Requires improvement

Pennine Care NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

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Date of inspection visit: 14 - 16, 22 June 2016
Date of publication: 09/12/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT2Y6	The Meadows	Rosewood ward, Saffron ward, Davenport ward	SK2 5EQ
RT203	Oldham Mental Health Services	Rowan ward, Cedars ward	OL1 2JH
RT204	Rochdale Mental Health Services	Beech ward	OL12 9QB
RT201	Bury Mental Health Services	Ramsbottom ward	BL9 7TD
RT202	Tameside Mental Health Services	Hague ward, Summers ward	OL6 9RW

This report describes our judgement of the quality of care provided within this core service by Pennine Care NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Pennine Care NHS Foundation Trust and these are brought together to inform our overall judgement of Pennine Care NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Requires improvement** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated wards for older people with mental health problems as requires improvement because:

- Three wards did not comply with the Department of Health's guidance on eliminating mixed sex accommodation.
- The layout of the wards did not allow staff clear lines of sight of patients. These were not mitigated by the use of mirrors to cover all areas of the ward.
- Overall compliance for mandatory training did not meet the trust's set targets.
- The trust policy on seclusion did not safeguard patients around nursing, medical and independent review as per the requirements in the Mental Health Act Code of Practice.
- Most patients on Saffron ward were being cared for and treated in their best interests but there were no formal considerations of these best interests and no consideration whether the restrictions faced by patients on Saffron ward amounted to a deprivation of liberty.
- On most other wards, where significant decisions were made, these decisions were not always supported by staff fully considering the best interests of patients and recording those decisions.
- Patients on some wards did not have meaningful activities because there was limited occupational therapy input and nursing staff were too busy attending to patients' basic care needs.
- On some wards, the quality of care provided for patients who had difficulty communicating was poor.
- Outside space was not always accessible due to the doors being locked.
- Dementia friendly signage on the wards was limited.
- Managers had not taken sufficient action to resolve issues with mixed-sex accommodation, ward layout, implementation of the Mental Capacity Act and quality of patient care.
- The shortfalls we found on our inspection highlighted some gaps in the governance arrangements.

However:

- The wards were clean, tidy and well maintained. Ligature risk assessments and environmental checks were in place.
- Patient risk assessments had been completed.
- Staff completed life story work with patients with dementia to enable them to provide person centred care.
- Staff considered patients' physical health needs on admission and on an ongoing basis.
- There were good systems in place to ensure the Mental Health Act was followed.
- All patients told us they were treated in a kind, caring and respectful manner.
- While the bed occupancy levels were high on most wards, most patients were admitted to their local catchment area or where this was not possible repatriated to the local area as soon as practicable.
- Patients' discharges were planned and involved multidisciplinary teams, families and carers.
- There were systems in place to manage complaints.
- Information leaflets were available in other languages should these be needed.
- Whilst Cedars ward was small and crammed, the trust had developed plans to address this.
- The trust were developing an older people's mental health strategy.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Summers, Rosewood and Cedars wards did not comply with the Department of Health's guidance on eliminating mixed sex accommodation. This was because wards were for both male and female patients, rooms were not fully ensuite and patients had to cross corridors designated for patients of the other gender to reach bathrooms.
- The layout of the wards did not allow staff clear lines of sight of patients. These were not mitigated by the use of mirrors to cover all areas of the ward.
- Overall compliance for mandatory training did not meet the trust's set targets.
- The trust policy on seclusion did not safeguard patients around nursing, medical and independent review as per the requirements in the Mental Health Act Code of Practice.
- Blanket restrictions were in place on most wards we visited.
- Safeguarding was not being reported properly.
- The fridge temperatures on Beech, Rowan and Davenport ward were above the required temperature levels.
- The trust should ensure prone restraint be avoided due to the increase risk from positional asphyxia.

However:

- The wards were clean, tidy and well maintained. The clinic rooms were fully equipped. Emergency equipment was checked regularly.
- Staff completed ligature risk assessments and environmental checks.
- The wards provided sufficient staff to keep patients safe and when agency staff were used, these were usually staff that were familiar with the wards.
- Staff only used restraint as a last resort.
- Staff completed patients' risk assessments.
- Staff knew how to report incidents.
- There were good medicines management practices in place.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

Summary of findings

- Most patients on Saffron ward were being cared for and treated in their best interests but there were no formal considerations of these best interests and no consideration whether the restrictions faced by patients on Saffron amounted to a deprivation of liberty.
- On most other wards, where significant decisions were made (for example, to give medication covertly or use restrictive holds to provide basic care), these decisions were not always supported by staff fully considering the best interests of patients and recording those decisions.
- Staff completed life story work with patients with dementia to enable them to provide person centred care, which took account of people's lives and interests, but this was rarely reflected in patients' care plans.
- Records did not clearly show that detained patients had been referred for support from an independent mental health advocate or whether a second opinion appointed doctor had been requested in a timely manner.
- Patients on some wards did not have meaningful activities because there was limited occupational therapy input and nursing staff were too busy attending to patients' basic care needs.

However:

- Staff considered patients' physical health needs on admission and on an on going basis. Staff took action to ensure that patients' physical health needs were monitored and treated.
- There were good systems in place to ensure the Mental Health Act was followed.
- There was effective multidisciplinary working in most teams and good working relationships between allied health professionals.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- On Rowan and Cedars ward, patients who had difficulty communicating were not always cared for appropriately. On some occasions, staff failed to anticipate patients' needs or provide the right help to resolve their distress.

However:

- All patients we spoke with told us they were treated in a kind, caring and respectful manner.
- The staff knew their patients well and had taken time with relatives to gather information about patient likes and dislikes.

Summary of findings

- Carers and relatives were mostly informed and kept up to date about their relatives' care and treatment.
- Friends and family tests had been introduced on most wards and the majority of responses were positive.
- The scores for the patient led assessments of the ward environment looking at dignity and wellbeing were all above the England average.
- Staff spent time orientating patients when first admitted to the wards.
- Patients and their family members were encouraged to be actively involved in the care and treatment of their family members.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Whilst the bed occupancy was, high on most wards, most patients were admitted to their local catchment area and where this was not possible, patients were admitted but then repatriated to the local area as soon as a bed became available.
- Ward staff planned discharge and involved multidisciplinary teams, families and carers.
- There were systems in place to manage complaints.
- All wards had access to advocacy services.
- Wards had access to specialist feeding aids and met patients' individual dietary needs such as soft food and food supplements.
- Patients were able to personalise their bedroom areas.
- Information leaflets were available in other languages should these be needed.
- Wards were accessible to patients who had a disability.
- A choice of foods to meet dietary and religious requirements was available on the wards.
- Whilst Cedars ward was small and crammed and this was not conducive to meeting patient needs, the trust had plans to address the environmental limitations

However:

- When patients presented with extreme challenging behaviour, there were no psychiatric intensive care beds for older people in the trust of the locality.
- Local access to appropriate discharge placements such as older people's mental health nursing facilities had caused patients' discharges to be delayed in some areas.
- Dementia friendly signage on the wards was limited.

Summary of findings

- Patients could not always access outside space due to the doors being routinely locked.
- Activities were provided on the wards but these were limited on most wards and there was poor access to psychological input on most wards.

Are services well-led?

We rated well led as requires improvement because:

- Managers had not taken sufficient action to resolve issues with mixed-sex accommodation, ward layout, implementation of the Mental Capacity Act and quality of patient care.
- The shortfalls we found in the trust guidance around same sex accommodation, person centred care, consent in relation to the Mental Capacity Act and the Deprivation of Liberty Safeguards and staff mandatory training highlighted gaps in the governance arrangements.

However:

- The staff were aware of the trust's vision and values and these were displayed throughout the wards.
- The trust was developing an older people's mental health strategy.
- The trust had a governance structure in place and the learning from incidents, complaints, compliments and incident reviews was shared throughout the wards.
- The trust has implemented the safer staffing agenda and had increased staffing on wards where patient need and acuity levels have been identified.
- Ward managers had the autonomy to increase staffing levels on the wards when patients' acuity increased.
- Staff were highly positive about working for the trust and all felt supported in the positions they were in.

Requires improvement

Summary of findings

Information about the service

Pennine Care NHS Foundation Trust had nine older people's mental health wards across Bury, Rochdale, Oldham, Tameside and Stockport. The wards provided assessment, treatment and care for people aged 65 years and older who have a functional mental health problem (such as depression, schizophrenia or bipolar disorder) or organic mental health problems (such as dementia).

These were:

The Meadows at Stockport

- Rosewood ward was a ten bed ward for male and female patients with organic mental health problems.
- Saffron ward was a 20 bed ward for male and female patients providing a step down service for patients suffering from predominantly delirium, dementia and depression.
- Davenport ward was a 20 bed acute ward for male and female patients providing assessment and treatment to patients mainly with functional mental health problems.

Oldham mental health services –

- Rowan ward was a 12 bed ward for assessment and treatment of functional mental health problems for older people.
- Cedars ward was a ten bed ward for male and female patients for older people with organic mental health problems.

Rochdale mental health services -

- Beech ward was a 14 bed ward for male and female patients providing treatment to patients who experience an acute deterioration of their mental health.

Bury mental health services –

- Ramsbottom ward was a 12 bed ward for male and female patients providing care and treatment for patients experiencing organic and functional illness.

Tameside mental health services –

- Hague ward was a 14 bed ward for male and female patients providing care and treatment for patients with moderate to severe functional mental health problems.
- Summers ward was an 11 bed ward for male and female patients for older people experiencing organic mental health problems.

Our inspection team

Our inspection team was led by:

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

Head of hospital inspection: Nicholas Smith, Care Quality Commission (CQC)

Team Leaders: Sharron Haworth (mental health) and Julie Hughes (community health) inspection managers, CQC.

The team that inspected wards for older people was comprised of four CQC inspectors, a pharmacist inspector, a CQC Mental Health Act reviewer and five specialist advisors which were a consultant psychiatrist, an occupational therapist, a nurse manager, a social work manager and a social worker.

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of 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 held about this service and asked other organisations to share what they knew. We carried out announced visits on 14-16 June 2016 and an unannounced visit on 22 June 2016 to two wards.

The inspection took place across all wards for older people.

During this inspection;

- We visited all nine of the wards at the five hospital sites
- We looked at the quality of the ward environment
- We observed how staff were caring for patients
- We spoke with 20 patients and 17 carers
- We received eight comment cards from people who used the service
- We spoke with the managers for each of the wards, the modern matron, two ward sisters, and two service managers
- We spoke with 43 members of staff from a range of disciplines and roles. Staff we spoke with included doctors, nurses, psychologists, a speech and language therapist, occupational therapists, nursing assistants, student nurses, a cleaner, pharmacists and an advocate
- We looked at 49 care records and 11 Mental Health Act records and 21 prescription charts
- We attended five multidisciplinary team meetings and three handover meetings
- We observed care on three wards, including using a formal observation tool called the short observation framework for inspection
- We observed two patient community meetings
- We observed two mealtimes to check that patients were supported to receive good nutrition and hydration
- We looked at all of the clinic rooms
- We looked at the arrangements for the management of medicines
- We looked at records about the management of the service including policies, minutes of meetings and results of audits.

What people who use the provider's services say

We spoke with 20 patients and 17 carers. They all reported staff treated them well and were all caring, kind and respectful. All patients were complimentary about staff and most said they felt safe. One patient on Saffron reported small items had gone missing. On Rowan ward, one patient commented there were not enough activities on the wards because staff were always busy with other patients. Patients generally commented about the lack of activities on the wards.

Summary of findings

As part of the inspection, we left comment cards boxes at various locations across the trust for people to tell us their experiences. We received six comment cards; five were from Summers ward and one was from Rosewood ward. These were all positive stating the staff were caring, patient, respectful and professional. One card stated the staff patience was limitless; their relatives had received the best care possible, staff answered questions about their family member truthfully and were always available. Another card stated the staff and carers had done everything in their power to give them the assistance they needed, and that they were truly grateful for the assistance they were receiving, "excellent".

We carried out a short observational framework for inspection on three wards. The short observational framework for inspection was a tool used to capture the experiences of patients who may not be able to express this for themselves. During our observations, we saw staff attended to most patient needs in a reactive way on Rowan and Cedars ward with some patients' needs not being addressed in a timely manner. Some patients were not stimulated and slept or were unresponsive within the ward environments.

Good practice

- Saffron ward was an innovative partnership between the acute medical ward at the local acute NHS trust, a local GP practice and the mental health trust to provide on-going care and treatment for patients with delirium which is acute confusional state brought on by a physical health condition. This helped to ensure that patients with delirium were not inappropriately placed on an acute medical ward.
- On Beech ward, the pharmacist provided a weekly drop-in session for patients, families and carers. They met with the family group to provide information on any of the medicines that the person was prescribed and discuss treatment options that then could be discussed with the medical team.

Areas for improvement

Action the provider MUST take to improve

The trust must ensure that arrangements for single sex accommodation are adhered to in order to ensure the safety, privacy and dignity of patients. The bathrooms should be available for members of each sex to use without passing areas occupied by a member of the opposite sex. There must be a dedicated female only lounge on each mixed sex ward.

The trust must ensure that when patients on Saffron ward who lack capacity are subject to restrictions, which may amount to a deprivation of liberty, staff consider the appropriate framework for providing care and treatment. This may include consideration of best interests as detailed in the Mental Capacity Act Code of Practice, the Mental Health Act or the Deprivation of Liberty Safeguards.

The trust must ensure that staff are provided with relevant updated training to keep them informed of important changes in Mental Capacity Act and Mental Health Act law.

The trust must ensure that patients on Rowan and Cedars ward receive person centred care that meets and anticipates their needs, including through improved activities.

The trust must ensure staff have received their mandatory training particularly in relation to intermediate and basic life support, conflict resolution level, and the management of violence and aggression level adapted for physical intervention with older people. Staff working in dementia care should receive formal training about dementia.

Summary of findings

Action the provider SHOULD take to improve

The trust should continue to improve the environment of the wards to provide better spaces for the care of patients with dementia or organic illness, in particular continue to improve the environment of Cedars ward to provide more communal space suitable for patients with significant cognitive impairment.

The trust should ensure prone restraint be avoided due to the increase risk from positional asphyxia.

The trust should ensure that where wards admit patients with cognitive impairments or with dementia then the wards provide dementia friendly environments and activities to meet individual needs and enrich the lives of these patients.

The trust should ensure that it improves the governance arrangements at Oldham's older people's wards through improved safeguarding action following incidents.

The trust should ensure they improve the safeguards regarding episodes that meet the threshold of seclusion.

The trust should ensure that standards of record keeping improve in the following areas:

- The recording that qualifying patients are informed of the independent mental health advocacy service and timely action where a patient does not understand their rights.
- The recording of the request to receive a second opinion appointed doctor.
- The recording of best interest considerations where significant decisions are made.

The trust should ensure that appropriate action is taken in line with agreed actions within the provider action statement provided following a Mental Health Act monitoring visit.

The trust should ensure that blanket restrictions are reviewed and where appropriate removed. To ensure all decisions about restrictions are made on an individualised basis.

Pennine Care NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Rosewood ward, Saffron ward, Davenport ward	The Meadows
Rowan ward, Cedars ward	Oldham Mental Health Services
Beech ward	Rochdale Mental Health Services
Ramsbottom ward	Bury Mental Health Services
Hague ward, Summers ward	Tameside Mental Health Services

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

On this inspection, we reviewed care and treatment of patients detained under the Mental Health Act. We found :

- The wards adhered to the Mental Health Act and Mental Health Act Code of Practice.
- There were good checklists and proformas provided by the trust to ensure the correct papers were available on the ward for each detention episode.
- Mental Health Act administrators sent through as a weekly ward report which showed any key actions that ward staff needed to take to ensure deadlines were met under the Mental Health Act.
- Detention paperwork was orderly up to date and stored appropriately.

- There were records relating to consent and capacity to consent to treatment for decisions around treatment for mental disorder given to detained patients.
- Patients were informed of their rights and where patients lacked capacity, their rights were repeated.

However we also found that there were some shortfalls on a small number of patient files:

- While recording of leave was largely good, on Ramsbottom ward it was not always clearly recorded whether relatives were given a copy of the section 17 leave form when they were acting as escorts as part of the conditions of leave.
- On two records, it was not clearly recorded whether a second opinion appointed doctor had been requested in a timely manner.
- Whilst independent mental health advocates proactively visited the wards, records did not clearly show that detained patients had been referred for support from an advocate or whether there was consideration if the patient would benefit from advocacy support.
- One patient was nursed in the low stimulus area and prevented from having contact with his peers. There was no clear indication of why the restrictions placed upon this patient was not considered as seclusion as defined in the Mental Health Act Code of Practice and the safeguards this contains.
- We did find a small number of continued issues with areas we identified in Mental Health Act monitoring reports where the trust told us that they had taken action. For example in the trust provider action statement for Cedars and Rowan wards, the ward managers stated that to further assure themselves that the action was embedded, they would carry out regular audits but we found that these audits had not taken place on a regular basis.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that:

- Patients on Saffron ward were subject to a number of restrictions. There had been no formal consideration of what could be done to reduce or remove these restrictions to ensure that patients were not arbitrarily deprived of their liberty.
- The Deprivation of Liberty Safeguard Code of Practice does recognise that patients who are subject to acute confusional state may be deprived of their liberty for a short period where there is likely to be a rapid resolution of their condition. However, all of the incapacitated informal patients had been on Saffron ward for over seven days and many much longer. There were no formal considerations of these best interests recorded for the majority of the incapacitated informal patients on Saffron ward.
- There had been no consideration of recent important case law for patients on Saffron ward, known as the Cheshire West case, which provided clarity on when a deprivation of liberty should be considered in such cases.
- On most other wards, where significant decisions were made such as decisions to give medication covertly or use restrictive holds to provide basic care, these decisions were not always supported by staff fully considering the best interests of patients and recording those decisions and often just recorded family being consulted.
- The trust had a proforma to record best interest considerations but we did not find this completed for relevant significant decisions on the files we looked at and staff confirmed that they did not routinely use it.
- Staff had some understanding of their responsibilities in undertaking mental capacity assessments when they were the principal decision maker.However, there were some gaps in understanding for example staff in Stockport did not fully understand the implications of the Cheshire West decision.

However we also found that;

Detailed findings

- Apart from Saffron ward, on most other wards patients were cared for and treated under a legal framework such as making a capacitated decision to stay as an informal patient or patients were detained under the Mental Health Act.
- On some wards, there was evidence that Mental Capacity Act audits had occurred to promote good practice and benchmark against the Mental Capacity Act Code of Practice.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

Most of the wards we visited had no blind spots so staff could observe patients in all parts of the wards. However, Beech, Hague and Summers ward had some blind spots. These were mitigated by the positioning of staff throughout the ward but could be further improved by the positioning of mirrors. Davenport ward had some mirrors fitted but these did not cover all areas in the ward.

Each ward we visited had a current ligature risk assessment completed. The ligature audit tools identified each ligature point with its own rating dependent on amount of time a patient would spend in each area and the amount of supervision they would receive. The trust information we reviewed indicated the sites with the highest average scores for ligature risks were Rowan and Cedar wards, both based in Oldham. Rowan ward had a bedroom modified for patients who were a higher risk of ligature with door alarms fitted should any weight be applied. The ligature risk assessment identified four ligature risks with comments on the ligature assessment stating to record, monitor, and manage the risks. Staff managed the risks with observation and ongoing risk assessment.

Six out of nine wards we visited complied with the same sex guidance for inpatient accommodation. However, Summers, Rosewood, Cedars did not. Patients on these wards were not segregated and patients had to walk through a corridor area with On Summers ward, there was only one bath on the ward in full operation and the patients' bedrooms were not fully en suite as they only had a toilet and hand wash basin in the bedrooms. This meant that males using the bath would have to pass by female bedrooms to get to it.

Female patients on Cedars ward were not able to access the female lounge unsupervised, as this had been assessed as un safe as there were no nurse call points. Female patients were only able to access this area with a member of staff present. As staff were not always in this area during our visit this area was locked to prevent access reducing the space available for patients to use. Rosewood ward had designated female only lounge but there was no signage to indicate this was a female only lounge.

Each ward had a fully equipped clinic room with accessible resuscitation equipment that was checked regularly. Medicines requiring refrigeration were stored appropriately and temperatures were monitored. The trust had completed an audit in relation to safe and secure handling of medicines and safe management of medical gases for mental health services produced in January 2016. The results indicated that six out of nine older people's wards were at 100% compliance. The three wards that were not were Ramsbottom, Beech and Davenport ward. These wards saw a minor decrease in the level of compliance compared to the previous audit. The trust has an action plan in place to address the issues identified and plans to re audit compliance.

All of the wards we visited were clean and well maintained with good furnishings. The trust completed an infection prevention and control, environmental audit of inpatient areas from July 2013 to January 2016.The audit assessment was based on standards in relation to cleanliness and maintenance of ward areas, storage of equipment and linen, infection control and hand hygiene measures, and handling clinical waste and sharps.

The audit result figures over this period showed an increase from 94 to 96% within the trust compliance rate of 90% in the older people's ward areas. The most recent audit January 2016 results showed the site with the highest number of medium risks was Beech ward. They were amber rated because commodes were dirty and on the medical equipment trolley, one item was out of date. Older people's services achieved an overall mean compliance rate of 96%, above the trust compliance rate of 90%.

The scores for cleanliness in the patient led assessments of the care and environment showed that Pennine Care NHS Foundation Trust was at 99%, which was above the national average of 98%. The patient led assessments of the care environments identified that all of the older people's wards we visited were above the national average. There was dedicated domestic support and appropriate cleaning schedules in place on the wards we visited. There were alcohol gels on the entrance to the wards for staff and visitors to use to prevent infections being carried onto the wards. Environmental risk assessments were undertaken regularly on the wards we visited.

Requires improvement

Are services safe?

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

Appropriate health and safety checks had been carried out on equipment such as checks on the fire extinguishers throughout the wards and appropriate electrical testing was in place.

There were nurse call systems in most patient areas and bedrooms. Cedars ward did not have an alarm system installed in the dedicated female lounge/activities room although this was not accessible without staff being present.

Safe staffing

The staffing levels for each ward were as follows:

Bury – Ramsbottom Ward

- Nine qualified staff
- Twelve unqualified staff
- There were no staffing vacancies
- Between 1 May to 31 May 2016, 102 of 104 required shifts were covered by bank and agency staff.

Oldham - Cedars ward

- Nine qualified staff
- Eight unqualified staff
- There were two qualified nurse vacancies
- Between 1 May to 31 May 2016, 339 of 368 required shifts were covered by bank and agency staff.

Oldham - Rowan ward

- Ten qualified staff
- Nine unqualified staff
- Three qualified nurse vacancies and two unqualified vacancies
- Between 1 May to 31 May 2016, 284 of 292 required shifts were covered by bank and agency staff.

Stockport - Davenport ward

- 11 Qualified staff
- 13 unqualified staff
- Three nurse vacancies
- Between 1 May to 31 May 2016, 203 of 210 required shifts were covered by bank and agency staff.

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Stockport - Rosewood ward

- Nine qualified staff
- 13 unqualified staff
- Two nurse vacancies and one unqualified vacancy
- Between 1 May to 31 May 2016, 123 of 136 required shifts were covered by bank and agency staff.

Stockport - Saffron ward

- 12 qualified staff
- 25 unqualified staff
- Four nurse vacancies and ten unqualified vacancies.
- Between 1 May to 31 May 2016, 153 of 160 required shifts were covered by bank and agency staff.

Tameside - Hague ward

- Ten qualified staff
- 11 unqualified staff
- Two nursing vacancies
- Between 1 May to 31 May 2016, 117 of 123 required shifts were covered by bank and agency staff.

Tameside – Summers ward

- Ten qualified staff
- 15 unqualified staff
- Two unqualified vacancies
- Between 1 May to 31 May 2016, 160 of 172 required shifts were covered by bank and agency staff.

Rochdale - Beech ward

- Ten qualified staff
- 13 unqualified staff
- Two qualified and two unqualified vacancies
- Between 1 May to 31 May 2016, 130 required shifts were covered by bank and agency staff.

The staff sickness levels reported by the trust from 1 May 2016 to 31 May 2016 indicated that of the nine older people's wards, Rowan had the highest percentage of staff sickness (15%) then Cedars ward with 14% and Ramsbottom ward with 12%. The lowest figures were Hague ward with 3% and Davenport with 3% sickness levels.

Expected and actual staffing levels were written on a board outside each ward. The trust did not use a staffing tool or staffing needs analysis to determine the number and grade of nurses required on any given ward. The trust stated they had calculated their staffing levels from a model that had evolved over time based on clinical judgement but that work was on-going with staffing model tools.

Requires improvement

Are services safe?

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

The number of staff on duty on each shift matched that of the establishment for each ward. However, Rowan ward manager was incorporated into the nursing establishment and they also provided cover to oversee treatment in the nearby electroconvulsive therapy suite two days a week. This meant that Rowan ward could at times be left with one nurse in charge of the ward and the ward manager had limited time to manage the ward.

Managers were able to adjust their staffing levels to take into account patient mix on the wards as well as increasing staffing levels when patients' levels of observation increased. All managers were clear that they had sufficient authority to increase staffing levels dependent on patient need.

All of the wards used bank and agency staff. This was highest on Cedars ward with 339 and on Rowan with 284 shifts being filled. However, we found that where possible agency and bank staff who were familiar with the wards were used.

A qualified nurse was always available on the wards at all times. However, we found one shift on Rowan ward had not been able to fill a nursing shift. This was managed with the use of a nurse from the adult wards on site.

We found there were enough staff on most of the wards we visited. However, on Rowan and Cedars ward we found that although staffing levels were safe they did not always allow for meaningful therapeutic input from nurses and others. We found on Rowan ward the levels of acuity and the number of patients with an organic illness mixed with the number of functional patients had affected the levels of direct therapeutic care and activities. This also meant that patients did not always receive their one-to-one care. The manager on the ward confirmed this. On Cedars ward, therapeutic activity and one-to-one quality time was limited due to the physical care needs of patients. This was confirmed during our formal observations of care on the unannounced part of the inspection. The trust had already increased the staffing on Cedar ward above the ward establishment. Following the inspection, we raised the need for improved therapeutic engagement on these wards. The trust informed us that they would further recruit an additional 3.8 whole time equivalent permanent nursing assistants. They were also increasing the share of occupational therapy input on Cedars ward by increasing the staffing establishment by an additional occupational therapy and technical instructor post.

Staff told us that escorted leave or ward activities were rarely cancelled. Where this occurred, it was an exception due to staff sickness or training and activities or planned leave would be rearranged. The trust informed us they do not routinely collect information about cancelled or delayed leave or activities.

Staff and ward managers told us there was adequate medical cover day and night and a doctor was able to attend the ward quickly in an emergency. Where the wards were based at a local acute hospital site then access to the on call doctor was available.

Overall, there were fluctuating rates of compliance with mandatory training. Rowan ward had the lowest compliance rate for mandatory training at 82%. There were wards where some training fell below 75% compliance. These were:

- Cedars ward - basic life support target: 95% the compliance figure was 37.5%, Intermediate life support target: 60% the compliance figure was 17%, Information governance level 1 target: 95% the compliance figure 69%.
- Rowan Ward - moving and handling level 2 target: 75% the compliance figure was 73%, conflict resolution level 2 target: 95% the compliance figure was 73%, basic life support target: 95% the compliance figure was 57%, intermediate life support target: 60% the compliance figure was 29%.
- Ramsbottom ward - intermediate life support target: 60% the compliance figure was 25%, child safeguarding level 2 target: 75% the compliance figure was 71%.
- Rosewood ward - moving and handling level 2 target: 75% the compliance figure was 63% ,infection control level 2 target: 95% the compliance figure was 70%.
- Saffron ward - child safeguarding level 2 target: 75% the compliance figure was 67%.
- Davenport ward - infection control level 2 target: 95% the compliance figure was 67%, child safeguarding level 2 target:75% the compliance figure was 63.5%.

Mandatory training rates in relation to basic life support were below the trust target on the older people's wards with eight out of nine wards not attaining the trust target rates of 95%. We were concerned that mandatory training rates in relation to basic life support were 37.5% on Cedars ward and 57% on Rowan ward.

Requires improvement

Are services safe?

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

The trust policy stated that staff undertaking manual restraint physical interventions had to complete immediate life support and basic life support. The intermediate life support training for staff had a compliance target of 60% of staff on each ward to have completed. Figures indicated six out of nine wards had staff trained and reached their target. There were three wards where intermediate life support figures fell well below required levels. These were Cedars ward with only 17% of required staff trained, Rowan ward with 29% of required staff and Ramsbottom ward with 25% of required staff. This meant that staff were not fully kept up-to-date to respond appropriately in a medical emergency.

Assessing and managing risk to patients and staff

There were no seclusion rooms on the wards and if a patient required nursing that is more intensive, they would have to access one of the adult psychiatric intensive care beds within the trust. Managers reported an issue in accessing these types of beds, as there were no specialist older people's challenging behaviour facilities in the locality.

On Cedars ward, one patient had recently been nursed in a low stimulus environment. This involved a patient with significant cognitive impairment who presented with management of violence and aggression issues being cared for in their cleared bedroom. There was a care plan in place around nursing this patient within a low stimulus environment and the rationale for separating this patient from other patients was recorded.

The trust's policy permitted the care of patients in a separate area under circumstances other than formal seclusion. While staff followed this policy, we consider that the events described above did amount to seclusion. The safeguards afforded by the policy around nursing, medical and independent reviews fell short of the requirements of the Mental Health Act Code of Practice for seclusion.

The trust had a violence reduction policy with positive and proactive interventions in place. The policy stated that where restrictive interventions were used they must always be done as a demonstrable last resort, using the least restrictive option and never involve the deliberate application of pain. The trust policy stated that the multidisciplinary team would carry out a review of the incident as soon as is practicable and a risk management plan would be produced.

The trust provided data to show there were 164 uses of restraint used across the nine wards between 1 December 2015 to 31 May 2016. The highest uses were reported on Cedars ward with 63 episodes and Davenport ward with 26 episodes. Cedars ward reported three uses of restraint in the prone position and Summers ward one. Prone restraint is when patients are placed faced down whilst being held by staff. National guidance states that prone restraint should be avoided where possible. This is because there are dangers with prolonged prone restraint such as patients being at higher risk of respiratory collapse. All of the four prone restraints used also administered rapid tranquilisation. The trust policy states that face down or prone restraint should be avoided where possible and minimised when staff are not able to avoid its use. In assisting with chemical restraint or in any other circumstance, prone restraint must be under five minutes in duration with turning into supine position (face up) as soon as the intra muscular injection is provided. The incident data we checked informed us that the restraints in this position were to administer medication and the small numbers of cases were mostly upon the patient's bed and where the patient had manoeuvred into a position where this was held for a short period of time. Prone restraint on beds should be avoided due to the increased risk from positional asphyxia. Staff we spoke with stated restraint was only used as a last resort only after de-escalation had failed. We did not see any restraint being used during our visit.

Staff on the older inpatient wards completed specific training in de-escalation and the use of restraint techniques in addition to conflict resolution level 2 training. Advanced training for all staff working with older people was required where restraint was required. This training required a refresher every 12 months according to the trust violence reduction policy.

The figures for Cedars ward that had with the highest use of restraint indicated their training of staff in conflict resolution level 2 was at 93% against a trust target of 95%.

Davenport ward, which was the second highest use of restraint, had 100% of staff trained in conflict resolution level 2. Rowan ward had the lowest number of staff trained in this area and the figures were 73%. Four out of nine wards had met the trust targets in training staff in this area.

We looked at 49 care records. Risk assessment of every patient had been completed on admission. The staff used a

Requires improvement

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trust approved risk assessment. The wards updated risk assessments during weekly reviews of patients or daily if required. Where patients were already known to mental health services, paper records were also available and access to local computerised systems stored the most recent risk assessments.

We found that falls risk assessments were completed and a malnutrition tool was used to identify patients who were at risk of undernutrition.

Staff had made efforts to remove or reduce blanket restrictions on the wards. Most patients could access their bedrooms throughout the day on the wards, however during our unannounced return visit to Cedars ward patient bedrooms were locked. A carer confirmed the bedrooms were always locked and they had been given the keys on the day of our initial visit. Staff confirmed that the doors to patient bedrooms were kept locked. They said that this was because of patient acuity levels. Although during our initial visit to the ward, we saw that some patients were in their bedrooms.

Not all patients had continual access to fresh air. The exceptions to this were Hague and Davenport wards in Stockport where there was a small enclosed courtyard, which was open all the time. On other wards, the doors to the garden areas were locked and patients could only access the gardens with staff supervision and/or carer supervision and where patients asked to go into the garden area. This would be difficult for some of the patients to ask staff due to their cognitive impairment.

There were some restrictions on supervised smoking and wards had set smoking times. We did however see on Rowan ward that where a patient wanted to smoke this was facilitated more frequently. Hague ward informed us the trust provided access to nicotine replacement for patients and this was assessed on admission.

All of the wards we visited had locked front doors with information displayed on the ward doors to inform informal patients of their right to leave the wards at will. Entry to and exit from the wards was controlled by a keypads or the use of swipe cards. Staff told us the doors to the ward areas were locked to keep patients safe. Patients on Hague and Davenport ward had access to drinks 24 hours a day. However, the other wards did not, but provided regular drinks and snacks throughout the day.

The trust had policies in place for the use of observations and staff were able to explain these to us. Staff were visible throughout the ward patient areas so that they could observe patients who were at risk to themselves and others and to minimise the risks from any identified ligature points. General observations of all patients were in place.

Most staff understood their responsibilities in reporting safeguarding concerns. However, staff on Rowan ward had not reported potential safeguarding incidents to the local authority. We reviewed 55 incidents reported on this ward over a six month period and of these, there were 11 potential safeguarding issues. These had not been reported due to the trust judgement ratings of these incidents. We reviewed the trust policies and procedures in place and clinical governance adult safeguarding integrated governance flow chart as well as the chart for categorisation of incidents trust wide. There were five grades in the trusts classification of incidents.

- Grade one in safeguarding adults stated; safeguarding concerns resulting in initial investigation does not proceed to safeguarding alert.
- Grade two was not listed,
- Grade three stated; alleged abuse, inclusive of criminal offence, neglect, physical abuse, radicalisation, institutional abuse, sexual abuse etc. Discuss with your line manager and safeguarding team. Referral to social care.
- Grade 4 stated; Actual abuse, inclusive of criminal offence, neglect, physical abuse, radicalisation, institutional abuse, sexual abuse etc.Discuss with your line manager and safeguarding team.Referral to social care.

These identified some issues about staff reporting via their incident reporting system and identifying safeguarding via a tick box and gaps in the grading's of safeguarding classifications and the governance flowchart. The safeguarding integrated governance flow chart clearly states report on the electronic safeguard, which staff use to report all incidents. It also states to complete and send safeguarding alert/notification to the local safeguarding team.

Incidents were graded. Lower level incidents (levels one to three) were managed locally at ward level and level four to five incidents were reviewed by locality managers. All

incidents were reviewed by the ward managers other senior staff and peers in the organisation. Where potential safeguarding issues were highlighted then these would be reviewed by the senior managers and escalated to the local authority safeguarding multi-agency teams where necessary. The trust had an identified safeguarding nurse and where staff were unsure about reporting an incident under safeguarding then they would be available to discuss any alerts. Staff we spoke to had a good understanding of safeguarding procedures and what to do when faced with a safeguarding concern and most apart from Oldham were aware of the local authority procedures in place.

On Rowan ward, we reviewed an incident that should have been reported via safeguarding. Records confirmed that although it had been reported on their incident reporting it had not been escalated to the local safeguarding team. The manager and service line manager confirmed that this incident should have been reported but action had been taken to safeguard the patient.

Beech ward had two ongoing safeguarding alerts, Ramsbottom ward had three, and Saffron and the Meadows had two each.

Training in safeguarding adults and safeguarding children was mandatory for staff. Safeguarding adults, training was an on-line training session. Safeguarding training in the trust indicated a trust compliance target of 95% of staff should be trained in safeguarding adults but figures in Stockport showed only 83% of staff were up-to date with their safeguarding adults training and 83% were up-to-date with safeguarding children training. The other geographical areas where the wards were located indicated 100% of staff being trained in safeguarding adults and most with safeguarding children training.

There were good medicines management practices in place on all of the wards. Regular audits were in place and pharmacists were accessible and present on the wards. Fridge temperatures were being recorded and where the temperatures were found to be incorrect, these were reported to estates management. The fridge temperatures on Beech, Rowan and Davenport ward were above the required temperature levels with no clear action following these high results. This could mean that medicines kept in the refrigerator were not fit for use. Medicines reconciliation was good with the wards faxing and informing GPs of medicines upon discharge. Patients' medicines were reconciled within 24 hours of admission from Monday to Friday. (Medicines reconciliation is the process of ensuring that all the medicines a patient needs are correctly prescribed on their hospital chart). The pharmacist on-call for the acute trust could be contacted 'out of hours'.

Records we looked at confirmed the wards had contacted the GPs on admission to the wards to seek updated information about individual medication.

Nurses told us that the trust's pharmacy staff provided an excellent service. We saw that pharmacists clinically checked prescriptions.

Staff were aware of addressing and reporting any outlier issues for example falls and or pressure ulcers and their electronic incident recording captured this data. A falls risk assessment was completed for patients where mobility issues were identified. There was a trust falls management group that monitored the number of incidents on the wards. Where there was a marked increase of incidents on a particular ward, then these were identified and discussed with actions to review and reduce the number of falls on older adult in patient wards.

Track record on safety

There were six serious incidents reported that required investigation between 24 January 2015 and 21 October 2015. There had been one on Davenport ward, three on Rosewood, one on Saffron and one on Rowan ward.

The incidents related to infection control incidents and an unexpected death of a patient. These incidents were incidents that required investigation by the trust.

Reporting incidents and learning from when things go wrong

Incidents were being reported on each ward. Staff we spoke with knew how to report incidents on the electronic risk management system used by the trust. Staff were able to describe what incidents should be reported. The system escalated notification of incidents to ward managers, and appropriate senior managers, dependent upon the severity. This ensured that senior managers had oversight of all incidents reported on each ward, who then could escalate toward appropriate investigation.

The trust produced a regular briefing and newsletter to staff that summarised information across the trust in relation to incident investigations, complaints outcomes and other events where learning was identified. We were informed by managers that this briefing was discussed in

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team meetings and supervision allowed staff to meet to discuss any feedback about lessons learnt as well as the newsletter. This helped to ensure lessons were learnt across staff groups and not just at the location where the incident originally occurred. Staff and ward managers reported access to debrief and support from their managers should this be needed following an incident as well as staff support.

The manager on Rowan ward identified learning from an incident relating to a patient swallowing a wipe. This promoted a change in practice where no wipes would be left in patient bedrooms.

Records confirmed that families and carers were informed of any incidents that were reported on their incident recording system.

Duty of candour

Staff were aware of the duty of candour requirements and the need to be open and transparent and explain to patients when things go wrong. Duty of candour regulations ensure that providers are open and transparent with patients and people acting on their behalf in general in relation to care and treatment. They set out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The incident reporting data had a checklist on the incident report to confirm if the incident required staff to take action to meet duty of candour requirements. During our inspection incident, reporting records confirmed that carers actually did receive a telephone call to inform them of a trust reported incident had happened to their relative.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

We looked at 49 care and treatment records of patients across the wards for older people. Patients had well-documented assessments and care plans that described how their needs would be met. Assessments included both medical and nursing assessments. Care plans were often standardised core care plans with some effort made to make them individualised. Well-being care plans were in place and these provided detailed information for when patients were discharged.

Care plans were reviewed on a weekly basis by nursing staff. However, this was often a brief review, which often only outlined whether the care plan was still required or not. The review did not comment on outcomes for patients, recovery principles, the efficacy of the care or treatment or the involvement of the patient in the review.

On most wards, staff provided effective care to patients. However, we found that patients on Cedars ward did not receive person centred care that met their needs, as there was a lack of meaningful activities. The occupational therapy input was limited to 18 hours split between two wards and there was no activities co-ordinator or technical instructor to facilitate appropriate meaningful activities. There was no programme of cognitive stimulation in evidence on the ward and staff were too busy providing personal care to provide meaningful activities in the absence of occupational therapy or a programme of activities.

Staff considered patients' physical health needs on admission and on an ongoing basis. Staff took action to ensure that patients' physical health needs were monitored and treated including consideration of physical health problems that required treatment or further investigation. There were appropriate investigations to rule out a physical health cause when people were referred with confusion or suspected early stages of dementia. The physical health checks included checks for deep vein thrombosis, this is important in older people due to their age and them becoming immobile.

There were multiple patient recording systems including separate consultant psychiatrist records, paper records and some electronic records. Records were stored securely on the wards we visited and staff were able to locate information we asked for in a timely manner. The trust was in the process of rolling out a fully electronic recording system, which would mitigate these issues in the older people's wards.

Best practice in treatment and care

Staff across the wards for patients with dementia staff worked with patients, relatives and carers to receive accurate information about patients' life stories. This ensured staff provided care and treatment to patients with dementia, which was individualised and respected patients' personhood in line with recognised research into providing quality dementia care. Staff were able to tell us about the lives and interests of patients in their care but this was rarely reflected in patients' care plans. The exception was Cedars wards where care plans did reflect patients' individual needs and clearly stated patients' interests.

Staff had completed malnutrition universal screening tool for relevant patients with corresponding care plans. Staff used the modified early warning system tool to help monitor patients' physical health care needs.

Some patients were receiving electroconvulsive therapy. Electroconvulsive therapy is a psychiatric treatment in which seizures are electrically induced in patients to provide relief from psychiatric illnesses. We saw that staff followed National Institute for Health and Care Excellence guidance on treating patients with electroconvulsive therapy including limiting the number of electroconvulsive therapy episodes, ensuring physical checks pre and post therapy and ensuring appropriate consent had been obtained from the patient or a second opinion appointed doctor. One patient on Davenport ward commented on her experience of receiving electroconvulsive therapy stating that they felt that they had benefitted from it and felt that their mood was much improved. The manager of Rowan ward at Oldham was also managing the provision of electroconvulsive therapy two days per week at the suite in Oldham.

Staff were following National Institute for Health and Care Excellence guidance when caring for patients with psychosis. For example, safe prescribing was considered resulting in most patients being given one, rather than multiple, antipsychotic medication. Where it was clinically necessary to give more than one antipsychotic or one antipsychotic above British National formulary guidance, this followed rules for the prescribing and on going

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monitoring of high dose antipsychotics. The medicines charts we checked confirmed this. The trust also confirmed that doctors in training had completed an audit from August 2015 to January 2016 regarding their adherence to antipsychotic prescribing in patients with dementia on the older age psychiatric wards. In addition, the pharmacists completed a yearly clinical audit on the antipsychotic prescribing in people with dementia in October 2015.

The environment of some wards did not meet with current good practice around providing dementia friendly environments. This was because the wards had often been adapted from wards, which were not designed specifically as dementia wards. This meant that some wards had limited space, poor utilisation of space and limited use of colour or other markers to help patients find their way around. Cedars ward in Oldham had limited communal space. One corridor on Cedars ward, leading to the activities room/women's lounge, was locked off, It could not be readily accessed due to the room being located in the staff area and no nurse call point being fitted in that room. The manager of Cedars ward told us of plans to extend the ward. Ramsbottom ward in Bury was on the second floor so did have access to outside space but this was down two flights of stairs or in the lift. Beech ward in Rochdale had improved their environment to make it more dementia friendly.

Skilled staff to deliver care

Ward teams included staff from a range of mental health disciplines, which included consultant psychiatrists, junior doctors, nursing staff, occupational therapists, technical instructors, nursing assistants and administration staff. Some teams also had access to psychologist input, speech and language therapists and/or physiotherapists. The input from these disciplines fluctuated in provision across all wards. Rosewood ward had access to a social worker. Saffron and Davenport had access to a visiting GP.

As well as mandatory training, some staff had attended more specialist training on personality disorder awareness, delirium, dementia training and cognitive behavioural therapy skills. Stockport older people's services had a dedicated education worker who provided specialist training to staff, patients and carers on various aspects of dementia care. However, we found that nursing assistant staff in particular had not received more specialist training to better understand and support the needs of patients with dementia. This was important as nursing assistants spent the majority of their time providing direct patient care and spent time undertaking enhanced observations of patients. One manager confirmed that some staff did not have the necessary skills to be able to engage with patients who are on a one-to-one, as they do not always know how to communicate appropriately with them. There was an e-learning module on dementia awareness but no figures were provided by the trust and they told us staff undertook this on an ad-hoc basis. The trust informed us that clinical skills training was ongoing for older people's mental health services with the last training dates in February 2016 where six ward staff members attended. Training was planned for June 2016 but cancelled because of the CQC inspection. The next clinical skills training was scheduled for October 2016.

All of the staff we spoke to told us they had received an annual individual personal development review in the last year and felt supported. Records indicated that the proportion of staff who had had an appraisal in the last 12 months ranged between 64% on Rosewood ward to 95% on Hague ward.

Staff reported there was good managerial and team support. Of the nine wards figures were provided for five wards with Ramsbottom ward only having 50% of their staff receiving clinical supervision. Beech, Davenport, Summers and Saffron wards had a figure of between 70% -100%.

Managers across the wards were able to tell us about how they were actively managing a small number of performance issues from a very small number of staff on the wards. Nursing staff did not routinely have access to independent clinical supervision, although management supervision did include staff talking to managers about the patients who they were named nurse for and included elements of reflective practice.

Multi-disciplinary and inter-agency team work

We observed five multidisciplinary ward round meetings and care reviews and three staff shift handovers. Discussions occurred with comprehensive information on each patient to ensure that all members of the nursing and multidisciplinary team were kept up to date on current issues with patients and to inform decisions about future care and treatment.

Staff within teams worked together to plan ongoing care and treatment in a timely way through the regular multidisciplinary meetings. Care was co-ordinated

Are services effective?

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between teams and services from admission through to discharge or transition to another service. Multidisciplinary meetings were used to collaboratively manage patients' needs, risks, treatment and appropriate care pathway options. Consultant psychiatrists worked in both inpatient and community settings so patients received continuity of care if they required admission to hospital.

Ward staff felt that there were good working relationships with staff from the community teams including intensive home treatment teams who helped support patients to be discharged from hospital, community mental health teams, and memory assessment teams. This helped to ensure patients were discharged and received care from the most appropriate team at any given time according to patients' needs.

Staff on Saffron ward worked with the visiting GP who provided lead medical input and staff from the rapid assessment, intervention and discharge team working in Stepping Hill hospital to ensure that patients on acute medical wards who were acutely confused received appropriate transfer to Saffron ward to receive more specialist medical input to treat their symptoms and consider diagnosis.

Staff and patients could access social care support from the local authority teams. This was via referral and the wards confirmed this worked well. The wards in Tameside had access to a social worker who was collocated within the trust community teams.

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

We carried out a number of routine Mental Health Act monitoring visits in 2015 and 2016 to the trust's wards for older people. We found overall good adherence to the Mental Health Act but highlighted a small number of areas for improvement. For each of these visits the trust sent us an action statement telling us how they had or would address the issues we found.

On this inspection, we reviewed care and treatment of patients detained under the Mental Health Act. We found the wards adhered to the Mental Health Act and Mental Health Act Code of Practice. There were good checklists and proformas provided by the trust to ensure the correct papers were available on the ward for each detention episode.

Mental Health Act administrators in the trust had systems and checklists to remind staff of their responsibilities including ensuring staff kept to key deadlines for patients. This was sent through as a weekly ward report, which showed any key actions that staff needed to take to ensure deadlines were met under the Mental Health Act.

Detention paperwork was orderly, up to date and stored appropriately. Detention papers showed that there had been appropriate medical and administrative scrutiny to ensure that where patients were detained under the Mental Health Act, each detention was supported by a full set of well completed detention papers. Recording of leave was largely good. However, on Ramsbottom ward it was not always clearly recorded whether relatives were given a copy of the section 17 leave when they were acting as escorts as part of the conditions of leave.

There were records relating to consent and capacity to consent to treatment for decisions around treatment for mental disorder given to detained patients. This meant that detained patients received treatment with the proper authorisation of medication for mental disorder. Legal certificates in the form of T2, T3 or section 62 forms were attached to patient's medication charts where appropriate. On two records, it was not clearly recorded whether a second opinion appointed doctor had been requested in a timely manner. As these patients were approaching the three month mark, their medication had to be authorised instead by an appropriate urgent treatment form (section 62).

Patients were informed of their rights and where patients lacked capacity, their rights were repeated. Records did not clearly show that detained patients had been referred for support from an independent mental health advocate or whether there was consideration if the patient would benefit from the independent mental health advocate. However, independent mental health advocates proactively visited the wards and introduced themselves to patients.

We did find a small number of continued issues with areas we identified in Mental Health Act monitoring reports where the trust told us that they had taken action. For example in the trust provider action statement for Cedars and Rowan ward, the ward managers stated that to further assure themselves that the action was embedded they would carry out regular audits but we found that these audits had not taken place on a regular basis.

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Requires improvement

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On Cedars ward, one patient had recently been nursed in a low stimulus environment. However, there was no clear indication of why the restrictions placed upon this patient was not considered as seclusion as defined in the Mental Health Act Code of Practice and the safeguards this contains.

Good practice in applying the Mental Capacity Act

Most patients on Saffron ward were being cared for and treated in their best interests. On the day of the inspection of the 20 patients on Saffron ward two were detained under the Mental Health Act, two were under Deprivation of Liberty Safeguard authorisations and the rest were being cared for or treated in their best interests. We asked the trust for fuller information and they told us that at the end of June 2016 of the 21 patients, one patient was detained under the Mental Health Act, one was subject to a Deprivation of Liberty Safeguard authorisation, 12 patients were informal but lacked capacity, five patients had capacity to agree to their admission and two were awaiting a capacity assessment.

Patients on Saffron ward were subject to a number of restrictions including being cared for on a locked ward, limited access to fresh air, no staff escorted leave, zonal ward restrictions, receiving medication covertly and a number of other restrictions which could have the effect of patients being deprived of their liberty and subject to the full and effective control of the ward staff. There had been no formal consideration of what could be done to reduce or remove these restrictions to ensure that patients were not arbitrarily deprived of their liberty due to the number of restrictions in place.

The Deprivation of Liberty Safeguard Code of Practice did recognise that patients who are subject to acute confusional state (for example, through a urinary tract infection) may be deprived of their liberty for a short period where there is likely to be a rapid resolution of their condition or if the deprivation may only last a few hours or a few days and a standard authorisation was unlikely to be granted in those circumstances. However, all of the incapacitated informal patients had been on Saffron ward for over seven days, many of these had been in for many weeks and two of these incapacitated informal patients had been on Saffron ward for much longer (one for nearly eight weeks and one for nearly six months).

Staff on Saffron ward were relying on acting in the patients' best interests to provide ongoing care or treatment. There were no formal considerations of these best interests for the majority of the incapacitated informal patients on the ward although there had been contact with family members. There was no consideration whether the restrictions faced by incapacitated informal patients on Saffron amounted to a deprivation of liberty. This was despite the trust having policies and checklists in place to support these decisions.

In addition, there had been no consideration of recent important case law, known as the Cheshire West case, which provided clarity on when a deprivation of liberty should be considered. This case overruled previous notions that if patients were not actively trying to leave the ward then they did not need the safeguards afforded to them from the Deprivation of Liberty Safeguards. Staff awareness of this important ruling was poor. We spoke to the service manager who accepted that there was a need for consideration of the legal frameworks and provided us with an action letter showing what they would do to consider the matter.

On most other wards, where significant decisions were made such as decisions to give medication covertly or use restrictive holds to provide basic care, these decisions were not always supported by staff fully considering the best interests of patients and recording those decisions. For example, some patients were receiving medication covertly. There was no record of best interest considerations other than consultation with family members, which was only one aspect of best interest discussions. The trust had a proforma to record best interest consideration but we did not find this completed for relevant significant decisions on the files we looked at and staff confirmed that they did not routinely use it.

Mental Capacity Act training was not a mandatory requirement for staff. The training was covered as small part of a three yearly refresher for staff. Staff had some understanding of their responsibilities in undertaking mental capacity assessments when they were the principal decision maker. However, there were some gaps for example staff in Stockport did not fully understand the implications of the Cheshire West decision.

The trust stated that there were 28 Deprivation of Liberty (DoLS) applications made in their most recent data submitted on 13 May 2016 for patients on the older adults' wards. The trust was notifying us of Deprivation of Liberty Safeguard applications, as they were required to do.

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However, the numbers of Deprivation of Liberty Safeguard applications reported to us did not match the number of applications the trust stated they made. This discrepancy may be because the trust tells us when the outcome of the Deprivation of Liberty Safeguard application is known and there were frequently delays in the local authority (the Deprivation of Liberty Safeguard supervisory body) processing applications because of the increase following recent court judgements (for example, in the Cheshire West judgement).

Requires improvement

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed positive interactions between staff and patients on most wards. Patients were treated with dignity and respect during most interactions we observed. We observed staff participating in activities, engaging and speaking with patients and providing care and support in a calm, kind, friendly and patient manner.

We spoke with 20 patients who were able to speak with us. They all reported staff treated them well and were all caring, kind and respectful. Patients and their family members made positive comments about the quality of the care and treatment they received. We spoke with three carers on Hague ward who all told us the staff were professional, caring and responsive to not only their family members but were supportive to them and were fully involved in their relatives care. Two patients on Summers ward reported that the staff "look after us and couldn't give us more", they felt safe and there was always something to do. We spoke to three carers on Summers ward they told us they were listened to and staff were always available to discuss their family members' care as well as being a fantastic support to them and their family. They all told us they felt their relatives were safe and all of the staff showed kindness, dignity and respect to their family members and to them. One patient on one of the wards told us about a member of staff that they felt was disrespectful. We passed this information on to the ward manager to consider.

On Rowan, Cedars and Saffron ward, we carried out a short observational framework for inspection. The short observational framework for inspection was a tool used to capture the experiences of patients who may not be able to express this for themselves. During our observations, we saw staff attended to most patient needs in a reactive way on Rowan and Cedars ward with some patients' needs not being addressed in a timely manner. We found that some patients did not receive any meaningful engagement from staff and staff did not anticipate patients' needs appropriately. This was evidenced when one patient soiled themselves twice without staff anticipating their toileting needs. Another patient had a clearly detailed care plan about how they could be supported and distracted from their distress levels, we saw that the patient was distressed for sustained periods but staff did not follow this care plan when providing care to this patient with only superficial consideration of their care plan to aim to distract them. Some patients were not stimulated and slept or were unresponsive within the ward environments. We also found that staff on Cedars ward did not fully anticipate the care needs of patients with dementia.

When staff did eventually promote some interaction these patients were responsive and their mood became positive. When staff did engage they did so warmly and attempted to support and comfort patients when they became distressed. Staff intervened appropriately to prevent patients from causing distress to other patients. Staff used de-escalation techniques such as verbal reassurance and appropriate distraction techniques to reduce patient distress.

We received six comment cards. These were all positive, stating the staff were caring, patient, respectful and professional. One card stated the staff patience was limitless, their relative had received the best care possible and staff answered questions about their family member truthfully and were always available.

The trust provided details of their friends and family test scores from April 2015 to April 2016 for seven out of nine wards. Some of the wards had low response rates: Beech (8), Cedars (4) and Davenport (13). Hague and Saffron had the highest responses over this period (71, 77). The results indicated that of people commenting on Davenport, Ramsbottom and Cedars ward 100% would recommend this ward to other patients with the lowest figures being for Beech ward showing 88% of respondents would recommend. Rowan ward had 25 responses with 84% recommending the ward. However, four responses indicated they would not recommend this ward.

When we talked to staff on the wards, it was clear they understood patients' individual needs. We saw detailed care plans on Cedars ward to help staff to further understand the individual needs.

Summers ward had information in patient bedrooms that provided a brief summary of what the patient liked and disliked as well as information about who their named nurse was. The wards had noted the likes and dislikes of patients in relation to their food and drinks they were served. The wards had involved carers and family members to further understand the individual needs of the patients they were caring for.

Requires improvement

Are services caring?

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

We observed two mealtimes during our visit, staff were aware of patients' likes and dislikes and we observed staff providing choice and assistance to patients who needed support to eat and drink. Staff on Hague ward encouraged patients to cook their own meals where possible. Patients on this ward had also made a choice that they wanted to shop for their own ingredients with support from staff. Wards had access to aids and adaptations to assist patients with eating their meals when required.

A carer reported on Rosewood ward that they had had access to a five week dementia course for carers and told us they felt this was invaluable in understanding their relative's condition.

The involvement of people in the care that they receive

The admission process onto the wards ensured that patients were orientated to the wards although this was sometimes difficult due to the patients' cognitive impairment. We saw evidence that most wards had tried their best to orientate patients by using coloured signage to their bedrooms and patient areas. The wards had information available for patients and their family members/carers to inform them about the ward. We found Rowan ward had no names on patient bedrooms and we saw during our inspection that patients asked to be taken to their rooms, as there was no indication which room was allocated to whom. This meant patients wandered into other patient bedrooms and became disorientated, as they were unable to find their room. This also meant that the privacy and dignity of some patients was compromised. One patient on Rowan reported they were unable to lock their room from inside. We discussed this with the ward manager who confirmed this had been reported to their estates management.

Patients where possible and their family members were actively involved in the care planning and risk assessments. We attended five ward reviews and multidisciplinary meetings and saw active involvement of patients and their relatives in these meetings. We saw patients were encouraged to maintain their independence especially on Hague ward where patients could prepare their own meals with assistance.

All wards had access to advocacy services and some advocacy services were co-located in the same building. The advocate on Hague and Summers ward had a presence on the wards and attended every ward round.

Families and carers felt appropriately involved in their family member's care and feedback from most of the wards we visited was highly positive. However, two carers on Saffron ward reported that there was a problem with communication from the ward. While they could ask the staff for information, no one sought them out to inform them of what was going on. Some carers had received misinformation, which had caused some anxiety. We were told that generally the quality of care was good on Saffron ward.

Patient ward meetings were held on each ward. Summers ward did not always have regular meetings due to the limited communication of their patients. Cedars ward also involved family members in their meetings. This gave patients and their carers the opportunity to give feedback about the service they received.

During our observations of Cedars ward, we saw the community meetings were inappropriate in the way they were presented with closed questions being asked of patients with limited communication and no other aids or adaptations to assist patients who had had a cognitive impairment to understand the content of the meetings or to contribute. Summers ward were unable to use a meeting format due to the nature of the patients. Cedars ward meeting minutes reported that sometimes dependent on how busy the staff were patients were sometimes not able to spend time with staff to discuss their care and treatment. The patient meeting held in June 2016 highlighted that the ward environment on Cedars was being discussed at senior management level as it was recognised the ward environment was not always conducive to patient wellbeing.

Some wards, such as Rowan and Hague wards, had introduced a patient satisfaction survey. Rowan patients had identified that there were not enough activities on the ward due to the nature of the ward and this was consistent with our findings and speaking with staff. Rosewood patients also highlighted the issue numerous times in their community meetings. Saffron and Davenport patients were positive about their access to activities. Hague and Summers ward had ward activities and had access to the day hospital located in the same building of which patients attended. Hague ward had access to a kitchen area where patients could access and cook a meal to maintain their

Requires improvement

Are services caring?

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

independence. Hague ward also had a 'pink elephant' tool used to seek feedback from patients and to improve services they provided as well as seeking feedback on what they were doing well on the ward.

We saw many comments and compliment cards on most wards as well as a letter from the chief executive commending one ward team.

Information requested from the trust identified that of all the nine wards visited; only Rowan ward had a patient with an advanced decision. The assessment tool used by the trust asked for information for staff to ask the question about patient advanced decisions in place.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The average bed occupancy for the wards in the last six months was more than 85% on all the wards we visited. Davenport ward at the highest bed occupancy of 121 %. Cedars ward was 106%. Rowan ward had 105% bed occupancy. Ramsbottom ward had 100% bed occupancy. The lowest bed occupancy in the wards we visited was Summers ward with 93% bed occupancy. The impact of the high bed occupancy would mean that when patients are on leave from the ward their bed is occupied by other patients and that patients are not able to access the correct bed in their local catchment area or patients are turned away when a hospital admission is needed.

Patients were admitted to their local catchment area wards where possible. Weekly bed management meetings with the community teams and wards sought to move patients back to their local area ward as soon as possible.

Patients had access to a bed on return from leave and we did not have any reports that due to the bed occupancy rates that this was a problem. Patients were not moved between wards during an admission episode unless this is justified on clinical grounds and it was in the interests of the patient.

Discharge was planned with the multidisciplinary teams, families and carers. Where community teams were involved in a patient's discharge, we saw they remained in contact with the wards and individuals.

Most wards managed patients who needed more intensive care with additional staff being accessed and increased levels of observations.

In the last six months, there had been 17 reported delayed discharges from older adult inpatient facilities. The trust did not provide figures for Saffron ward. The ward with the highest number of delayed discharges was Rowan ward with four. It was not always clear whether relevant patients were considered delayed discharge patients because there were some patients on the wards who had been in hospital for some time but they had not been formally considered a delayed discharge patient. This was despite staff confirming that these patients were not receiving active assessment or treatment, which required them to be in hospital.

There were 19 readmissions to eight wards within 90 days of patients being discharged. The ward with the highest number of readmissions within this timescale was Davenport ward with six readmissions followed by Hague ward that had five readmissions. The wards reported the lack of appropriate community placements to move patients onto if patients were not able to return home, for example a local older people's mental health nursing home. Ward managers reported to their senior managers about patients whose discharge was delayed. This was reviewed weekly, wards submitted information to senior managers, and the trust to ensure as much as possible was being done by the trust and community teams to facilitate discharge when patients were deemed fully ready.

Patients' GPs were informed of their discharge by fax and post.

The facilities promote recovery, comfort, dignity and confidentiality

The older adult wards we visited were different in their setup. Most wards were located on the ground floor apart from Ramsbottom ward. Most of the wards we visited had en-suite facilities some with a shower toilet and sink but some wards had just a toilet and a sink in single rooms. Staff told us on Rowan ward that the en-suite showers were not always accessible to patients with an organic illness and or physical problems as some rooms required patients to step up into the shower bases. On Beech ward, the rooms were not all en-suite.

All of the wards had access to a clinic room although some did not contain an examination couch. There were meeting rooms and some quiet areas on the wards where patients could meet their friends and relatives. We saw some patients chose to meet their friends and relatives in their bedrooms. Most wards had facilities for patients to make a phone call in private. Saffron ward did not have access to a private phone and patients were informed to ask the staff to enable them to make a telephone call. Where a separate area was not available or additional privacy was needed then staff on most wards would facilitate a portable domestic phone or access to a walk around phone. We saw patients with their own mobile phones and some had their own personal laptops in their rooms. Some patients in their community meetings had asked for access to Wi Fi facilities on Saffron ward. The minutes stated that this had been

Are services responsive to people's needs?

Good

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

asked for several times. However, staff stated that it could possibly be a risk issue, there were implications around data of the NHS and that this could be extremely costly. We did not see any further action to address this issue.

There was some dementia friendly signage on the wards we visited however; more could have been done on some wards where patients with a dementia or organic illness were admitted on a functional ward, especially on Rowan. All of the wards had access to outside space but most of the wards had their garden areas locked with the exception of Hague and Davenport ward. Ramsbottom ward was located on the first floor, which meant patients did not have free access to a garden area and this had to be facilitated by staff if patients wanted to access the outside space.

All of the wards had a dining room and lounge; however, on Cedars ward these areas were small and crammed and were not conducive to the wellbeing of the patients. During our inspection, we were told plans had been discussed to extend and refurbish the ward area. Information requested confirmed that plans had been drawn and costed to improve and provide a more suitable dementia friendly ward.

The wards did not all provide free access to hot drinks or snacks. Most wards facilitated dispensing drinks and snacks throughout the day and evening. Some wards had access to a water fountain. Hague and Davenport wards provided a beverage station for patients to access hot and cold drinks 24 hours a day.

Wards had access to specialist feeding aids and provided individualised meals for example soft pureed and thickened fluids for people who may be at risk when eating. When required food supplements for patients at risk of malnutrition, and finger foods to encourage patients with dementia to pick up food and improve their wellbeing and food intake were provided.

Patients were able to personalise their bedroom areas. Patients on the wards at Stockport had a wooden name plaque on their bedroom door, which was made for them on admission. Some wards did not provide lockable storage in patient bedrooms and patients were advised at community meetings and on admission where items could be stored safely if not taken home by their relatives for safekeeping.

Access to activities on the wards fluctuated in provision across the footprint of the trusts older people's wards. Some wards had access to occupational therapy and technical instructors. Ramsbottom ward did not have access to an occupational therapist but had daily input from an activities support worker. Summers ward had an occupational therapist for one day and had an activity support worker daily Monday to Friday. Davenport ward had a therapy room with occupational therapy and an activities programme available via a therapy team. All of the wards had limited input from psychology and physiotherapy; input was provided but on a minimal basis with Rowan and Cedars receiving the lowest input of one hour a week. Rowan and Cedars only received 18 hours per week of occupational therapy split between both wards. There was no provision of ward based activities at the weekends although nursing staff and nursing assistants facilitated some activities at weekends. Rosewood had access to a social worker Monday to Friday 9am to 5pm. The Royal College of Psychiatrists 2014 Accreditation for Inpatient Mental health Services for acute inpatient services for older people recommends, 'patients have access to staff trained and supervised to deliver psychological interventions for at least one half day(four hours) per week per ward/unit'.

Meeting the needs of all people who use the service

Eight of the nine wards were located on the ground floor, Ramsbottom ward was located on the first floor and access was via lift. All wards had full disabled access available. Patient bedroom areas differed in provision with some wards providing en-suite rooms with a bathroom and shower whilst others provided a toilet and sink facility. Some of the bedrooms on Rowan ward were not accessible to patients with a disability due to having to step up into the shower area. However, disabled facilities were available in the other bedrooms. The showers on Beech ward also had a large step to get into them, which would be difficult for patients with limited mobility.

Information leaflets were available for patients who spoke a different language and interpreters and signers could be accessed. Information was also available to inform patients and their relatives about their treatment and care.

Are services responsive to people's needs?

Good

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A choice of foods to meet dietary and religious requirements was also available on the wards. Access to appropriate spiritual support was available and the ward staff would assist in facilitating where needed.

Listening to and learning from concerns and complaints

The total number of complaints received in the last 12 months was 14. One was fully upheld and six partially upheld. One complaint was referred to the ombudsman.

Davenport Ward received the highest number of complaints with eight. Communication issues and staff attitude received the highest number of complaints with six.

Information was displayed throughout the wards to inform patients and their families of how to make a complaint and also informing patients of their rights under the Mental Health Act. Carers and family members were aware of how to make a complaint but most told us they felt confident raising these issues with the wards staff.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

The trust's vision was to deliver the best care to patients, people and families in their local communities by working effectively with partners, to help people to live well. The trust had ten principles of care which were developed in collaboration with staff and these were:

- Safe and effective services
- Meaningful and individualized
- Engaging and valuing
- Constructive challenge
- Governance procedures enable
- Focused and specific
- Competent skilled workforce
- Clear and open communication
- Visible leadership
- Shared accountability

The trust also had five strategic goals to help them steer the organisation in the right direction and to support the vision and values. These were:

- Put local people and communities first
- Provide high quality whole person care
- Deliver safe and sustainable services
- Be a valued partner
- Be a great place to work

The trust had an older people's service line planning group that met every two months. These meetings included the five service managers from each of the trust's boroughs, various consultant psychiatrists and other managers within the teams. Recent minutes from March 2016 showed that the trust was in the process of developing an older people's mental health strategy. These meetings allowed the sharing of information and enabled the development of older people's services within the trust.

When we spoke with staff on the older people's wards, they showed professional commitment to providing high quality care and were positive about the trust's values. The trust vision and values were displayed throughout the wards we visited. Staff were aware of who the senior managers were within the trust and senior managers had visited most wards.

Good governance

The trust had a governance structure in place to oversee the running of the older adult wards. Managers reported into governance meetings monthly. Some managers reported that each geographical area had previously visited each other's wards to share learning and felt this was good practice to learn from each other's practice.

The trust completed a governance review report in April 2016 for older people's mental health services. This report provided a summary of key themes and action plans for divisional directives that had arisen from any incidents, incident reviews, complaints, complements and any other relevant activity. The report stated that this report needed to be cascaded across the directorate through team meetings, supervision, individual personal development reviews, appraisals and training events. This report allowed staff to learn from incidents and to implement any recommendations made to improve individual patient care and treatment. An example of shared learning and changes to practice was evidenced on Rowan ward.

Overall, there were inconsistent rates of compliance with mandatory training. Rowan ward had the lowest compliance rate for mandatory training at 82%. There were some wards where training fell below 75% compliance rates so we could not be assured that most staff on the wards were kept up-to-date with their mandatory training.

The trust monitored annual appraisal rates having for non-medical staff was the lowest on Rosewood ward that being 64% and the highest on Hague ward 95%.Rowan ward had 71%. Overall, the figures for all the other wards were good.

The trust policy for supervision stated supervision should take place every four to six weeks. Despite requests, the trust did not supply all the data for the wards visited. Of the nine wards figures were provided for five wards with Ramsbottom ward only having 50% of their staff receiving supervision. Beech, Davenport, Summers and Saffron wards had a figure of between 70% and 100%.

The trust informed us that in 2014 the trust undertook an extensive audit of clinical supervision that demonstrated 70% compliance rate and a 91% satisfaction rate with the clinical supervision received. Since then, the executive

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director of nursing had led a piece of work across the North West looking at clinical supervision standards. This has included bringing a local university into the trust to support them to review their own policy, practice, standards and to develop clinical supervision. The trusts comprehensive review had resulted in a more standardised approach that was fit for purpose within busy clinical areas; the benefits of which may be realised across multiple clinical domains according to the trust. The review would also inform the trust's strategy on clinical supervision resulting in an action plan for 2016-2017.

In their data return against rates of clinical supervision, the trust did not have a target for monitoring take up of clinical supervision. The returned rates for teams captured a range of modes of clinical supervision including one to one clinical supervision, group supervision, and critical reflection as part of a team meeting to discuss patient care and where subject matter experts such as clinical psychology staff facilitated one to one patient discussions.

All wards had access to a ward clerk to assist in any administrative tasks throughout the wards although this fluctuated in levels of administrative support across all of the nine wards.

The trust's senior managers and commissioners had considered their joint approach to the safer staffing agenda for all inpatient services. The trust reported there have been a number of drivers for change, which they had discussed at Pennine Care NHS Foundation Trust's contract management board. These included:

- Ensuring wards had adequate and appropriate staffing level and skill mix
- Addressing the burden of one –to-one observations, both from an acuity point of view and a financial pressure
- Affordability of the model in the long term and the need to prevent admissions to avoid acuity and dependency
- More self-management and focus on recovery
- Addressing the physical health needs of their mental health service users.

Staff actively participated in clinical audits. Pharmacy staff ensured they regularly audited medication management arrangements, notified ward managers, and senior nursing staff if there were issues that required addressing with individual staff members. Other audits that staff had been involved in were ligature audits, health and safety audits, fridge and emergency equipment audits and infection control. Audits of prescribing and monitoring of antipsychotics were also in place. Friends and family tests were in place on the wards.

Incidents were reported via the trust incident reporting system. There have been a total of 124 strategic executive information system reportable incidents recorded for the trust over the past 12 months. The governance department then reviewed the incident reports before being reviewed and closed by the patient safety improvement group.

The trust had violence reduction policy and a restrictive intervention reduction programme

Overall, we found good systems in place to ensure that the Mental Health Act was being adhered to on older people's wards. However, we found improvements were needed to the application of the Mental Capacity Act and the Deprivation of Liberty Safeguards, especially on Saffron ward. Safeguarding was good across most wards; however, Rowan ward needed to ensure incidents of safeguarding were appropriately reported and reviewed in line with the local authority and trust safeguarding policies.

Some wards had key performance indicators to meet for commissioners. Saffron ward had sickness and staff training. Rosewood ward had advancing quality that worked to improve the consistency and reliability of healthcare to help ensure every patient got the best care every time and therefore better outcomes. They also had key performance indicators in relation to staff sickness and training.

Most wards had key performance indicators and commissioning for quality and innovation payment framework in relation to physical health monitoring and the safety thermometer.

The ward managers reported they had sufficient authority to manage their own wards and had support from their locality managers. The managers met weekly with the community team managers to review their bed availability and to discuss and plan discharges. Ward managers were aware of the trust risk register and could escalate items to be added to their senior managers.

Are services well-led?

Requires improvement

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Leadership, morale and staff engagement

The trust provided a staff wellbeing service that offered free support to help employees reduce stress and improve their mental wellbeing. This service also helped staff to stay in work or return following an absence.

Staff sickness reported by the trust from 1 May 2016 to 31 May 2016 indicated that of the nine wards visited that Rowan had the highest percentage of staff sickness this being 15% with Cedars ward being 14% and Ramsbottom ward being 12%. The lowest figures indicated Hague ward 3% and Davenport with 3%, which were below the national average of 5%.

Staff told us that they knew how to use the whistleblowing process and there was a policy they could refer to if they needed to. All of the staff felt that they could raise individual concerns without fear of victimisation.

Staff we spoke with were highly positive and morale was good on the wards we visited. However, the ward managers highlighted the levels of acuity and patients needing personal care on Cedars and the patient mix on Rowan as issues. This had been highlighted to the trust senior managers and increased staffing had been agreed as well as plans to improve the environment on Cedars ward.

Staff we spoke with reported they had opportunities within the trust for leadership and development. All staff reported good team working and received mutual support within the teams they worked in.

Staff had access to various forums within the trust. An example was the nursing forums which staff were encouraged to attend.

We saw that staff were being open and transparent to explain to patients and their families when something went wrong. We saw records that informed us that patients' families had been contacted with appropriate consent if an incident had been reported about their family member.

Commitment to quality improvement and innovation

None of the wards had signed up to The Royal College of Psychiatrist's accreditation for inpatient mental health services for wards for older people.

The trust reported Saffron ward in Stockport had been developed to keep older people with delirium out of hospital. An economic study of Saffron ward reported that it cost £1,000 a week less for patients to be on Saffron ward than in an acute hospital. In 2014/15, around 6000 bed days were deflected from the acute wards with estimated savings of £0.55 million.

The trust attended a multiagency dementia strategic group within the Tameside and Glossop area to further develop the services for the needs of patients with dementia in this local area. These meetings involved local commissioners, public health, the local acute hospitals as well as the Alzheimer's society and other local organisations.

Rosewood ward were taking part in the advancing quality initiative which worked to improve the consistency and reliability of healthcare to help ensure every patient got the best care every time and therefore better outcomes.

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 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment must only be provided with the consent of the relevant person **How the regulation was not being met** Staff on Saffron ward at The Meadows, were not considering the need for a legal framework where patients over 16 who lack capacity were subject to restrictions, which may amount to a deprivation of liberty such as full consideration of best interests as detailed in the MCA Code of Practice, the Mental Health Act or the Deprivation of Liberty Safeguards. The trust were not ensuring that staff at the Meadows were provided with relevant updated training to keep them informed of important changes in MCA and MHA law, for example the implications of precedent case law such as the Cheshire West case. This was in breach of regulation 11(3)

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 Service users must be treated with dignity and respect. **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Summers, Rosewood and Cedars wards did not comply with the Department of Health's guidance on eliminating mixed sex accommodation.

This was because:

On Summers ward, there was only one bath on the ward in full operation and the patients' bedrooms were not fully en-suite as they only had a toilet and sink in the bedrooms. This meant that males using the bath would have to pass by female bedrooms to get to it.

On Rosewood, there was only one shared bathroom on the ward. This meant that males using the bathroom would have to pass female bedrooms to get to it.

Cedars ward had only one functional bathroom on the ward. This meant that male patients wanting to use the bath would have to pass by female bedrooms to get to it.

There was a designated female only lounge on Cedars ward but this was closed and not accessible to patients.

This was a breach of regulation 10 (2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. **How the regulation was not being met** Staff on all wards apart from Beech ward had not received their mandatory training in basic life support.

This section is primarily information for the provider

Requirement notices

Staff on Cedars, Rowan and Ramsbottom ward had not received their mandatory training in intermediate life support. Not all staff working in dementia care had received formal training on dementia.

This was a breach of Regulation 18 (2) (a)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

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

The care and treatment of service users must be appropriate, meet their needs and reflect their preferences.

How the regulation was not being met

Patients on Cedars ward did not receive person centred care that met their needs as there was a lack of meaningful activities with limited occupational therapy input and staff did not fully anticipate the care needs of patients with dementia. The care people received was not adapted to provide effective care to people with dementia because there was minimal training to nursing assistant staff about providing dementia care.

This was a breach of regulation 9 (1) (a)-(c) and 9 (3) (h)