the last two years. We saw that therefore in older people's services there were problems with recruitment of staff and some wards were short staffed. The trust had temporarily closed a ward to address these staffing issues.

The 2014 NHS Staff Survey showed that the trust were worse than the England average across a number of domains including for number of staff receiving health and safety training in last 12 months, feeling more pressure at work, staff feeling satisfied with the quality of work and patient care they are able to deliver and agreeing that their role makes a difference to patients. The trust board discussed the staff survey and had identified action to aim to address these low results, such as the listening into action initiatives.

Duty of Candour

The trust had discussed the responsibilities of the duty of candour regulations with the board and for staff to raise awareness of the requirements of the duty of candour regulations. Information about duty of candour had been circulated by service managers so that all staff could review and action.

Team managers reported that they had received awareness training in 'duty of candour'. The chief executives reflections on the trust website talked about the importance of duty of candour and the new regulations that NHS trusts would need to be compliant with. We saw in the core services that staff were open and transparent when things went wrong.

Requires improvement

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

We rated effective as requires improvement because:

- There was not a strong recovery focus evident in community mental health teams and patients were being retained on the caseload of teams longer than was clinically required.
- There was limited evidence of coherent and consistent care pathways, outcome measures and performance data in community teams.
- Staff within certain services had not received recent clinical or management supervision and many staff had not had a recent appraisal despite efforts by the trust to address this issue.
- There was inconsistent medical cover at Anson Road which was impacting on patient care.
- Roles and responsibilities between the acute and mental health trust staff were not clearly defined to ensure effective care when patients received care jointly.
- Care plans were not always holistic and person centred in some services.
- We continued to find systemic issues with the operation of the Mental Health Act (MHA). Documentation was not completed correctly in line with the requirements of the MHA and MHA Code of Practice. We found issues across in-patient services in the MHA records relating to detained patients' rights, medication authorisations, leave, appropriate checks to ensure lawful detention and timely renewals of detention. The operation of the Act was particularly poor on the wards for older people.
- Where patients were subject to a deprivation of liberty safeguards (DoLS), the authorisations pending agreement from the local authority were not kept under review or updated as needed and decisions about time limitations were not properly communicated.

However, peoples' needs were generally assessed and care planned using appropriate tools. The perinatal, memory service and ECT service were accredited.

Our findings

Assessment and delivery of care and treatment

The trust had clinical audit programmes in place which were monitored by the quality committee, and fed into the trust board. Local audit programmes were in place that were linked to local NICE adherence, local risk, complaints and trends identified through incident reporting.

Over the last two years the trust have been performing at a very similar rate to the England average for the proportion of admissions to acute wards gate kept by the CRHT team. However, during the last reported quarter (quarter 2 of 2014/2015) the local rate had fallen to 5% below the national average.

We found wards assessed the needs of each patient before they were admitted. Care plans provided specific details of interventions, which should be put in place if the patient's mental health deteriorated, to prevent a relapse of their illness. We saw evidence that care plans were developed with patients to meet their identified needs under the framework of the Care Programme Approach (CPA) across most services. This was a particular way of assessing, planning and reviewing someone's mental health care needs. The care plans we looked at were centred on the needs of the individual patient and demonstrated a knowledge of current, evidence based practice. Care plans on SAFIRE and rehabilitation wards were goal orientated and had clear pathways to other services. The care plans on the acute wards were not always individualised, holistic or recovery focused. In the community based services, it was not clear that all the teams worked in line with the principles of the recovery model from looking at care records. Staff undertook a risk assessment of patients on admission. This was to ensure that patient need could be safely met on the ward and that the management of risk was consistent with the level of risk the individual posed.

Requires improvement

Are services effective?

Across most services, physical healthcare assessments took place. The trust had arrangements to ensure that physical health issues were properly assessed and treated. The trust had a range of policies to ensure that physical health issues were considered. Clear assessment and physical health check were undertaken on admission and any ongoing physical health problems were followed up appropriately.

The care plans for adults receiving care by the community mental health teams were regularly reviewed however there was little evidence of a recovery focus or comprehensive discharge planning. The service carried out 95% of CPA reviews within 12 months in line with the trust target. However, there was a lack of medical input into CPA reviews which often consisted of the care coordinator and patient only. This meant that reviews were taking place outside of the CPA framework best practice.

In the services we inspected, most teams were using evidence based models of treatment. Staff provided care to people based on national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines and were aware of recent changes in guidance.

Outcomes for people using services

The trust had accreditation for it electroconvulsive therapy service to assure and improve the quality of the administration of electroconvulsive therapy and for its memory service through the memory service national accreditation programme. The perinatal team were members of the Quality Network For Perinatal Mental Health Services, a quality network run by the Royal College of Psychiatrists. The trust had not sought accreditation with the Royal College of Psychiatrists for its acute in-patient wards, rehabilitation wards, crisis teams or community mental health services.

The trust participated in the National Audit of Psychological Therapies for Anxiety and Depression which showed that the trust performed worse than the national average in a number of areas:-

- capturing equality data.
- waiting times. However, there has been a decrease of approximately 1000 people waiting from September 2013 to February 2015.
- treatment for high intensity psychological therapy continuing until recovery or for at least the minimum number of sessions recommended by the NICE guideline for the service user's condition/problem.
- therapists providing therapy under supervision, and receiving formal training to deliver the therapy provided.
- service users reporting being provided with information and choice about their treatment
- service users reporting a high level of satisfaction with the treatment that they receive – access.
- collecting outcome data in order to determine the effectiveness of the interventions provided.
- clinical outcomes of service users receiving psychological therapy in the therapy service being comparable to benchmarks achieved by similar profile therapy services.

There was no psychologist on any of the acute or PICU wards or older people's services. Consequently there were no psychological interventions or family therapies available to the patients unless they had been receiving input from community teams prior to hospital admission.

A range of audits were carried out to monitor the effectiveness of the service. On in-patient wards we visited we saw weekly audits to ensure care plans and risk assessments were up to date, regular medication audits and monthly infection control audits.

Patients were assessed using the Health of Nation Outcome Scales (HoNOS).

The trust had a strong research and development function and benefited from commissioning bespoke research and learning from research projects. However it was not always clear that the benefits from these research and development functions led to changes or improvements in operational services provided by the trust.

Staff skill

The 2014 NHS Staff survey involved 287 NHS organisations in England. Over 624,000 NHS Staff were invited to participate using a self-completion postal questionnaire survey or electronically via email. 255,000 responses were received from staff, a response rate of 42% compared to 49% in 2013. In the NHS Staff Survey 2014 the trust have performed worse than national average for 'Percentage of staff appraisal in last 12 months' and 'Percentage having well-structured appraisals in last 12 months' with a slight worsening of scores compared to the 2013 results. The trust confirmed that appraisal has been a particular focus over the past year in view of the 2013 Staff Survey results. A task and finish group was set up between May and September 2014 and met every three weeks. The aim was to revise the

appraisal process and address staff concerns and compliance. The outcome was a revised personal review process which was implemented in December 2014. Improvements in compliance and quality were expected in this coming year.

In relation to supervision and appraisal, we found the following issues:

- On Cedar and Maple wards appraisal dates had slipped due to changes in management.
- In the perinatal service management supervision was not taking place and clinical supervision was only occurring on an ad-hoc basis.
- Clinical supervision was not evidenced within the rehabilitation services and only 48% of staff on Acacia ward had received an annual appraisal.
- On Blake ward supervision was not occurring but there were plans to reintroduce it.
- There was wide variance in the percentage of staff receiving appraisals within the community mental health teams, for example in the North Mersey CMHT there was 0% compliance, in the North West CMHT was 41%, in the North East CMHT compliance was 55%, in the North West CMHT compliance was 59% whilst in South Mersey CMHT compliance was 92%.

The most recent staff survey did show a slight improvement on the percentage of staff reporting good communication between senior management and staff.

Multi-disciplinary working

In most services care was delivered by multi – disciplinary teams consisting of consultant psychiatrists, nursing staff, social workers, pharmacists, occupational therapists and other health and social care professionals depending on the services being received. However some teams lacked psychologist input which meant that care could not always be offered that met NICE guidelines about promoting non-pharmaceutical approaches to some disorders.

We saw that there were multidisciplinary team meetings held on a weekly basis in the in-patient areas. In most cases, patients attended and were actively involved in the multi-disciplinary meetings. At times, patients chose not to attend or were too unwell to attend these meetings. In these instances, members of the MDT would meet with the patient following the meeting to discuss what had taken place and what decisions were made about the individual patients care and treatment.

We saw examples of good multidisciplinary and collaborative team working in most core services. Staff that we spoke with were knowledgeable about the needs of the people. We saw examples of good handover of patient information from in-patient teams to community mental health and crisis teams. We found examples of inpatient services working alongside the intensive home treatment teams to provide person centred care and treatment to people.

However, there was a lack of psychologist input at MDT meetings. At Anson Road, one of the rehabilitation wards, multi-disciplinary team meetings did not always have a responsible clinician who could make medical decisions. In addition, there was poor medical attendance at CPA reviews in some community team meetings for adults of working age which meant that these activities were being conducted outside of CPA best practice. We found that some people were being discharged without full involvement of the community care co-ordinator or community consultant psychiatrist. This all meant that people were not receiving care from a full multidisciplinary team across all core services.

Community mental health teams for older people demonstrated good inter-agency working with other organisations, for example, working with GPs. The older people's day service was not being used as effectively as it could be by other services. In particular, inpatient services were not referring early enough so that engagement could begin prior to discharge from the ward.

We saw that older people's services worked collaboratively and in partnership with a number of other providers within their specialist in-patient services. On Cavendish ward, the consultant described good relations with the large geriatric medicine service which provided geriatric liaison to the ward on a regular basis.

On Anson ward whilst they were awaiting the commencement of a locum consultant from April 1 2015, the junior doctor attended the meetings. However, it was unclear how patients would continue to have the participation of a consultant psychiatrist/responsible clinician who could approve changes to detained patients leave or treatment. In addition, the occupational therapist told us they were rarely involved in the meetings.

There were liaison psychiatry teams in the local acute hospitals.

Requires improvement

Are services effective?

Information and Records Systems

Staff had access to the information they needed in order to deliver effective care and treatment. Electronic patient notes allowed trust staff to have access to updated information in a timely and accessible way. However, in the community based services for adults of working age, local authority staff had to input information into their own recording systems and also the trust electronic patient notes system. This meant there was duplication of notes and time wasted as the systems were not synchronised.

Consent to care and treatment

The trust had Deprivation of Liberty Safeguards (DoLS) policy and an associated procedure for staff to follow. The policy took into account the most recent supreme court judgements following the Cheshire West case.

We saw some good examples of facilitation of capacity assessments that ensured patients were supported to make specific decisions. Staff we spoke with understood that capacity fluctuated and that people may have capacity to consent to some things but not others. They were clear about their responsibilities in undertaking capacity assessments and continuous monitoring to ensure people were able to understand and agree to decisions being made or that they were made in the best interest of the person. Where relevant staff understood the requirements to involve an independent mental capacity advocate depending on the decision and the unbefriended status of the person.

Across the wards we observed that staff supported patients to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests and this was recorded, recognising the importance of the person's wishes, feelings, culture and history.

Most staff understood the issues relating to mental capacity and consent, with the exception of staff on the older people's wards who weren't fully clear about the rules regarding DoLS. Mental Capacity Act and DoLS training were mandatory with a trust target of 90%. However compliance was varied. Most notably within services where mental capacity and consent issues were likely to come to the fore, we found that uptake on staff training on the Mental Capacity Act (MCA) as 44% on the older people's inpatient wards and 42% for staff in older people's community services

The trust had only submitted one Deprivation of Liberty Safeguards notification to us. However the trust reported that they had submitted ten Deprivation of Liberty Safeguarding applications to the supervisory body (the local authority) in the six months ending 11th November 2014, with six of these applications made from the Maple unit. The trust were required to notify us so that we can monitor the use of DoLS safeguards and take appropriate action where necessary. We raised this with the head of social work who accepted that the trust did not have a proper process to ensure that we were notified but agreed to ensure that appropriate notifications were made in future.

There were several issues around the use of deprivation of liberty safeguards (DOLS) authorisations on the older people's service.

- Urgent DOLS were requested without a standard authorisation meaning that the urgent DOLS could not be extended.
- The supervisory body had made the decision that urgent DOLS authorisations were not time limited. This information had not been passed to clinical staff.
- It was unclear how the outcome of DOLS authorisation requests were communicated to staff.

Within crisis services, a patient who was seen by the liaison team had been placed on restrictions on the general hospital wards. Staff were not sure of whose responsibility it was to provide a mental capacity assessment and apply for a deprivation of liberty safeguard, or whether the restrictions put in place were necessary.

Assessment and treatment in line with Mental Health Act

We found that where the Mental Health Act (MHA) was used that people were detained with a full set of corresponding legal paperwork which was kept in the MHA department. However, we found in several cases that copies of the documents weren't kept on the wards. This meant that ward staff could not always assure themselves that patients were lawfully detained. For example on the older people's ward, one patient was admitted to the ward and the detention papers were misplaced. This became apparent when the patient was reviewed for electro convulsive therapy. The notes indicated that during this time staff were unclear whether the patient was detained.

Requires improvement

Are services effective?

In several instances a copy of the outline report prepared by the approved mental health act professional (AMHP) was not present in the records as recommended by the MHA Code of Practice (CoP). On one patient file, it was not clear whether an AMHP had followed the correct process during the assessment for detention. We asked the trust to get legal advice about this matter to check whether or not the patient was lawfully detained.

The MHA manager told us that there was currently no consistent process in place for medical scrutiny of all detention documents to ensure that the medical reasons for detention are properly evidenced and checked.

There was an independent mental health advocacy service (IMHA) service available and most qualifying patients spoken with were aware of this. The IMHA service was well advertised on the wards.

We found restrictive blanket policies in place with regard to smoking times and access to courtyard areas on most wards which affected detained patients. We also found blanket policies in place with regard to patients opening mail in front of staff. No patients were permitted to refuse and no individual risk assessments had taken place around this issue.

Across the wards there was variable evidence that people had their rights explained to them on admission to hospital. For example, one patient on the acute wards who had been detained four days prior to our inspection had not been informed of their rights as required under section 132 of the MHA. In some cases it was documented that patients had been given their rights but there was no record of the level of patient understanding.

We had concerns about adherence to section 58 rules around consent to treatment for treatment for mental disorder to detained patients in all wards. We highlighted the following concerns:

- On one acute ward we found that 40% of the legal certificates (T2s and T3s) showed medication which was prescribed and/or administered for mental disorder not authorised on the certificate. This was in spite of a recent audit having taken place. We found issues in all core services providing in-patient care to a greater or lesser extent. Therefore some medications were being administered which were not authorised by a T2 or T3 certificate. This meant that some patients received medication which not lawfully authorised according to the rules of the MHA.
- On one older people's ward, there was a one month gap between section 58 authorisation being required (under the three month rule) and a form T2 being completed. This meant that the patient had been treated without legal authorisation for one month.
- There was no evidence that the responsible clinician (RC) had discussed the reasons for treatment or the effects and side effects of medication on many files. No evidence of the (RC) recording assessment of capacity to consent or if it was recorded, simply stated as "patient had capacity". This was despite the development of a trust form specifically for discussions with patients and recording capacity and consent which was not in use across the core services we visited.
- BNF categories not being used on T2 certificates, neither was the name of the drug to be administered used
- T2 or T3 certificates were not always held with prescription cards and/or not present on the ward at all. The originals were held in the MHA office. We could not therefore be assured that staff administering medication were checking that they had the legal authority to give medication to detained patients.

While we saw that the conditions of the patient's leave had been clearly specified and signed by the patient's responsible clinician, there was no record that the patient had been given a copy of the form in line with the CoP. Most patients we spoke had not been offered a copy of their leave form. This meant that patients were not fully supported to understand the conditions of their leave to promote adherence to these conditions. Some patients were not able to take escorted leave or had their leave significantly reduced as staff escorts were not always available. Detained patients on Anson Road were without a designated responsible clinician for a short period which delayed leave and discharge decisions.

The non-executive director with responsibility for the MHA had little understanding of the Act and what the Board responsibilities were. They told us that the MHA department had been under resourced for the past few years but that very recently all posts had been recruited into. None of the non-executive directors sat on the hospital manager hearings.

Requires improvement

Are services effective?

Many of the associate hospital managers had been in post for many years. Associate hospital managers consider renewals and appeals against detention under the MHA. The associate hospital managers had not received any individual appraisal in that time. There was no process to ensure that existing associate hospital managers were appraised periodically to assess their continuing suitability. Associate hospital managers had received annual training to keep up to date on case law pertaining to their role. They also had three committee meetings per year.

The trust had three levels of MHA governance meetings:

- ward manager/community manager governance meetings.
- division governance meetings.
- mental health legislation monitoring group.

It was not clear that these meetings were fully effective as we continued to find systemic issues with Mental Health Act adherence. For example, the operation of the Act was particularly poor on the older people's service.

At recent MHA monitoring visits we carried out before the inspection, we continued to raise issues with:

- MHA documentation not being completed correctly or available across the wards.
- detained patients not being fully supported to understand their rights.
- medication for mental disorder not being properly authorized, including decisions not being made within the required three months.
- poor recording of capacity and consent decisions in relation to treatment for mental disorder.
- patients not being given copies of the leave and
- the need for improved systems to ensure patients' detention was legally supported by the appropriate documentation and renewals occurring within appropriate timescales.

The trust provided action statements telling us what action they would take to address the issues we raised on these MHA monitoring visits. On this inspection, we continued to find poor adherence to the MHA and the promised changes from the trust not being fully actioned or embedded. This was despite the fact that the trust had appropriate flagging systems in place to remind staff of their duties; however clinicians and nursing staff across the wards did not always take appropriate and timely action to act and ensure adherence to the MHA and Code of Practice at all times.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

- Overall the trust was providing a caring service for people across all core locations.
- Throughout the inspection we saw examples of staff treating people with kindness, dignity and compassion.
- The feedback received from people who used services and their visitors was generally positive about their experiences of the care and treatment provided by staff within the trust.
- Where people could not speak with us, for example in older people's services, we saw positive and warm interactions.
- Most people stated that they felt that they were involved in their care.
- Most staff were knowledgeable about people's needs.
- People had access to advocacy when they were in-patients, including specialist advocacy for people detained under the MHA to facilitate effective participation.
- Staff were also aware of the emotional aspects of caring for people and made sure that specialist support was provided for people where needed.
- The trust board heard a patient story at every board meeting to remind the officers of the primary purpose of the trust to ensure people get good quality care that meets their needs and aids their recovery from mental ill health.

However patients' full participation was not always evidenced in care planning documents to reflect their involvement. It was therefore not always clear that patients had been fully involved in drawing up their written plans of care in meaningful ways and as active partners, for example patients identifying their own recovery goals. The local service user group felt that their concerns were not always listened to and the trust did not respond appropriately to the issues they raised.

Our findings

Dignity, respect and compassion

We observed positive interactions between staff and patients in a number of different care settings across the range of mental health services. Patients were treated with compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner.

Most patients we spoke with were complimentary about staff attitude and engagement. On the wards, we saw staff interacted with and engaged positively with patients.

The trust had a range of meetings in the inpatient services to ensure patients had an opportunity to explore issues and make decisions about the ward.

We observed mealtimes on all three older people's wards. We saw patients were supported to eat when assistance was necessary and appropriate aids such as cutlery, plates with guards and non-slip mats were available for them.

The in-patient services scored well in recent Patient-Led Assessments of the Care Environment (PLACE) annual assessment. These self-assessments are undertaken by teams of NHS staff and patient assessors (members of the public must make up at least 50% of the team). The trust scored high for privacy, dignity and wellbeing. When compared with other organisations, this put the trust 3% above the England average.

Involvement of people using services

The trust was one of the first mental health trusts in the country to introduce the patient stories initiative which involved a range of patient stories being used at the trust board meetings for learning and sharing purposes. Patient stories highlighted how services had responded to people's care and treatment needs. We observed a trust board meeting and saw the powerful nature of starting the formal board meeting with one of these stories.

The trust had a service user and carer involvement group which met regularly. There was evidence of positive outputs from this group. We met with representatives from this group who felt well supported and valued by the trust. The local service user group felt that their concerns were

not always listened to and the trust did not respond appropriately to the issues they raised. Members of the Manchester User Network did not feel that the trust engaged well with the independent user network movement giving examples with the way the trust had handled particular issues and had still not fully developed properly agreed terms of engagement with such groups.

We did not see service user engagement integrated fully across clinical governance arrangements. For example, clinical audits did not evidence involvement by service users in the design of audits or during service redesign processes at an early stage; nor was there routine expectations that clinical auditing methods would ensure that the patients' voice was heard.

We saw that people had an opportunity to attend ward rounds to be involved in and decide on their own care. The majority of patients we spoke with both within the focus groups and during our visit to the teams told us they had been involved in developing their care plans with staff to a greater or lesser extent.

However patients' full participation was not always evidenced in care planning documents to reflect their involvement. It was therefore not always clear that patients had been fully involved in drawing up their written plans of care in meaningful ways and as active partners, for example patients identifying their own recovery goals. We saw care plans were mainly written in clear and accessible language. However they were not always written from the patient's perspective of their care and did not always evidence patient involvement, for example at Anson Road. On the acute wards, care plans were not person centred and where people had complex needs or limited reading abilities and learning needs they had not been adapted in any way to make them accessible. On the older people's wards, we also saw care plans contained inaccurate information about patients because they had been cut and pasted from another patient's care plan. For example referring to a female patient as the male gender. This meant patients' care plans were not person centred. Many of the patients spoken to had been not offered or given a copy of their care plan. Four of the seven recent Mental Health Act monitoring visits highlighted concerns with a lack of evidence to show that patients were involved in care plans as full participants in line with the participation principle of the MHA Code of Practice.

There was evidence of family involvement in care. We were told that relatives and carers were routinely invited to review meetings and saw evidence of this at the MDT meetings we observed.

Patients had access to advocacy services. We saw most wards had information freely available to support patients and relatives and carers to access advocacy services and information about drop in or other local support groups for them to be able to discuss their concerns with the ward managers. We were told by patients that advocates regularly attended the community meetings.

On the inpatient wards, there were regular community meetings for patients. In the community meetings, we saw patients were happy to communicate and discuss the things that mattered to them. For example on one older people's ward activities were discussed and a new idea of having a 'thoughtful tree' on the wall which patients could contribute to was discussed. This opened up a discussion about wishes for patients to identify as part of their recovery and treatment.

People using the substance misuse and older people's day service attended service specific quarterly forums providing them with an opportunity to be consulted and raise concerns about the services they received.

Patients and carers of people using community services for adults of working age told us that they were involved in decisions about their care. The care records we reviewed demonstrated this. This was further corroborated by the most recent Community Mental Health Patient Experience Survey. The Community Mental Health Patient Experience Survey 2014 was conducted to find out about the experiences of people who received care and treatment. Those who were eligible for the survey were receiving specialist care or treatment for a mental health condition, aged 18 and above and had received community services.

Analysis of data showed that the trust was performing 'about the same' as other trusts in most of the major areas, including whether people in the community felt well supported by mental health staff.

The trust scored better than most trusts in four of the questions. This included a score of 8.5 which meant it was one of the 'best performing trusts' for the question 'were you involved as much as you wanted to be in discussing how your care is working?'. The trust was rated 7.8 which was 'about the same' as other trusts for the question 'were

Good

Are services caring?

you involved as much as you wanted to be in agreeing what care you will receive?'. The trust scored about the same as other trusts for the question 'have NHS mental health services involved a member of your family or someone else close to you as much as you would like?'

Emotional support for people

During our observations of home visits with staff from community mental health teams, we saw members of staff who provided good emotional support to people and their wider families. We received good feedback from the relatives and carers we spoke with about the care provided and their level of involvement in care and decision making. For example, carers we spoke with in the community adult service had received a carer's assessment and had an associated care plan in place. One carer told us how they had been well supported and had been able to access carer breaks.

We held engagement events before the inspection including with people who used the community mental health services. These people told us of mixed experiences of care. Some people stated they had received the support that they needed whilst others had less positive experiences with the difficulty for out-patients in accessing key people when required or receiving limited support.

We saw that people admitted as in-patients to mental health units were supported to maintain contact with their family and continue links with their local community.

Staff responded to people in distress in a calm, gentle and respectful manner whilst ensuring they anticipated patients' needs. This meant that staff evidenced the chief nursing Officer's "6 C's of nursing" and implemented these good practice guidelines into their practice to ensure they provided emotional support to people.

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as requires improvement because:

- There were a number of blocks within the system so that people were not always receiving the right care at the right time, for example crisis teams could not pass people through to community mental health teams (CMHTs), there were delays in receiving CMHT support and there were significant delayed discharge arrangements.
- Two detained patients in long stay rehabilitation could not be discharged in a timely manner due to the lack of a responsible clinician at Anson ward.
- There were a number of incidents of waits in assessing people presenting with mental health problems within the emergency department some of which involved waits of beyond 12 hours. Despite efforts to reduce these incidents, they continued to occur.
- Patients receiving longer term rehabilitation services on Acacia ward were cared for within 4 bedded bays which compromised privacy and dignity and did not aid recovery. The dignity of patients on the acute wards was not always being maintained.
- The links between the acute and community adult teams needed strengthening to ensure improved communication and better patient flows.
- Patient activities were cancelled on the acute wards.

However staff had access to interpreting services for patient whose first language was not English. Services we visited had disability access and disabled facilities such as toilets and bathrooms. Where there was no wheelchair access in community based services, alternative appointments were made either at the person's home or a venue close to where they lived. Information about raising concerns and complaints was available to all patients in the wards, and community mental health services. There were good systems for managing complaints.

Our findings

Planning and delivery of services

The trust work alongside three clinical commissioning groups, one local authority, the Trust Development Authority (TDA) and NHS England.

Manchester had a diverse array of service providers covering the needs of people with mental health needs. The early intervention service was provided by Rotherham and Doncaster Mental Health NHS Foundation Trust. CAMHS services were provided by the local acute trust. Low secure services were provided by the two neighbouring mental health trusts. Learning disability services were provided by the local learning disability partnership board and independent providers. Manchester Mental Health and Social Care NHS Trust provided the community and in-patient services for adults and older people. This meant that when people presented at accident and emergency department with suspected mental health issues, staff had to negotiate a complex service delivery environment to ensure people received appropriate care.

Historically in common with many inner city mental health trusts, Manchester Mental Health and Social Care NHS Trust has continuing levels of high bed occupancy. This led to many patients being treated in out of area placements – with many utilising private beds in the north east of England. In recognition of this, the CCG commissioners commissioned additional bed capacity for Manchester residents through arrangements with neighbouring mental health trusts to ease the bed occupancy issues. Whilst this has released some of the pressures within the system, bed occupancy levels remain persistently high.

Admissions into the acute beds were usually gate kept by the trust's crisis teams. People were not always offered a bed in their local area. For example patients from North Manchester could be admitted to South Manchester and vice versa. However we saw that when a bed was available in the patient's own locality, arrangements for transfer would be made where clinically appropriate. However the local health commissioners had concerns about the use of out of area beds despite the increase in bed capacity. There wasn't fully active management of patients placed out of

area to return them to their home area as quickly as possible, with limited clinical involvement. With the impending closure of one older people's ward, older male patients who could not be discharged were transferred to Cavendish ward. The trust had made arrangements to assist relatives to travel from North Manchester to visit their family members and attend meetings.

Diversity of needs

Manchester comprises of many diverse ethnic populations. It has a higher than the England average ethnic minority population, as measured by non-white residents, accounting for 31% of the population. People who identified themselves as Pakistani make up the largest ethnic minority group in Manchester accounting for 9% of the population. The second largest ethnic minority group in Manchester is people who identify themselves as African. The group is fairly evenly distributed across the city with the largest cluster in Moss Side ward. There is a significant Chinese population clustered around the city centre. The north of the city has a large community of people of the Jewish faith, including orthodox Jewish people.

People's diversity and human rights were respected. Attempts were made to meet people's individual needs including cultural, language and religious needs. Staff had access to interpreting services provided face to face and telephone services through the trust's linkworker scheme. The scheme's main focus was to ensure high quality communication between mental health staff and patients, carers and families who speak little or no English. The scheme promoted access of mental health services to black and minority ethnic communities. Linkworkers also provided training and raising of cultural awareness among the staff. We were given a number of examples where this had been used to support people whose first language was not English. We observed the use of face to face translation during a carer's visit with an individual whose first language was Urdu. Staff could access leaflets in different formats and languages as required through the scheme.

A choice of meals was available with significant effort made to ensure a varied range of cultural needs were met representing the multi-cultural nature of the communities the trust served.

Services we visited had disability access and disabled facilities such as toilets and bathrooms. Where there was no wheelchair access in community based services, alternative appointments were made either at the person's home or a venue close to where they lived.

There were several multi faith rooms across the trust that patients could access. When possible, staff tried to get people out into the community to maintain spiritual and religious needs. Contact details for representatives from different faiths were provided. Local faith representatives visited wards and could be contacted to request a visit if needed.

Right care at the right time

There had been a small number of long waits in A and E over the last 12-18 months with some people waiting over 12 hours for an assessment and then an appropriate bed. An appropriate escalation arrangement was in place to ensure that patients were not kept in A and E for such long waits and appropriate pathways were developed. Despite these escalation arrangements there had been occasions where the appropriate protocols had not been followed to ensure timely patient assessment and flow through the system.

There were blocks within the patient flow system to ensure that people were cared for by the most appropriate service. Some people had remained with the crisis and home treatment service for six months when the organisational aspiration was six weeks. This was because other services such as early intervention and community mental health team (CMHT) had stopped accepting referrals because of their work load, patients requiring these services continued to receive ongoing support by the HTT.

Crisis teams were the gatekeepers to the acute admission beds. The national threshold is to gate keep 95% of all admissions to psychiatric inpatient wards. The trust was performing above this threshold on the most recent available figures with 97%.

Bed occupancy was consistently higher than the national average. In the first quarter of 2014, this was recorded as 97% falling slightly to 94% in the subsequent quarter. It is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.

Referrals into the peri-natal service were received from a large catchment area covering the North West of England.

Requires improvement

Are services responsive to people's needs?

The unit responded quickly and had often admitted patients the same day or within a few days if beds were available. NHS England reported that the service was very responsive to referrals.

At the time of our inspection the dining arrangements on Cavendish wards were insufficient. Patients were eating their meals in the main lounge as well as the dining room. The size of the dining room could not safely or comfortably accommodate all of the patients on the ward taking into account the specific needs of the patients, such as the numbers of patients with limited mobility or using wheelchairs. We addressed this matter to the trust due to the numbers of patients accommodated on the ward. The trust provided us with assurance the numbers of patients were reduced to twenty by 7th April 2015.

When a patient required the use of seclusion they were transferred to Juniper or Blake psychiatric intensive care unit (PICU), which was constantly at capacity bed status. This meant that existing patients had to be quickly re-assessed and arrangements made to transfer a patient to another ward during an admission episode to accommodate the patient who needed the use of the seclusion room.

The Department of Health publishes monthly data relating to delayed transfers of care across 242 acute and non-acute NHS trusts, including both the number of delayed days and the number of patients who experienced a delayed transfer of care each month. Between December 2013 and November 2014 62% of delayed patients on the last Thursday of each month were due to reasons of 'housing – patients not covered by NHS and community care act' with 67 patients falling into this category and a further 25 patients awaiting appropriate community placements or packages. Between December 2013 and November 2014 63% of delayed days were a result of 'housing – patients not covered by NHS and community care act' with 1971 delayed days. Whilst many of the patients who were subject to delayed discharge had complex social circumstances such as homelessness or seeking asylum, it wasn't always clear that active steps were taken to facilitate discharge and overcome barriers.

The trust provided details of two services with targets for days from referral to assessment. The trust was currently not meeting either of these targets. These services were improved access to psychological therapies where the target was 28 days from referrals to initial treatment; the trust indicated that the actual mean wait was 112 days between April and September 2014. The trust reported that the IAPT service was under resourced which provided the principle reason for these delays. The other was the community mental health adults area teams where the target was 21 days from referrals to initial treatment. The teams' actual mean wait was 64 days between April and September 2014.

From April 2013 to September 2014 the trust has followed up between 93% and 98% of discharged patients on the care programme approach within 7 days. The trust was above the England average for 4 of the last 6 quarters. In the latest quarter the trust was 1% above the England average.

Referrals into community mental health teams for working age adults were either accepted by a duty team or by a single point of access. Some teams had waiting lists whilst others did not. Urgent referrals would usually always be seen within 72 hours and routine referrals within 28 days. Where there were waiting lists, routine referrals could wait six – eight weeks before being assessed.

Community staff told us that it was difficult to discharge patients and proactively engage in recovery work with patients. This was reflected in the length of stay figures. Many patients had been in the service for several years and treatment and care was based upon maintaining their level of functioning and health rather than promoting recovery and discharge. The mean length of stay ranged from 1394 days in the North Mersey CMHT up to 1996 days in the Central West CMHT. This was higher than expected. Staff told us that one of the primary reasons for delayed discharge was concern over the reduction of community support services. The trust had attempted to address this with a pilot scheme which has involved setting up a health and social care clinic at the North West CMHT

Learning from concerns and complaints

Our analysis of data from our intelligent monitoring before the visit showed that the trust received 214 formal complaints between period April 2013 to March 2014; a very slight increase from the previous year. Complaints therefore represented a very small number of incidents compared to the overall extent of daily interactions between the staff of the trust and people using the service

Requires improvement

Are services responsive to people's needs?

throughout its services. Twenty four complaints received and investigated in 2013-14 were upheld and 6 referred to the Health Service Ombudsman. Complaints were received for 58 different wards or teams. Of the 196 complaints received 24 had been upheld.

There were four service areas where there were more than ten complaints; all of which were community mental health service for adults of working age:

- South Mersey community mental health team (CMHT);
- The West CMHT
- Outpatient North
- Outpatients Central

Nursing and health visiting professionals were the most complained about professional body within the trust in both 2012/2013 and 2013/2014 followed by the medical professionals. From 2012-2013 the majority of complaints were about 'admissions, discharge and transfer arrangements' and 'all aspects of clinical treatment'. From 2013-2014 the majority of complaints were about 'all aspects of clinical treatment'. However in 2013/4 a significant proportional increase in complaints categorised as 'other' was recorded; with nearly 25% of complaints categorised as other (compared to 10% in 2013/4).

Information about raising concerns and complaints was available to patients in the wards, and community mental health services. The trust informed patients about the patient advice and liaison service (PALS) which also offered support to patients who wished to raise a concern, complaint or a compliment.

Patients we spoke to were able to tell us how they would make a complaint and most patients felt that they could raise concerns and staff would listen to them.

The complaints database showed that complaints were actively managed, recorded, tracked and progressed to ensure people received a speedy response. We case tracked 12 complaints. We saw evidence that attempts were made to resolve people's complaints and an apology given where necessary. Appropriate learning had been drawn from complaints. Staff received feedback on the outcome of investigations of complaints either individually from the ward manager or through team meetings and emails.

Feedback from PALS were shared with patients via the 'you said….we did' boards located in all the ward environments.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

We rated well led as requires improvement because:

- The trust had stated vision and values. The vision did not fully articulate or reflect this current situation and future uncertainty of the trust.
- The trust board was not proactive in formally considering the options appraisal processes to address the uncertainty of the trust's future position.
- The trust had withdrawn from foundation trust status due to financial viability issues requiring intervention by the NHS trust development authority.
- The commissioners of the trust had concerns about its performance and whilst staff were working to address these concerns, continued issues arose, for example continued 12 hour breaches for people in mental health crisis waiting in the emergency department, without staff following the agreed escalation process on at least one occasion.
- There were acknowledged gaps within the non-executive director experience, including managing complex healthcare organisations and mental health experience capability.
- On occasions, the board had received reassurances from the executive team rather than seeking full assurances themselves when significant decisions were made.
- Staff morale was poor. The trust had commissioned an external review but the action to address the morale was limited in scope.
- The audits that the trust carried out picked up issues which we identified but often the action plan was not properly implemented to support systemic change and improved practice.
- There was limited best practice identified.
- The trust had a significant research and development function but this was not fully utilised within operational services.

However staff in many core services were supported by good local managers.

Our findings

Vision and Values

In the majority of wards and teams that we visited, the trust's vision, values and strategic goals were on display.

The trust had the following strategic objectives:

- to provide services which are always of the highest quality, evidence based and responsive to local needs.
- to maintain our market position in research development and teaching in mental health and well-being services.
- be proactive and influential with our partners and in the development of sustainable services.
- to value our staff so that the Trust is an employer of choice for caring, compassionate and committed professionals.
- to deliver organisational growth, structured around needs.
- to be an efficient, effective and sustainable organisation

Staff received a weekly e-mail known as the 'Mid-day Mail' which disseminated key information to all staff groups.

Community staff were not able to discuss the organisation's vision or values and many said they were unaware of who the senior management within the trust were. The development of the vision and values occurred several years ago and many staff were not employed at that time. There was limited evidence of the trust engaging with current staff to develop, refresh and embed the vision and values. Teams reported that they felt the board was not visible, with the exception of long stay and rehabilitation services who had recently had visits by members of the executive team.

However the vision and values did not fully articulate or reflect the current situation of the trust in terms of its' future direction.

Governance

There was a clear governance structure in place that included a number of committees that fed directly into the board. The following committees/groups provided

assurance to the board; a quality board, an audit committee, a transformation programme board, a finance and investment committee, a research and innovation committee, a workforce and organisation development committee, and a remuneration committee,

The trust board of directors were accountable for the running of the trust. They provided the overall strategic leadership to the trust. The non-executive members of the board held the executive members to account. However the chair acknowledged that on occasions the board had received reassurances from the executive team rather than seeking full assurances themselves when significant decisions were made. For example the recent temporary changes to older people's in-patient wards. The chair acknowledged that there were gaps within the non-executive director experience, including managing complex healthcare organisations and mental health experience. The non- executive director responsible for oversight of the Mental Health Act did not have mental health law experience.

Wards had key performance indicators around admission and physical health; these were audited weekly. We saw that the governance structures were not as embedded from senior management level to the wards. We did see that in most clinical environments staff teams did discuss issues of quality. Locally good governance varied between core services and down to individual ward level with little evidence benchmarking between similar services. We saw that in some areas, local governance arrangements were good whilst in others they were not effective.

Our findings showed that some of the trust's governance systems were not effective. This is demonstrated by:

- A failure to fully address shortfalls relating to adherence to the Mental Health Act raised when we carry out MHA monitoring visits.
- A number of identified regulatory breaches that we identified which were not picked up or addressed fully by the trust's own systems.
- Items remaining on the corporate risk register for significant periods of time without reductions in the stated risk levels.
- Continuing patient safety concerns at NHS England risk summit with some improvements noted but issues not fully addressed.
- Continued problems with managing patient flows and a lack of locally embedded systems to address these, for example the community mental health teams had undergone a protracted community service review and did not have fully embedded standardised operating procedures about admission into and discharge out of secondary mental health services. In addition the number of out of area placements remained persistently high.
- Continued poor staff survey results.
- Staff recruitment and retention issues. This had been so significant that the trust had taken action to close one of the older people's wards, Cedar ward, due to the trust not being able to recruit suitable registered nurses for later life services.

At the end of December 2014, the trust was in deficit by £1.4m, £1.9m behind plan. This was projected to be a £1.8m deficit by the end of the financial year 2014/5. The projection was adjusted due to the levels of financial risk as a result of higher than planned usage of costly out of area beds, higher use of agency staffing due to sickness, acuity and patient safety reasons, and challenging cost improvement targets.

The Trust did not have an agreed sustainable plan for its future direction given its financial viability issues and withdrawal from foundation trust status. The commissioners had planned to tender the mental health services but they had put this on hold whilst further discussions were held through a partnership board of CCGs, local authority commissioners and the trust. The trust executive team and managers were not proactively engaging with staff, patients and stakeholders over its' future options.

Leadership and culture

We attended both the public and private board meeting that took place during our inspection. We saw that the public part of the meeting was conducted efficiently, and largely without challenge. The private board meeting was well attended with varied and good contributions from members. The contributions were noted to be well informed, relevant, succinct and respectful. The chief executive led the items effectively. Board members were noted to challenge effectively. It was clear that the executive team and non-executives had a good grasp of the key issues facing the trust. We saw that the risk register was reviewed and amended as part of the board meeting. We found that the non-executive directors displayed insight into the challenges the trust faced.

Requires improvement

Are services well-led?

Staff were generally aware of whistle blowing processes. Staff stated that they would raise concerns but they were not confident they would be acted on. Some of the staff we spoke to felt there was a blame culture within the trust.

As a non-foundation trust, Manchester Mental Health and Social Care Trust were being supported by the NHS trust development authority (TDA). The TDA was responsible for providing leadership and support to the non-foundation trust sector of NHS providers. The TDA oversaw the performance management of these NHS trusts, ensuring they provide high quality sustainable services, and provide guidance and support on their journey to achieving foundation trust status or alternatives. The level of TDA oversight and escalation was judged as 'requiring intervention'. This level of intervention was used where a trust had significant delivery issues, including clinical and /or financial challenges; the TDA had concerns about the board's capacity to deliver improvement and was therefore keeping its' progress under close review, with the potential to deploy external interventions.

Representatives from the local clinical commissioning groups told us that the trust did not engage positively with them and did not involve the local communities or other organisations in how services were planned or designed. The trust also told us that the relationship between them and the local clinical commissioning groups was a difficult one. Despite the efforts of all the agencies including support by the TDA to improve the professional relations between the trust and the local clinical commissioning groups, there continued to be engagement issues between these organisations. We were concerned that this might adversely affect the provision of high quality patient care but recognised that both parties worked to ensure there was no detriment to quality care.

Fit and Proper Person Requirement

This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. We saw that the trust met the requirements of the fit and proper person requirements. It was already part of the trust's approach to conduct a check with any and all relevant professional bodies (for example, medical, financial and legal) and undertake due diligence checks for senior appointments.

Engagement with people and staff

Staff within core services told us they felt supported within their own team and by their team managers. They felt services were managed well locally. However many staff did not feel supported or valued by senior management within the trust. We found that staff morale was low, particularly in community mental health and crisis services for adults. The corporate risk register identified that staff engagement was poor throughout recent changes to the service. This initially came on to the risk register in July 2013 and remains on their risk register. The low morale of staff was corroborated by poor staff survey results.

In the NHS Staff Survey 2014, the trust performed worse than the England average in 11 out of 12 questions. This included results relating to staff motivation, job satisfaction, effective team working, support from immediate managers, work pressure and suffering work related stress in the last 12 months. This also included suffering physical violence from patients, relatives or public in last months, harassment or bullying or abuse from patients/relatives in last 12 months and harassment or bullying or abuse from staff in the last 12 months. The trust's highest four rankings in the 2014 NHS Staff Survey included: staff working extra hours (better than England average), staff feeling secure about raising concerns regarding unsafe clinical practice (similar to England average), staff experiencing physical violence from staff (similar to England average) and good communication from senior managers to staff (similar to England average). The trust's lowest five rankings in the staff survey included: staff motivation, recommending the trust as a place to work, effective team working, receiving job relevant training, and agreeing feedback from patients/service users was used to make informed decisions in their directorate/ department.

The trust sickness rates have remained consistently above the England mental health and learning disability services average over the past 18 months. The aggregated national average sickness rate for mental health and learning disability services stands at 4.9% as of March 2014. A significant number of wards and services, 23 in total, were above this level. Six services, all in-patient areas, had average sickness rates over 10%. Blake Ward (the PICU at Laureate House) had the highest sickness rate at nearly 21%.

The percentage of overall staff turnover in the trust from November 2013 to October 2014 was 14% of the whole time equivalent workforce which was much higher that the

Requires improvement

Are services well-led?

England average. Cedar ward had the highest turnover rate at 36%, followed by Bridges Day Unit at 25%. The trust had acted to close Cedar ward due to an inability to recruit and retain staff.

The trust scored low in recent friends and family tests in relation to both questions whether staff would recommend the trust as a place to work test and recommend the trust as a place to receive care or treatment.

Due to persistently low staff survey results and whistleblowing concerns, the trust commissioned a rapid diagnostic report headed by Professor Stephen Singleton OBE for the purpose to improve quality and safety of services. A 90 day plan was developed incorporated into a refresh of a three organisation development strategy**.** The action to address the poor morale was limited in scope and the mitigation action in the corporate risk register did not assure us that that the trust was robustly addressing these concerns across the organisation.

We saw some recent examples where board members spent time within services to understand the challenges faced and were aiming to engage with front line staff including through initiatives such as commissioning an external review into culture and initiatives such as 'listening into action'. However these initiatives had limited reach into front line services. The future of the organisation was continuing to cause difficulties for the front line staff. There had not been the appropriate level of engagement from leaders to ensure that this uncertainty was managed well.

Continuous Improvement

The trust participated in external peer review and service accreditation. These were:

• The ECT accreditation scheme for the ECT clinic. The trust has been accredited as excellent.

• the Memory Services National Accreditation Programme for memory services

• The Quality Network for Perinatal Mental Health Services

The audits that the trust carried out frequently picked up issues but often the action plan was not properly implemented to support systemic change and best practice. For example our Mental Health Act monitoring visits regularly reported that consultant psychiatrists were not fully recording capacity to consent decisions for treatment for mental disorder in line with the Code of Practice. The trust produced a form to improve practice in this area but this proforma was still not routinely used and we continued to find capacity to consent discussions lacking in care records.

There was limited evidence to show how patient's views and experiences were captured and used to drive improvement or influence service development. A review of community mental health services had been implemented 18 months ago but there was no evidence that this had been evaluated.

We identified good practice within the perinatal service. However across other core services we did not find notable good practice despite the trust having a significant research and development function which was not fully utilised within operational services. We did not see this research and innovation embedded within core services, for example, the environments in the older adults organic wards did not reflect identified good practice in providing dementia friendly environments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Person-centred care in community services for adults of working age and acute wards for adults of working age and psychiatric intensive care units** Person centred care - Regulation 9 HSCA (RA) Regulations 2014 We found that the registered person had not ensured that patients received person centred care. This is in breach of regulation 9(1) (b) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: **Person-centred care in community services for adults of working age** The provider did not ensure that each patient had an effective recovery focussed care plan and discharge plan in place to make sure they did not remain in services longer than was clinically appropriate. The provider did not ensure that care and treatment was delivered and reviewed in line with CPA best practice guidance. This included medical representation at patients' CPA reviews and ensuring patients were discharged from hospital without their community care coordinator and consultant's knowledge and involvement. **Person-centred care in acute wards for adults of working age and psychiatric intensive care units at Park House and Laureate House**

This section is primarily information for the provider

Requirement notices

Care plans were not always person-centred and did not reflect personal preferences. Patients had not been provided with relevant information and support when they need it to make sure they understand the choices available to them.

Assessments were not always being reviewed regularly and whenever needed throughout the person's care and treatment.

Where the trust shares responsibility for providing care and treatment with other services through partnership working, a clear care and/or treatment plan, which includes agreed goals, must be developed and made available to all staff and others involved in providing the

care.

There were not nutritional and hydration assessment completed to support the wellbeing and quality of life.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Good governance in community services for adults of working age and on acute wards for adults of working age and psychiatric intensive care units** Good Governance - Regulation 17 HSCA (RA) Regulations 2014 We found that the registered person did not have systems or processes established and operating effectively to assess, monitor and improve the quality of service provided in the carrying on of the regulated activity (including the quality of the experience of service users involved in receiving those services). This is in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 17 (1) and (2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: **Good governance in community services for adults of working age**

This section is primarily information for the provider

Requirement notices

The trust did not ensure that incidents were investigated in line with trust policy and there were robust systems in place to make sure learning or good practice was shared within and across the service.

The trust did not ensure that all staff received mandatory training and appraisals in line with trust policy.

The trust did not ensure there were systems in place to effectively monitor, improve and evaluate the quality of service provision across the service including feedback from patients.

Good governance in acute wards for adults of working age and psychiatric intensive care units

In some of the areas visited there were not systems or processes to assess, monitor and improve the quality and safety of the service.

Some wards did not have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.

Where risks had been identified, the service had not always introduced measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Management of medicines in older people's community services and Anson Road** Safe care and treatment - Regulation 12 HSCA (RA) Regulations 2014 We found that the registered person had not protected people against the risk of unsafe medication arrangements. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

How the Regulation was not being met at older peoples' community mental health services provided from Park House:

At the office base of the north east and north west community older people mental health teams, the arrangements for recording the stocks of medication and ensuring safe access to medication were not adequate.

How the Regulation was not being met at Anson Road:

The MHA medication records were incorrect on Anson ward regarding their agreed medication limits on the T2 and T3 certificates when checked against the medication prescribed to patients. There was no evidence that the responsible clinician had informed patients about the purpose or side effects of the medication.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Dignity and respect on the acute wards for adults of working age

Dignity and Respect - Regulation 10 HSCA (RA) Regulations 2014

We found that the registered person had not made suitable arrangements to ensure the dignity of service users. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met:

How the regulation was not being met on the acute wards at Park House:

The use of shared bays did not ensure that when people receive care and treatment they were treated with dignity and respect at all times.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Equipment on wards for older people** Premises and equipment - Regulation 15 HSCA (RA) Regulations 2014 The provider had not ensured that patients were protected from the risk of unsafe equipment by ensuring equipment was properly maintained and suitable for its purpose. This was in breach of regulation 16(1)(a) Regulation 16 HSCA 2008 (Regulated activities) Regulations 2010 Which corresponds to The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 15(1)(e) **How the Regulation was not being met at the older people's wards at Park House:** • Cedar and Maple wards had kitchen fridges with broken door seals and thermometers which did not record an accurate temperature. Temperatures were seen to be operating above the maximum safe storage for food and dairy products.
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Adherence to the MHA and DoLs legislation in wards for older people with mental health problems** Good governance - Regulation 17 HSCA (RA) Regulations 2014 The provider had not ensured that patients were protected against the risk of inappropriate or unsafe care and treatment by means of the operation of safe systems designed to assess and manage risks relating to the health, welfare and safety of patients. This was in breach of regulation 10(1)(b) Regulation 10 HSCA 2008 (Regulated activities) Regulations 2010 which corresponds to

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17(2)(a) **How the Regulation was not being met at the older people's wards at Park House and Laureate House:** The Mental Health Act and Code of Practice and Mental Capacity Act Deprivation of Liberty Safeguards were not being adhered to.
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staffing within long stay/rehabilitation wards and acute wards for working age adults** Staffing - Regulation 18 HSCA (RA) Regulations 2014 We found the provider did not have sufficient numbers of staff deployed or supervision, appraisal and/or training arrangements in place in order to ensure that qualified staff were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. This was in breach of regulation 22 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the Regulation was not being met at Anson Road:** • Ward managers did not monitor staff clinical supervision to ensure it was compliant with the trust protocol. • We found that 50% of staff had completed their annual appraisals on Acacia ward. **How the regulation was not being met on the acute wards for adults of working age:** In some areas there were insufficient numbers of suitably qualified, competent, skilled and experienced persons deployed.

This section is primarily information for the provider

Requirement notices

Not all of the staff had received appropriate support, training, professional development, supervision and appraisals to enable them to carry out the duties they are employed to perform.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Premises within the long stay/rehabilitation mental health wards for working age adults** Premises and equipment - Regulation 15 HSCA (RA) Regulations 2014 We found that the premises used by the service provider were not suitable for the purpose for which they were being used. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the Regulation was not being met on Acacia ward at Park House:** • In several clinical areas the beds provided were in bays. • The beds in these areas were only separated by curtains. • There was no clear guidance in the ward information about how the dormitories operate. • The curtains in these areas were not drawn around the bed spaces at all times. • There was no guidance for those patients sharing a dormitory to ensure people are respectful of each other's privacy and dignity.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Privacy and dignity in crisis services**

This section is primarily information for the provider

Requirement notices

We found that the registered person had not ensured that the privacy and dignity of some patients was being met. This was in breach of regulation 17 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 (1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the Regulation was not being met on Safire ward at Park House:

At SAFIRE ward, care was provided in mixed sex accommodation which did not meet the guidance on same sex accommodation (SSA) and the Mental Health Act (MHA) Code of Practice (CoP).