CareQuality Commission

Pennine Care NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Bury Mental Health Services Tameside Mental Health Services Oldham Mental Health Services Rochdale Mental Health Services Stockport Mental Health Services	RT201 RT202 RT203 RT204 RT205
Community services for people of working age	Trust Headquarters	RT2HQ
Wards for older people with mental health problems	The Meadows Oldham Mental Health Services Rochdale Mental Health Services Bury Mental Health Services Tameside Mental Health Services	RT2Y6 RT203 RT204 RT201 RT202
Community services for older people	Trust Headquarters	RT2HQ
Long stay/rehabilitation wards for people of working age	Tameside Mental Health Services Stockport Mental Health Services Stansfield Place Rhodes Place Heathfield House Specialist Services Division	RT202 RT205 RT243 RT2X9 RT210
Forensic/low secure wards	Tameside Mental Health Services Rochdale Mental Health Services	RT202 RT204

Summary of findings

Crisis and health-based places of safety	Bury Mental Health Services	RT201
	Stockport Mental Health Services	RT205
	Rochdale Mental Health Services	RT204
	Oldham Mental Health Services	RT203
	Tameside Mental Health Services	RT202
Child and adolescent mental health wards	Fairfield Hospital	RT201
Child and adolescent community services	Trust Headquarters	RT2HQ
Community based mental health services for people with a learning disability	Trust Headquarters	RT2HQ
Adult social care	Cambeck close	RT2C4
Community health services for children, young people and families	Integrated Care Centre	RT2F3
	Radcliffe Primary Care Centre	RT2D8
	Milnrow Health Centre	RT2H6
Community health services for adults	Trust Headquarters	RT2HQ
Substance Misuse Service	Trust Headquarters	RT2HQ
Community health Inpatient services	Butler Green House	RT2C1
	Bealey Community Hospital	RT2C3
	Grange View - Enhanced Intermediate Care Unit	RT2M3
Community End of Life Care	Ellen House	RT2HQ
	Blenheim House	RT2HQ
	Bealey Community Hospital	RT2C3
	Butler Green House	RT2C1

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

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 services at this Provider	Requires improvement ●
Are services safe?	**Requires improvement** ●
Are services effective?	**Requires improvement** ●
Are services caring?	**Good** ●
Are services responsive?	**Good** ●
Are services well-led?	**Requires improvement** ●

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

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Summary of findings

Overall summary

We rated Pennine Care NHS Foundation Trust as requires improvement overall because**:**

We rated six services as requires improvement, these were:

- Wards for older people with mental health problems
- Acute wards for working age adults and psychiatric intensive care units
- Community based mental health services for adults of working age
- Mental health crisis services and mental health-based places of safety
- Community end of life care
- Community health services for adults

The main areas for improvement were:

- Department of Health guidance on same sex accommodation was breached in the wards for older people and the acute wards for working age adults and psychiatric intensive care units
- Trust medicines management policy was not being observed in a number of the services we visited in recording, cancelling medicines, care plans for when required medicine and rapid tranquillisation. Temperatures for fridges and rooms were above the recommended guidance from the manufacture or the trust policy to safely store medicines. There were date expired needles and syringes in an emergency anaphylaxis kit in the Heywood, Middleton and Rochdale school nurse service at Milnrow Health Centre.
- On Saffron ward, for older people, staff had not considered the need for a legal framework where people over the age of 16, who lack capacity, were subject to restrictions, which may amount to a deprivation on liberty. Consideration of best interest as detailed in the Mental Capacity Act Code of Practice, the Mental Health Act or the Deprivation of Liberty Safeguards. Patients' capacity to consent to admission and treatment was not being assessed for patients admitted to Saffron ward. There were a number of patients on this ward who were not detained under the Mental Health Act, but lacked the capacity to

consent to an informal admission. These patients were subject to restrictions, interventions and control without the safeguards of an appropriate legal framework.

- In a number of the core services we visited we found that mandatory training was under the trust minimum. In some services less than 75% of staff had completed basic life support and intermediate life support. This would have a detrimental effect on patients of that service who required life support in an emergency.
- Supervision policy was not being adhered to fully across the trust, in some files we could not find any records to show that supervision had taken place for up to two years and in some we could not find any record of supervision at all. Staff in Trafford Healthy Young Minds team were not receiving separate clinical and management supervision.
- The trust had different recording systems across the trust, some of which do not link in with the trust electronic notes system. This meant that not all teams were able to access patient care records easily and some services used a mixture of paper and electronic records.
- In two of the home care and treatment teams, there were missing care plans and risk assessments and physical health check recordings. One children's nutritional and dietetics service did not keep contemporaneous, accurate and complete records, there were missing pages, unsigned entries and missing reviews and follow-ups.

We will be working with the trust to agree an action plan to assist them in improving the standards of care and treatment.

However,

The main good points were:

- Staff were on the whole responsive, respectful and caring and professional in their attitudes and worked to support the patients.
- Staff had a good understanding of safeguarding and the trust had systems and policies in place to support the reporting of incidents.

Summary of findings

- The trust had business continuity plans in place across services for emergencies and staff were aware of them and in some instances had used them.
- Staff we spoke to told us they were supported by their managers in accessing training opportunities that were suitable to their needs and development.
- The trust had a well-structured governance pathway to monitor outcomes for patients.
- My shared pathway was being used to promote recovery and positive outcomes for patients across the trust.

- We found that multidisciplinary team working was well developed across the trust both internally and in developing links with external agencies.
- The trust were working in conjunction with others when planning services for patients and had developed working relationships with other agencies.
- The trust had a range of facilities that provided and promoted recovery, comfort, dignity and confidentiality to the patients and families in their care.
- The trust had clear vision and values and staff were aware of these and could articulate their understanding.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement ●

We rated the provider as requires improvement because:

- We rated eight out of the 16 services we inspected as requires improvement for safe.

- Of the core services we visited we found that the Department of Health guidance on same sex accommodation on three wards for older adults and three wards for working age adults had been breached. Patients had to pass areas belonging to the opposite gender to reach bathrooms on the older peoples and adults of working age mental health wards. On an older peoples ward a female designated lounge was closed to patients. Male and female bathrooms were next to each other on two adults of working age wards.

- Trust medicines management policy was not being followed in three of the services we visited in recording, cancelling medicines and rapid tranquillisation. We found that temperatures for fridges and rooms were above the recommended guidelines on Southside and South wards, acute wards for working age adults and psychiatric intensive care.

- In five of the core services we visited, we found that patient care records did not have person centred care plans, risk assessments or contemporaneous records in all of their patient's files.

- In seven of the core services we visited, we found that mandatory training was under the trust minimum in basic life support, intermediate life support. Patient safety could be compromised if they required life support from staff in these services.

- Supervision policy was not being adhered to fully across the trust, with some records not completed to show if supervision had taken place or not. Staff in one Healthy Young Minds Team were receiving joint management and clinical supervision and not separate supervision in trust policy.

- We found in two of the services we visited that the waiting times were over the trust policy for that service. This meant that patients were waiting longer than 12 weeks for assessment and longer than 18 for treatment in the Health Young Minds service

Summary of findings

- We found that on long stay, older age adults and adults of working age and psychiatric intensive care wards that bank and agency were used to cover vacancies and sickness at a higher than average level.

- Three of the six incidents we looked where the duty of candour applied the trust had not written to the families to offer formal apologies.

However:

- The trust instigated a seven minute briefing information bulletin for shared learning and this was well embedded across the services we visited.

- The trust scored 99% overall in its Patient Led Assessment of the Care Environment scores for cleanliness.

- Staff had a good understanding of safeguarding and the trust had systems and policies in place to support the reporting of incidents. Staff were aware of how to report incidents and escalate them through the system.
- Pharmacy staff provided good support to ward staff when needed and there were systems were in place for reporting medicines errors and incidents.

- The trust had plans in place to recruit to staff vacancies across services and where possible used regular bank and agency staff to temporarily fill vacancies.

- The trust had business continuity plans in place across services for emergencies and staff were aware of them and had on occasion, used them.

Are services effective?

We have rated the trust requires improvement because:

Requires improvement 🟠

- We rated five out of the 16 services as requires improvement.

- The trust have different recording systems across the trust, some of which do not link in with the trust system. Some services use a combination of paper and electronic records for the same service, leading to some difficulties in staff accessing patient records in a timely way, particularly in out of hours services.

- The monitoring of physical health was varied across the mental health services, with some of the mental health services not monitoring physical health and recording it in their care records.

Summary of findings

- We found that staff supervision and appraisal was not being applied as trust policy across all the services. The rates were varied across the services and recording was not accurate in some supervision files.

- There were inconsistencies in staff composition in teams within the same service, with different levels of staff and different skill mix of staff.

However:

- My shared pathway was being used to promote recovery and positive outcomes for patients across the trust.

- The trust had a well-structured governance pathway to monitor outcomes for patients with a framework developed to ensure this was effective.

- The trust have developed arrangements for working jointly with other agencies in a suicide prevention plan.

- Staff we spoke to told us they were supported by their managers in accessing training opportunities that were suitable for their needs and development.

- We found that multidisciplinary team working was well developed across the trust in the clinical teams, for the patients benefit.

- Care and treatment was being provided in line with best practice guidelines in some of the services we inspected.

- We found that the recording, reviewing and documentation of patients on sections of the Mental Health Act was generally well recorded.

Are services caring?

We rated caring good because:

- We rated caring in 14 of the services as either good or outstanding.

- Patients told us they felt cared for and involved in decisions about their care and were able to make a contribution to their care plans. Patients told us that staff were respectful, compassionate and caring.

- We observed staff interactions to be on the whole, positive and delivered sensitively when caring for patients and their families. On wards where patients were unable to give their opinions, we carried out the short observational framework assessment and observed that this was the case for these patients.

Good ●

Summary of findings

- From the Friends and Family Test in January 2016, 98% of patients who used the service would recommend it to others.

Are services responsive to people's needs?

We rated the service good because :

- We found that staff knew how to handle complaints and learning from complaints was shared with other staff across the trust.

- The trust were working in conjunction with others when planning services for patient's and had joint working arrangements with other statutory organisations.

- The trust had a range of facilities that provided and promoted recovery, comfort, dignity for patients.

- The trust provided services that were meeting the needs of the populations they served.

However

- Some of the buildings the services were being delivered in did not wholly meet the patients' needs in confidentiality, outside space and decorative order.

- Some of the services we visited had not made adequate arrangements to secure records on the premises and were potentially accessible to others.

- There were high bed occupancy rates in some services across the trust. This meant that some mental health patients going on leave returned to a different care environment, due to a new admission on that ward. Patients were not always transferred to psychiatric intensive care units immediately due to high bed occupancy.

- On the wards for working age adults there was high bed occupancy across all of the wards which led to patients' needs not being met in a timely manner. Patients told us that requests were not responded to quickly because the staff were so busy. On Norbury ward, the office door was closed and we saw that patients were queuing outside the door with requests which were not responded to straight away.

- On wards for working age adults patients did not always have a bed to return to upon return from leave. Continuity of care was disrupted as patients were sometimes admitted to a bed in other parts of the trust or out of area. This meant that patients were cared for by a different nursing team on a different ward.

Good ●

Summary of findings

- Patients in some community services were waiting longer than the targets for assessment and commencement of treatment. This meant that patients were waiting longer than 12 weeks for assessment and longer than 18 for treatment in the Health Young Minds service.

- In two of the services we visited the waiting times were over the trust policy for that service. This meant that patients were waiting longer than 12 weeks for assessment and longer than 18 for treatment in the Health Young Minds service.

Are services well-led?

We rated well-led as requires improvement because:

- There was a lack of cohesive working across the boroughs in some of the services. Teams in some services did not have much interaction between them and worked separately.

- There were inconsistencies regarding skill mix in teams across, different areas of the same service.

- We found inconsistencies in local governance arrangements across the crisis and health-based places of safety with care plans, risk assessments, performance indicators and audits.

- Some services did not consider themselves to be fully integrated into the trust.

- There was no fixed timescale for completing management investigations and some investigators had not had investigation training. Investigations were not all sufficiently thorough, actions did not identify nor any future risk mitigation plans identified. They were not always undertaken by an impartial investigator.

However:

- The trust had clear vision and values and staff were aware of what these were.

- There were systems in place for reporting of incidents and staff knew how to use the systems for reporting and recording.

- The trust had a well-developed complaints strategy and a dedicated complaints team to process these. Complaints were handled in a timely manner, with the complainants being kept informed of progress with phone calls and meetings.

- The trust have a range of services that are participating in national and local initiatives and research projects.

Requires improvement ●

Summary of findings

- There is a clear governance structure with a well-defined reporting mechanism across most of the trusts services.

Summary of findings

Our inspection team

Our inspection team was led by:

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

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leader: Sharron Haworth, Care Quality Commission

Team Leader: Julie Hughes, Care Quality Commission

The team included CQC inspectors and a variety of specialists:

- Mental health nurses
- Mental Health Act reviewers
- Consultant psychiatrists
- Social workers
- Speech and language therapists
- Pharmacists
- Senior NHS managers
- Occupational therapist
- Psychotherapist
- Learning Disability nurses
- Safeguarding nurse

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 get to the heart of 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, the inspection team:

- Reviewed a range of information we hold about the provider and asked other organisations to share what they knew. These organisations included Monitor, NHS England, clinical commissioning groups, Healthwatch, Health Education England, Royal College of Psychiatrists, General Medical Council, other professional bodies and user and carer groups
- spoke with the chief executive officer, medical director, head of corporate governance and the chairman on 24 May 2016
- spoke with eight staff in the week prior to the inspection including: safeguarding lead, associate

director of quality governance, patient safety lead, risk manager, head of corporate governance, complaints manager and the Mental Health Act lead and team manager
- held a focus group for carers on 6 June 2016 with seven people attending
- due to the complexity of the trust it was agreed with the chief executive and nominated individual that we visited the trusts older peoples and adults of working age community services on 31 May and 1 June 2016. The figures of which are included below.

During the announced inspection of the week commencing 13 June 2016 the inspection team:

- listened to a presentation from the trust
- held 12 focus groups for staff which were attended by 100 staff
- held two focus groups for independent advocacy leads and independent hospital managers, which were attended by 13 people
- held a focus group for governors where six people attended
- held a focus group for commissioners where seven people attended

Summary of findings

- spoke to 266 patients
- spoke to 56 carers
- looked at 261 patient records
- completed 152 medication reviews and carried out seven medicine management checks
- carried out 15 home visits
- spoke to 471 trust staff
- looked at 193 staff records
- we spoke to two volunteers
- we looked at 16 Mental Health Act records
- we carried out three Short Observational Framework for Inspection
- we attended five groups, seven assessments,11 meetings for patients

- we attended nine handover meetings and 20 multidisciplinary meetings
- we looked at 36 comment cards
- we visited 32 wards and three intermediate care inpatients units.
- we visited 16 teams
- we visited four health-based places of safety
- we visited the learning disability short breaks and supported living service

We carried out unannounced inspections on 14 to 17, 22, 27, 29 and 30 June 2016.

Information about the provider

Pennine Care NHS Foundation Trust provides mental health, community and specialist services across the areas of Bury, Heywood, Middleton, Rochdale, Oldham, Tameside, Stockport, Glossop and Trafford in Greater Manchester to a population of 1.3 million people. It provides the following services:

- Acute mental health wards for adults of working age
- Community based mental health services for adults of working age
- Long stay/rehabilitation mental health wards
- Child and adolescent mental health wards
- Child and adolescent mental health community services
- Forensic/low secure mental health wards, in the trust these wards are called Rehabilitation and High Support Directorate (RHSD) Wards
- Mental health wards for older people
- Community based mental health services for older people
- Mental health crisis services and health-based places of safety

- Community based mental health services for people with a learning disability
- Community based health services for adults
- Community based health services for children, young people and families
- Community health inpatient services
- Substance misuse service
- Adult social care - respite services Cambeck Close
- End of Life service

Pennine Care NHS Foundation Trust was formed in 2002 and provides services from 263 sites. The trust has an income of approximately £280 million, and employs more than 5,500 staff. Including 2,952 nurses, 1,250 support staff, 118 allied health professionals, 159 doctors and dentists and 79 other personnel.

Pennine Care NHS Foundation Trust has not been inspected under the new inspection methodology. All the locations previously inspected under the old methodology were fully compliant.

What people who use the provider's services say

During the inspection, the team spoke to 266 people using the services and 56 of their relatives and carers.

People who used the crisis and health-based places of safety were extremely positive about the service and would recommend the service to others.

People who used the child and adolescent community mental health services were positive about the treatment,

Summary of findings

which they found caring and supportive. They felt they had been involved in their treatment. One parent expressed concern about the length of time they had to wait for treatment for their child.

People who used adult's mental health services were positive about the service and their involvement in their care. However, one person told us they had not been involved in their care plan.

People who used the older adult's mental health service said staff were kind and respectful. Some commented on the lack of daily activities on the wards.

People accessing the learning disability short stay and the supported living facilities told us that the staff made them feel safe and supported and encouraged them to eat healthily. They also told us that they had access to a wide range of professional staff for their medical needs.

People who used the children and young people's community health service were positive about the staff and service. However, there were some concerns about the waiting times and staff continuity.

One of the service users of the substance misuse service told us that it was the best service they had used and that it had been essential in beating addiction and establishing recovery.

Good practice

In the older peoples service:

- Saffron ward demonstrated an innovative partnership between the acute medical ward at the local acute NHS trust, a local GP practice and the mental health trust. This was to provide ongoing care and treatment for patients with delirium, which is acute confused 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.

In the learning disability service:

- As part of learning disability awareness week the children and adults who use Cambeck Close produced a healthy eating recipe book called Cooking with Cambeck.
- The community teams routinely supported people with a learning disability to be involved in staff interviewing.
- The Oldham service was facilitating a supported internship for a person with a learning disability.

In the children and adolescent mental health inpatients:

- Staff had secured funding to train an 'expert parent' who would provide support for others.

- Patients were involved in delivering group therapy sessions alongside the psychology team.

- The wards used iPads to encourage patients to take part in surveys.

In the End of Life Care Service:

- The Oldham SPCT had undertaken a project to seek the views of the Bangladeshi and Pakistani community for end of life care. This is an example of outstanding practice because the views of the community were instrumental in the service reshaping the way it delivered care to these communities. Through the changes, the service made more people from the Bangladeshi and Pakistani communities had chosen to die in their own home.

- The documentation of medicines management for end of life medication was outstanding. There was a sheet for each medication and the route of admission was clearly stated. The documentation was outstanding because it was so clear. This clarity meant that the opportunity for error was minimised.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

The trust must ensure that patient areas are clean and in good decorative order and that, effective monitoring systems are in place to evidence this. We found concerns at the health-based places of safety at Stockport and Tameside.

The trust must ensure that there is an effective system in place to make sure that the water system is flushed when not in use in line with trust policy to prevent the risk of legionella disease. We found concerns in one of the health-based places of safety across the trust.

The trust must ensure that staff receive mandatory training and supervision in line with trust policy and that this is recorded accurately. We found concerns with the levels of training in the following services:

- The crisis and health-based places of safety teams
- Older people's inpatients services
- Community based mental health teams for working age adults
- Acute wards for working age adults and psychiatric intensive care
- Learning disability service in Stockport
- Community health inpatient services
- Substance misuse service

The trust must ensure that each patient has a comprehensive assessment of his or her needs, an up to date risk assessment and care plan in place. We found concerns in the following services:

- The crisis and health-based places of safety
- Learning disability community team bases
- Community based mental health teams for working age adults
- Acute wards for working age adults and psychiatric intensive care
- Oldham children nutritional and dietetics service
- Community health services for adults

The trust must ensure that patients are cared for in single sex accommodation in line with guidance to ensure safety, privacy and dignity of patients. The bathrooms should be available without members of each sex having to pass areas occupied by the opposite sex. We found concerns in the following services:

- Older Peoples inpatient services
- Acute wards for working age adults and psychiatric intensive care

The Trust must ensure that when patients 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.

The trust must ensure that an accurate, complete and contemporaneous record is kept for each patient. We found concerns in the following services:

- Community based mental health teams for working age adults
- Oldham's children's nutrition and dietetics service

The trust must ensure that all wards comply with national guidelines and trust medicines policies. We found the following concerns:

On some acute wards for working age adults and psychiatric intensive care wards staff were not in all cases:

- Completing observations according to the trust policy following administration of rapid tranquillisation
- following trust policy when cancelling a medicine on a patient's chart
- ensuring that fridge temperatures are properly monitored and maintained
- ensuring that the temperature in clinic rooms is within recommended guidelines
- ensuring that medicines were administered and recorded as prescribed
- ensuring that patients are afforded privacy when receiving medication

In the community health services for children, young people and families:

- vaccines and medicines were not always being stored, managed, transported and disposed of in accordance with the standards set out in the trust policy

- In the learning disability service:

- Side-effect monitoring was not happening for people prescribed antipsychotic medication
- In the community health service for adults:

Summary of findings

- The trust must ensure that the medication policy is adhered to at all times.
- In the end of life service:

- The service must develop a trust wide system of incident monitoring for end of life patients to identify themes occurring for end of life patients.

- The service must provide sufficient specialist palliative care staff to ensure that specialist advice and treatment can be provided in a timely manner.

- The service must develop a trust wide end of life strategy which includes a vision of end of life care for all patients and national guidelines for end of life care.

- The service must develop a governance system to monitor the implementation of the end of life strategy.

Action the provider SHOULD take to improve

The trust should ensure that teams have information leaflets about the services provided for patients. Where this is required, patients and carers are offered information in an accessible format. We found concerns at the following services:

- learning disability services
- community mental health teams for working age adults

The trust should ensure that the electronic care record system is fully embedded across all teams.

- In the Older Peoples wards the trust should provide more communal space suitable for this group of patients. This should include providing dementia friendly environments and activities to meet the needs of these patients.

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

On older peoples wards;

- Recording that qualifying patients are informed of the independent mental health advocacy service and timely action where a patient does not understand their rights
- Recording of the request to receive a second opinion appointed doctor
- Recording of best interest considerations where significant decisions are made
- Appropriate action is taken in line with agreed actions within the provider action statement provided following a Mental Health Act monitoring visit.

On the acute wards for working age adults and psychiatric intensive care units;

- Ensuring that patients detained under the Act have their rights explained regularly and the original detention papers are placed in patients are records.

- The trust should ensure that blanket restrictions are reviewed and, where appropriate, removed to ensure all decisions about restrictions are made on an individual basis and in line with Positive and proactive care best practice guidance.

![Care Quality Commission logo]

Pennine Care NHS Foundation Trust

Detailed findings

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.

The trust had good systems in place to support the administration and implementation of the Mental Health Act. The Mental Health Act lead and team manager oversee the application of the Act. The Mental Health Act lead is the chair of the Mental Health Act Scrutiny Committee, which meets on a two monthly basis to examine national guidance, recent changes in the law and recent case law. This reports into the Quality Group, which in turn reports to the Performance and Quality Assurance Committee and then to the Board of Directors.

Training in the Mental Health Act was not mandatory, although staff across the core services demonstrated a good understanding of their duties and responsibilities under the Act. The Mental Health Act administrators who provided a weekly ward report to remind ward staff of their responsibilities under the Act and the time frames within which these should be met monitored overall adherence to the Mental Health Act. The Mental Health Act team produced regular briefing sheets which were circulated to staff. They provided a monthly half day training session and up-date in the Mental Health Act, Mental Capacity Act, Code of Practice up-dates and Deprivation of Liberty Safeguards.

We conducted 22 Mental Health Act monitoring visits between 1 May 2015 and 10 May 2016. We identified 88 issues from the visits across all the wards. Participation, respect, purpose and least restriction were the highest category with 49% of the total. Consent to treatment was next with 15% of the total. Stansfield Place had the highest number of issues in a single visit with nine identified, while Hague ward had none in a single visit.

With few exceptions, detention papers were available in the patients' files and these included copies of the approved mental health professional reports, hospital manager's reviews and appeals to the first tier tribunal where relevant. There was a clear system in place for the administration of the Act which included a checklist for effective receipt and scrutiny of detention documents.

Detained patients were given information about their legal status and rights on admission in accordance with section 132. There was evidence that this information was repeated at monthly intervals or more frequently where patients had not initially understood.

Patients had access to an independent mental health advocate service. Patients who lacked the capacity to instruct an advocate were automatically referred to the independent mental health advocate by the Mental Health Act office.

We saw that documentation relating to the authorisation of section 17 leave was well completed. There was evidence that risk assessments were completed before leave was authorised. We found that leave was granted on an individual basis according to need and stage of recovery. However, it was not clearly recorded whether relatives were given a copy of the section 17 leave form on one ward. This was especially important where relatives were required to act as escorts as part of the conditions of leave.

(Note: Patients detained in hospital under the Mental Health Act, require specific permission granted by the

Detailed findings

responsible clinician to leave the hospital. This permission to leave the hospital grounds, to visit their family for example, or for a trial visit home prior to discharge can be given under section 17).

In relation to section 58, we found that prescribed medication was authorised by an appropriate certificated (T2, T3 or section 62 forms). Assessments of the patient's capacity to consent to medication was clearly documented prior to the first administration and at the three month point. There was also evidence that a patient's capacity to consent to medication was kept under review and action taken where a patient either lost or gained capacity.

(Note: Section 58 of the Mental Health Act sets out the circumstances in which medication or treatment can be given to patients without their consent. Form T2 is a certificate of consent to treatment completed by a responsible clinician (the doctor looking after the patient whilst in hospital) to record that a patient understands the treatment being given and has consented to it. Form T3 is a certificate of second opinion completed by an independent doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent.)

There may be times when these patients would be prevented from leaving the area they had been confined to and thus they would be secluded within the definition provided by the Code of Practice. The policy did not refer to the management of patients at these times in terms of supporting staff to recognise when this intervention had become seclusion. We were concerned that patients separated in this way and prevented from leaving. The seclusion policy contained a section regarding nursing patients in a separate area. We recognise that this was to support the management of distressed patients in a discrete and sensitive way, away from the main ward population. We were concerned however, that there would not be afforded the procedural safeguards of seclusion in accordance with the Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards are rules on how someone's freedom may be restricted in their best interests to enable essential care or treatment to be provided to them. The safeguards ensure that the least restrictive option that can be identified to meet a specific need is applied.

Most of the staff we spoke with had a good understanding of the Mental Capacity Act and their responsibilities. Training in the Mental Health Act was not mandatory. Overall adherence to the Mental Capacity Act was monitored by the Mental Health Act administrators who provided a weekly ward report to remind ward staff of their responsibilities under the Act and the timeframes within which these should be met. The Mental Health Act team produced regular briefing sheets, which were circulated to staff. They provided a monthly half-day up-date in the Mental Health Act, Mental Capacity Act, Code of Practice up-dates and Deprivation of Liberty Safeguards.

We saw examples of best interest assessments in the acute wards for working age adults and psychiatric intensive care, where there had been decisions around the residence and physical health of the patients. However, on Saffron ward, for older people, staff had not considered the need for a legal framework where people over the age of 16, who lack capacity, were subject to restrictions, which may amount to a deprivation on liberty. Consideration of best interest as detailed in the Mental Capacity Act Code of Practice, the Mental Health Act or the Deprivation of Liberty Safeguards. Patients' capacity to consent to admission and treatment was not being assessed for patients admitted to Saffron ward. There were a number of patients on this ward who were not detained under the Mental Health Act, but lacked the capacity to consent to an informal admission. These patients were subject to restrictions, interventions and control without the safeguards of an appropriate legal framework.

Detailed findings

Over the period 1 May 2016 to the 31 May 2016, there have been six deprivation of liberty applications made at the trust.

The Mental Capacity Act does not apply to children under the age of 16. For under 16 year olds the Gillick competence assessment is used to determine capacity and decision making ability. The Gillick competence test requires the young person to be sufficiently mature and be able to understand and makes some decisions themselves. We saw that staff had considered whether the young person had capacity and a sufficient level of understanding during their assessment.

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

Summary of findings

Our findings

Safe and clean environments

The trust provide 263 different services. There are 22 registered locations, across a large geographical area in Greater Manchester. These include hospital site/s and community bases and provided both mental and physical health services. The trust had an estates strategy and a capital investment plan in place, with identified areas for improvement.

Most of the trust sites we visited were found to be clean and well maintained. We saw from cleaning schedules that most were cleaned on a regular basis. However, the section 136 suite at Stockport was not clean. The toilet was stained, the shower base was dusty and the sink blocked with tissue. The service could not provide assurance that the policy relating to the prevention of legionella disease was being adhered to.

All locations provided handwashing facilities, hand gels and personal infection control equipment. The trust provided data confirmed there were no cases of any hospital acquired infections on any of the community health inpatients for the past year.

Pennine Care NHS Foundation Trust scores 99% in its Patient Led Assessment of the Care Environment scores for cleanliness, which is slightly above the national average.

Of the core services we visited we found that the Department of Health guidance for same sex accommodation was not being met in several locations. On Cedars, Summers and Rosewood wards for older people rooms were not en suite and patients had to access areas designated for the opposite gender to reach bathrooms. On Cedars ward, there was a designated female only lounge, but it was closed at the time of the visit and therefore, not accessible to patients.

The same guidance was also not being met on Hollingworth, Southside and Northside wards. On Northside and Southside wards male and female bathrooms were next to each other. On Hollingworth ward, there was a female bathroom on a mixed corridor, this meant that females would have to pass through male designated areas to access this.

Trust information we reviewed showed that Rowan and Cedars, older people's wards, had the highest scores for ligature risks. The audits provided guidance of what action to take after the audit to reduce or manage risks. These were being managed by staff on the wards.

Safe Staffing

Data received from the trust for the staff establishment at 31 May 2016 included:

- Total whole time equivalent qualified nurses was 2412 with 334 vacancies
- Total whole time equivalent nursing assistants was 1447 with 148 vacancies
- Total number of shifts filled by bank or agency staff where there is sickness or absence was 7279
- Total number of shifts not filled by bank or agency where there is sickness or absence was 1818

In a twelve month period to the 31 May 2016 the trust had:

- Substantive post leavers of 486 which is 12%
- Substantive post vacancy rate was 10%
- The overall sickness rate was 5%

In the mental health community teams across the trust, we found that there were enough staff to meet the needs of the patients. Caseloads were of a manageable level to ensure safe care was being delivered. Cover was provided when staff were off work and long-term sickness was covered by agency staff that were familiar with the patients. Overall, the turnover rate in the community teams was low. In the substance misuse service, caseloads were confirmed as on average 80 service users. Caseloads had increased due to new model of care and staffing structures.

Bank and agency staff were used to cover sickness on:

- the long stay wards at a rate of 8%

Are services safe?

- adults of working age and psychiatric intensive care at a rate of 7%
- older peoples wards at a rate of 7%

Of these, Rowan and Cedars, both older people's wards had sickness rates of over 14%.Rowan had a 24% vacancy rate and Cedars 13%. Cedars ward had the highest use of bank and agency staff for a three month period up to the end of April 2016, with 339 shifts covered and 29 uncovered. Rowan had a rate of 284 shifts covered and only eight not covered for the same period. On Southside and Northside wards for working age adults 166 shifts and 163 shifts were filled by bank and agency and 14 and 13 shifts not filled respectively. Hollingworth ward had 185 shifts filled with bank and agency, with 29 shifts unfilled.

In the community health inpatient services, the staffing situation at Bealey Community hospital was on the risk register and action plans were in place to mitigate the risk. This was due to high levels of sickness, regular bank and agency staff had been used to cover this. There was high turnover of community nurses in Trafford at 18% and Bury was 13.8%. This was higher than the national average on 10% for nurses and health visitors in the NHS workforce statistic April 2016 report. The wheelchair service was also on the corporate risk register due to a lack of staff. The highest sickness levels across the trust is in the Trafford Immunisation Team with an overall sickness rate of 35% with a 51% vacancy rate and an establishment of 1.5 whole time equivalent posts and no leavers over the past 12 months.

On the mental health wards for working age adults, staff also had responsibility for bed management out of hours and the wards had high bed occupancy levels. This took them away from patient related care on the ward.

The trust had put a plan in place to recruit to all vacancies and was working towards this. Agency and bank staff were used to fill vacancies until these can be recruited to.

The trust had a mandatory training programme. However, it was not meeting its own targets on all the wards and services we visited. We found that basic life support training was below their mandatory training targets in several areas. The trust's data reported that in 18 out of 291 of it's community, mental and physical health teams there was a zero return for training in basic life support.

Assessing and managing risk to patients and staff

The trust had systems in place to escalate concerns. There was an example of a safeguarding concern from a group of staff. This was escalated to regional staff side representative and to the Department of Health. A review was carried out by the Department of Health and the trust has worked with staff to improve practice.

Trust information we reviewed showed that Rowan and Cedars, older people's wards, had the highest scores for ligature risks. The audits provided guidance of what action to take after the audit to reduce or manage risks. These were being managed by staff on the wards.

We saw information concerning winter planning and travel arrangements in adverse weather conditions. Staff had access to a snow mobile should they need it.

The trust was participating in the NHS sign up to safety campaign, focussing on reducing avoidable harm. They had instigated safety initiatives as part of the campaign in patient safety.

The trust used a dashboard to report and monitor safety performance. We saw evidence that the safety thermometer was being reviewed and action taken in the community health inpatient services.

They had an infection control lead on the wards, who undertook six monthly hand washing audits. All staff received infection control training as part of their mandatory training. We found that staff had a good understanding of infection control and made good use of the facilities provided. We observed the use of "I am clean" stickers to confirm if equipment had been cleaned and when.

On the substance misuse service, only 9% of staff had completed fire safety training. The service had a fire safety risk assessment in May 2016 identifying areas that needed addressing. These had all been actioned and addressed at the time of the inspection.

The trust had implemented guidance from the National Institute for Health and Care Excellence guidelines on violence and aggression.

For the period 1 March 2016 to 31 May 2016 there have been three episodes of recorded seclusion across all the mental health services of the trust. There have not been any recorded incidents of long-term seclusion in the same period. The trust had five seclusion rooms one at the

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Cobden Unit, the psychiatric intensive support ward in Stockport and two in the child and adolescent mental health wards, one in Prospect place and one at the Tatton Unit at Tameside General Hospital.. These rooms were also used as de-escalation and a low stimulus area. However, we also found that in the children's and adolescent mental health wards there was some confusion regarding the use of the nursing away from others policy. Staff had not adhered correctly to the Mental Health Act code of practice or the trust policy. In the older people wards, we found that staff were not always safeguarding patients around nursing, medical and independent review.

The trust had policies and procedures in place for restrictive practices and had regular audits to monitor and review these. The trust promoted a least restrictive practice across their locations and supported proactive and positive interventions in the first instance. We did find that on the long-term wards and the forensic wards the use of restrictive practices was low.

For the period 1 December 2015 to 31 May 2016 there were 268 incidents of restraint with a total number of 114 patients being involved?

Of these restraints, 34 were prone (face down restraint) and 28 of these resulted in the use of rapid tranquillisation. The trust counts any restraint as prone if at any time the patient is on the floor in a face down position. We found that:

- On the older people's wards, Cedars ward had the highest number of restraints recorded with 63, of which three were prone restraint.

- On the adult psychiatric intensive care, wards there were 110 incidents, with 26 prone restraints. Norbry ward had the highest with 30 episodes involving 10 patients. Of these, seven required prone restraint and rapid tranquillisation. The lowest was Arden, with four episodes of restraint and three different patients.

- On the child and adolescent wards, there were 95 incidents of restraint involving 27 patients. Of these five were in the prone position and one leading to the use of rapid tranquillisation.

We found that there were blanket restrictions in place on the older people's wards. On Cedars ward we found that bedrooms were locked during the day on an unannounced visit, this was confirmed by staff and visiting relatives. On the day of the announced inspection, however, we

observed some patients in their bedrooms. Patients were also restricted in their use of outdoor space on most of the wards which they could only access this with staff support. The exception to this was Hague and Davenport wards in Stockport, with access to a small open access courtyard. Patient's had access to cigarettes, but this was limited by the ward staff and was supervised. We did see, however, on Rowan ward, a more flexible approach to frequency of cigarettes for one patient. The doors on the older people's wards were locked, with patients who were able to leave the ward, given the key code.

The trust had a safeguarding policy for children and adults in place. Most staff we spoke to demonstrated a good understanding of safeguarding, of when to report an incident of safeguarding and how to report it. There was a procedure in place to escalate and review incidents and the report to the local authority. Staff from different services across the community adult's service gave us examples of safeguarding alerts they had raised and demonstrated a good understanding of safeguarding. However, we found that staff on Rowan, an older adult ward, had not reported a potential safeguarding incident to the local authority. This was recorded in the individual's clinical record and an incident had been reported at ward level, but his had not been escalated to the local authority.

Ward staff told us that the pharmacy team provided good support when needed. Pharmacists attended the multidisciplinary team meetings and consultant ward rounds and were valued members of the team. Support to the community teams, however, was less comprehensive, but named pharmacists were available to answer queries if needed. Two pharmacists told us of the work they were doing with consultants at the mental health outpatient's clinics in identifying patients who would benefit from a medicines optimisation review. The pharmacy team were also responding the learning disability 'Call to Action' initiative with regard to treatment optimisation in physical health related conditions and shared care issues particularly in the transition between children's and adults services.

Systems were in place for assessing and reporting medicines errors and incidents through the Managing Prescribing Risk sub group of the Drugs and Therapeutic Committee. Reports were shared through the divisional governance meetings. The trust has developed a 'Learning

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through medication errors' bulletin to raise staff awareness of audits, medication errors and national guidance. Trusts pharmacist collected data relating to near misses on inpatient wards.

A trust audit programme was in place to assess medicines handling in accordance with trust policy and national guidance. The audits were reported through the Drugs and Therapeutic Committee. In the community services, we saw that an improvement had taken place in overall compliance with trust standards for Patient Group Directions.

In the mental health service the trust subscribed to the 'Prescribing Observatory for Mental Health UK' to audit prescribing standards and benchmark themselves against other similar trusts. The trust was monitoring omitted doses as part of their 'Sign up to Safety' campaign.

We discovered an error on Southside acute mental health ward for working age adults, resulting in a patient missing six days' worth anticoagulant medication.

In the substance misuse service, staff generated and handed out prescriptions, but did not store medicines on site. Staff had received training and been assessed as competent to do this.

The community children service stored some vaccines in their school nursing locations. We did find some concerns relating to storage, transporting, managing and disposal of medicines. The community health inpatients locations stored their drugs including controlled drugs appropriately and had regular checks on them. An audit of 38 sites from September to October 2015, showed 2241 omitted or delayed dosages of medication from the prescription charts of 271 patients. It showed that 19% did not have a valid clinical reason for omission and 13% of these appeared in the trusts critical medicines list. Recommendations and action plans have been put in place, including raising awareness to staff.

In the community adult's service, pharmacy staff were delivering medicines safety learning lunchbox sessions for community nursing staff. There were plans to deliver these sessions to all staff who administered medicines. However, we discovered in one of the three services we visited, that out of date medicines were in the medicine cabinet. We raised this and the trust removed them at the time of the inspection.

The trust had placed prescribing guidelines on small credit card size cards that were available to staff in community and primary care locations.

Track record on safety

Trusts are required to report serious incidents and never events through the National Reporting and Learning System and to the Strategic Executive Information System. They are required to report incidents of any severity at least once per month. The most recent Patient Safety Incident Report (1 April 2015 to 30 September 2015) for all mental health organisations states that 50% of all incidents were reported to the National Reporting and Executive Information System more than 27 days after the incident occurred. The trust has an individual record of 50% of its incidents being reported more than 44 days after the event, which means that it is considered a consistent reporter.

Trusts also report using their own internal reporting system and we have used all of these systems to analyse the data. Serious incidents are required to have an investigation carried out and the investigation reported via the trusts internal systems. The trust had a Patient Safety Improvement Group that reviewed incidents and investigations and produced reports monthly.

The trust had recorded 47 incidents of death/severe incidents on National Reporting and Learning System in the past six months. The trust had recorded three serious incidents in the past six months. The trust have not had any recorded never events in the past six months.

Of incidents reported to National Reporting and Learning System, 24% were related to patient accident, 18% to self-harming behaviour and 15% to disruptive, aggressive behaviour.

In the Strategic Executive Information System reports, the highest number of incidents relates to pressure ulcers at 51% of the total and apparent/actual/suspected self-harm meeting the serious incident criteria at 25%.

In the NHS staff survey 2015:

- Nineteen percent of staff had said that they witnessed potentially harmful errors, near misses or incidents, which is three percentage points lower than the national average of 22%

- Staff reported errors, near misses or incidents at a rate of 92% which is the national average and indicates that staff know when to report incidents

Are services safe?

- The trust scored better than average in scoring 11% of staff experiencing physical violence from patients, relatives or members of the public, compared with a national average of 15%

- One percent of staff said they experienced physical violence from other staff in the past 12 months, from a national average of two percent. This is a one percentage point decrease from the same category in the previous NHS Staff Survey

- Twenty six percent of staff experienced bullying and harassment form patients, relatives and the public in the previous 12 months, two percentage points lower than average

- Eighteen percent of staff said they experienced this from other staff. This is three percentage points lower than the national average.

Reporting Incidents and learning when things go wrong

The trust has an electronic system in place for reporting incidents. Staff we spoke to knew how to report incidents and what their responsibilities were. The number of incidents reported by the trust between 1 January 2015 and 31 December 2015, when benchmarked, show they were in the middle 50% of reporters of incidents. The National Reporting and Learning System report, considers that the trust report more incidents than average, with a higher proportion that are no or low harm. The trust is considered to have a maturing safety culture. Incidents reports are escalated through senior management and corporate team meetings and into the patient safety implementation group.

We reviewed five incident investigations at trust level and found them to be of variable quality, some were thorough and identified actions however others did not identify mitigation plans to reduce the likelihood of incidents re-occurring or identify lessons learnt. They were not always timely, one took over a year to complete. Staff reported and records and investigations confirmed that investigations completed were not always carried out by a member of staff unbiased enough to complete the investigation for example we found that the manager of the service where the incident occurred had completed the review, which presented potential conflicts.

In child and adolescent mental health community teams, however, we discovered that two of the teams had reported two serious incidents from January to December 2015. We looked at the investigations into these and found that they were comprehensive and involved carers and families.

Staff we spoke to informed us that they were fully supported in reporting incidents and had de-brief session if needed. We saw evidence of lessons learned being disseminated with the wearing of red tabards when giving out medication in the community health inpatient services.

In the substance misuse service, incidents were graded on a sliding scale, with the most serious requiring a management review. There had been 16 incidents in the preceding six months before the inspection. Learning was shared and discussed at governance meetings.

We discovered that not all staff had received training in investigation skills, meaning that some staff investigating incidents had not received specific training. The governance manager advised that they had commissioned an external organisation to provide a series of training courses throughout the year to equip staff with the skills for completing thorough investigations with clear outcomes to ensure consistency across investigations. This meant that for the time being, a non-impartial member of management staff, who may also have not received any specific investigation skills training, was conducting some investigations. This may potentially lead to investigations being completed without sufficient rigour.

The trust had initiated a seven-minute briefing, which they circulated to all services with learning from incidents presented in a brief format. Staff told us they found this easy to read and very informative. We saw an example of this with an incident review as the topic. After reading the review teams are invited to reflect and discuss the findings.

Senior managers from across the trust attended monthly governance meetings where recent incidents and coroners reports were discussed, learning from them was shared in the meeting. Pharmacy staff also presented recent medicines errors and any near misses at the meetings. This was then shared at the directorate team meetings and from there taken back to team/ward meetings by team and ward managers.

Duty of Candour

The statutory duty of candour was introduced in the NHS in England in November 2014. The responsibilities associated

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with it are contained in regulation 20 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.The trust is required to act in a way that is open and transparent in the way it provides care to patients.

The trust had Duty of Candour guidance for staff including the expectation of holding a meeting with the patient and their family to discuss the incident and apologise then follow up with a written apology and summary of the meeting. However if the family or patient refused to meet with the trust, the trust guidance does not state that they should write to the family and patient anyway with their enquiries, findings and apology.

We reviewed six of the most recent incidents where the duty of candour applied. All met the trust's completion deadline, had thorough investigations completed and had action plans in place. However, we noted that in three of the incidents reviewed the trust had not written to the family formally apologising.

Anticipation and planning of risk

The trust had business continuity plans in place across it locations to mitigate against emergencies. We heard from staff how they had been put into practice during recent floods when their building was unsafe. Staff at the Bury audiology team had undertaken training and joint exercises with the police and fire service.

The Sign up for Safety, an NHS England initiative aims to reduce avoidable harm by 50%. With this in mind the trust have developed a safety improvement plan across the following areas;

- Falls prevention and reducing avoidable harm
- Safe discharge, transfer and leave from inpatient facilities
- Reducing hospital and community acquired avoidable pressure ulcers
- Reducing omitted and delayed medications

The trust's Suicide Prevention initiative aims to give all patients across the mental health services a routine seven day follow up. There is a plan to work in partnership with external organisations to deliver preventative approaches.

Are services effective?

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

Summary of findings

Our findings

Assessment and delivery of care and treatment

The trust had been rolling out a programme of installing the electronic care record system. Across some of the services, some had the electronic reporting system, some had written care records and others had a mixture of the two systems. Some staff worked across both systems and one of the learning disability teams we visited used the local social service care record system and one from the trust. Information was held on the same patient in both systems and required the use of both systems to see the whole record. In the Trafford Healthy Young Minds team, staff told us that due to commissioner's request they were using the EMIS system and not PARIS like the rest of the service. Staff were concerned how this would have an impact when patients transferred to other services in the trust. In the mental health crisis service the teams were using a combination of both paper and electronic care records. This meant that the care record system was potentially not effective across all areas of the trust.

We found differences in the children, young people and families' service across the trust. Some services were electronic, though not all the same system throughout. In the Family Nurse Partnership service, all records were electronic, but had to be printed to hand over to another service. In the substance misuse, service they had both paper and electronic records, securely stored and password protected.

In the community adult's service, the trust was in the process of introducing a number of different electronic record systems. At the time of inspection paper records were held in the patient's homes and later written up when staff returned to their office. Community nurses were able to access patients test results through fax and phone contact.

In the End of Life service, we found discrepancies in recording patient information between the district nurses and the specialist palliative care teams in Oldham. One team used paper notes and the other the electronic note system. We found that a multiagency communication sheet that should have been used between the teams was missing from patient notes.

Of the locations we visited, we found varying standards of recordkeeping and care planning. Of the care records that we examined across the services some were comprehensive and provided all the information needed to ensure effective care. However, staff had not maintained care records of a consistently high standard in the:

- community services for people of working age
- community based mental health services for people with a learning disability
- crisis and health-based places of safety
- acute wards for adults of working age and psychiatric intensive care units
- community health services for children, young people and families.

Some of the records did not contain care plans, risk assessments, evidence of capacity assessments where appropriate. Some services had a template for the care plans and risk assessments, others did not. In the child and adolescent mental health community service, they did not use a care plan format at all. These were captured in case notes or letters to patients and parents. This could be a risk to patients as information could be missed without a guide. Care plans on wards for older people were often standardised core care plans with some effort at individualisation. We could not be assured that in some services patients had been involved in developing their own care plans. This meant that care planning was not effective across the trust for all patients.

In the mental health service we found that some areas were good at recording physical health in patient records but some were not. On the crisis and health-based places

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of safety physical health screening and monitoring was not included in records. However, we did find a small selection that had some assessments in them. None of the records contained any recording of allergies.

My Shared Pathway was used to promote recovery and positive outcomes for patients across the trust.

We saw that in the children, young people and families' service, developments in telemedicine and the use of technology was used to improve service delivery. In the community health inpatients service, we found that nutrition and hydration had been assessed and risk assessed in all the records we reviewed. Pain relief was managed on an individual basis, patients told us they were asked about their pain and supported to manage it.

Best practice in care and treatment

There was a well-structured governance pathway, which monitored outcomes. The trust had identified priorities for improvement for 2015/2016 in patient safety, patient experience and clinical effectiveness.

The trust was working with external agencies to deliver an Admissions Avoidance strategy across a range of services.

The trust had a plan of internal audits in place to monitor performance and reviews that have been undertaken by the Audit Committee. We heard that current audits included:

- non-medical prescribing antimicrobial audit
- antibiotic prescribing
- Prescribing Observatory for Mental Health lithium monitoring

In the National Audit of Schizophrenia the trust scored above average in the areas of the patient's views being taken into account when prescribing medicines and explaining the purpose of the medicine prescribed. The trust scored below average in involving the patient in deciding which anti-psychotic to prescribe and in explaining side effects to look for. The trust performed in the bottom 10% in relation to patient satisfaction and poor in the areas of advice given regarding diet and exercise. Overall, the trust performed in the mid-range of most key standards in the survey.

Staff we spoke to described various meetings and groups that information that they obtained information from. This was cascaded from trust level down to staff on the ground floor. Some staff told us that efforts had been made

recently to attend wider trust meetings with peers from other areas that they had never worked with before. We spoke to groups of staff who did not have a mechanism for joint working across the trust with their peers. Staff told us that they were aware of best practice guidance and that they were available on the trust intranet.

In the children, young people and families' services, work was underway to achieve national targets and standards across the service.

Skilled staff to deliver care

All trust staff including seconded, bank and agency staff and volunteers received the trust corporate induction. This incorporated information on the organisation, principles of care and some mandatory training. Each service had its own local induction, which covered service specific roles, and we saw evidence of local induction checklists and completed induction packs in personnel files we reviewed. Mentorship and preceptorship was offered to support newly qualified staff, junior staff and staff in a change of role.

Staff we spoke to told us they were supported by their manager in accessing training opportunities in order to develop their roles. Staff told us they could access specialist training, with some on degree programmes as well as in house training. However, in some of the older people wards we found that nursing assistants had not received specialist training for the patient group they were looking after. Staff in the substance misuse service told us that accessing training had been more difficult due to reduced funding and staffing levels. This could potentially have a detrimental effect on the patients.

Medical staff scored an overall 93% for re-validation across the trust. While many services had a 100% rate, Oldham child and adolescent mental health and paediatric services scored 66% each.

The NHS Staff Survey 2015 showed that the trust scored 89% of staff having received an appraisal, which is close to the national average of 91%. However, in Bury Early Intervention and Home Treatment Team the appraisal rate was 59% with 10 out of 17 staff receiving appraisal. Trust data revealed a small number of community services where the score was zero for staff completing appraisal.

Rates for both managerial and clinical supervision varied across the trust. Clinical supervision was delivered in both group and one to one sessions. Some services were up to

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date with providing regular supervision. However, staff at Trafford Healthy Young Minds team had not had regular management supervision in the past 12 months. In the community mental health teams for working age adults, there were some records that indicated that no clinical or management supervision had been given. However, in the Tameside north team clinical discussions were taking place during management supervision. The Bury health visiting service and Bury community children's nursing service had a supervision rate of 0-10%. In the community health inpatients service, staff told us they received annual appraisals. There was data that showed that between 50% and 60% of staff had received clinical supervision.

Across the trust, we noticed some inconsistencies in the staff mix across different teams within the same service. There were some inconsistencies in how psychiatry was provided across the trust. Managers were aware and had plans to recruit to the deficits when future vacancies arose.

There was evidence in the staff files that we reviewed, of the trust addressing performance and disciplinary issues with staff, relevant policies and procedures had been followed.

Multidisciplinary working

In the NHS Staff Survey, the trust scored 4 on a sliding scale of 1 to 5, with 5 being excellent, for staff reporting effective team working. There were staff meetings and multidisciplinary meetings held on a regular basis across the trust. We found that this was more prevalent in the individual clinical business units than across the range of clinical business units.

Many services worked in a multi-disciplinary way with others. The crisis and health-based places of safety service, were joint working with the police in the implementing of the section 136 suites. The street triage service also had strong links with the police, who reported that they had a positive relationship with the service and team members. The accident and liaison team were integrated within the accident and emergency departments, where they worked.

The trust had external links with other providers who they have a contract with to provide some services. For example, in the substance misuse service, two other organisations had been commissioned to provide recovery programmes.

Adherence to the Mental Health Act Code of Practice

Although training was not mandatory, some staff had accessed training. Many staff we spoke to had a good understanding of the Mental Health Act and the code of practice. The Mental Health Act team provided training and guidance across the trust and includes training on changes in the Act or practice. Recently the team have provided training following the Cheshire West case. We found that some staff had accessed a train the trainer's course in the Mental Health Act and had plans to disseminate this to their teams.

The trust had systems in place to support the appropriate use of the Mental Health Act through the Mental Health Act team manager and lead. Overall adherence to the Mental Health Act was monitored by the Mental Health Act administrators who provided a weekly ward report to remind ward staff of their responsibilities under the Act and the timeframes within which these should be met. The Mental Health Act team produced regular briefing sheets which were circulated to staff. They provided a monthly half-day training up-date in the Mental Health Act, Mental Capacity Act, Code of Practice up-dates and Deprivation of Liberty Safeguards. Mental Health Act applications are considered at the Mental Health Act scrutiny group, which meets on a bi-monthly basis. The trust had systems in place to ensure the governance is overseen and supported at a wider trust level.

Some mental health staff told us that they would access support from the Mental Health Act administrator if they needed to and others the approved mental health professional in the mental health access team. This indicates that staff had a variety of people to obtain advice.

As part of the inspection, we carried out reviews of care and treatment of patients detained under the Mental Health Act. We found on the older peoples wards that the correct paperwork was present in patient's records. We saw that documentation relating to the authorisation of section 17 leave was well completed. There was evidence that risk assessments were completed before leave was authorised. We found that leave was granted on an individual basis according to need and stage of recovery. However, it was not clearly recorded whether relatives were given a copy of the section 17 leave form on one ward. This was especially important where relatives were required to act as escorts as part of the conditions of leave.

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(Note: If someone is detained in hospital under the Mental Health Act, it is against the law for them to leave without specific permission granted by the responsible clinician. Permission to leave the hospital grounds, to visit their family for example, or for a trial visit home prior to discharge can be given under section 17)

In the learning disability community service, patient's had their rights explained in a way that used accessible information. We found in other services that patients had their rights explained at the start of treatment and at regular stages throughout their treatment. We also saw this across other services, though we did find some issues of recording irregularities in the Rochdale, Tameside and Bury Early Intervention teams. There was access to the appropriate support services, where patients needed this.

Good Practice in applying the Mental Capacity Act
The trust had systems in place to support the correct implementation of the Mental Capacity Act and the Deprivation of Liberty Safeguards. Training was not mandatory across the trust. The Mental Health Act manager and Lead oversaw the application of the Act and safeguards. The Mental Health Act administrators provided a weekly ward report to remind ward staff of their responsibilities under the Act and the time frames within which these should be met monitored overall adherence to the Mental Health Act. The Mental Health Act team produced regular briefing sheets, which were circulated to staff. They provided a monthly half-day training up-date in the Mental Health Act, Mental Capacity Act, Code of Practice up-dates and Deprivation of Liberty Safeguards. The trust had systems in place to ensure good governance arrangements at trust level. Staff overall had a good understanding of the five principles of the Mental Capacity Act and how these applied to their work. The Mental Health Act team provided training and guidance across the trust and includes training on changes in the Act or practice. Recently the team have provided training following the Cheshire West case, which provided clarity on when a deprivation of liberty should be considered.

The Mental Capacity Act does not apply to children under the age of 16. For children and young people under 16 years the Gillick competence assessment is used to determine capacity and decision making ability. The Gillick competence test requires the young person to be sufficiently mature and be able to understand and makes some decisions themselves. There are policies in place to support staff and in the community teams, we saw guidance that had been circulated for staff.

In the children's and adolescent community teams we saw that staff had considered whether the young person had capacity and a sufficient level of understanding during their assessment. Clinical records demonstrated that consideration of capacity had been given. Formal assessments were carried out by doctors where required. Staff were able to receive guidance from doctors in the teams when required.

In the substance misuse service, staff would postpone treatment, if the client attended intoxicated or under the influence of substances.

In the children, young people and families service we saw evidence of the use of the Gillick competency and the Frazer guidelines (to make a best interest's decision to provide contraceptive advice, treatment or both without parental consent). Staff told us that where possible they sought the consent from the child first, rather than the carer.

In the community health inpatients service, staff told us that they rarely came across a patient that fit into the criteria to be assessed, but that they were aware of the principles of the act.

Patients on Saffron, one of the older person's mental health wards, were subject to a number of blanket restrictions. We did not find any evidence of any formal consideration to reduce or remove these. We found that no consideration had been given to the training received in the Cheshire West case, which provides clarity on when Deprivation of liberty should be considered. The trust did provide the checklists and policies to support staff in being able to make a decision, however, this was not being implemented by ward staff. This demonstrated that the ward staff did not use the checklists correctly.

Are services caring?

Good 🟢

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

Summary of findings

Our findings

Dignity, respect and compassion

During the inspection we observed interactions between patients, staff and carers. Patients and carers told us that staff involved them in decisions about their care. Interactions on the whole were positive, respectful and compassionate in the services we visited. We spoke to patients and carers and obtained feedback from them. This was on the whole positive across the services. The child and adolescent mental health services had developed a child friendly method of gaining feedback from the patients. We looked at care records and found that most were contemporaneous. Patients told us they were able to get involved in their care planning.

We carried out the short observational framework assessment in some areas. This enabled us to capture the experiences of people who were unable to tell us themselves. On North ward one of the acute wards for working age adults, the care was particularly exemplary in the way it was delivered.

We observed staff meetings and noted that staff referred to patients in a respectful and compassionate way. Staff from Bealey Community hospital had come in on their day off to facilitate a support group and play bingo with patients. They were raising money throughout the year, with activities, in order to buy Christmas presents for patients in hospital.

We found evidence throughout the inspection of staff maintaining the patient's confidentiality. On the Community Mental Health teams for working age adults, we found evidence in records of staff maintaining patient's confidential information from family members when asked to do so. In the community health adult's service, although staff were aware of privacy and dignity, some areas were three bedded treatment rooms divided by curtains. This means that consultations could be overheard by other patients present.

In the 2015 Patient Led Assessment of the Care Environment, which is a self-assessment undertaken by the trust. The trust scores for privacy, dignity and wellbeing were 90% which is above the England average of 86%. All of the trust locations had a score above the England average with Heathfield House scoring the highest at 95%. Of the community location, Butler Green House scoring the highest with 93%.

The Friends and Family test was launched in April 2013 and asks people who use the service whether they would recommend it to others.

- From the trusts survey for mental health services from:
- December 2015, 89% would recommend the service, with a response rate of two percent.
- January 2016, 85% would recommend the service, with a response rate of one percent.
- February 2016, 88% would recommend the service, with a response rate of one percent.

- For the community health services:
- December 2015, 94% would recommend the service, with a response rate of seven percent.
- January 2016, 95% would recommend the service, with a response rate of six percent.
- February 2016, 98% would recommend the service with a response rate of six percent.

The Staff Friends and Family test which was launched in April 2014, asking staff if they would recommend it as a place to receive care and to work.

- From the survey 1 January 2016 to 31 March 2016:
- The number of staff who would recommend it as a place to receive care is 69%, below the England average of 79%
- The number of staff who would not recommend it was a place to receive care and treatment is six percent, lower than the England Average of seven percent.
- The trust had a one percent response rate to the survey, lower than the England Average of 12%
- The numbers of staff who would recommend the trust as a place to work is 60%, compared to the England average of 62%.

Are services caring?

In the CQC Community Mental Health Patient Experience from 2015, 850 questionnaires were sent out and 206 responses were received. The trust scored the same as other trusts in nine out of 10 questions. The questions related to aspects of care such as planning, organising and reviewing. The trust did score better than average in the question relating to planning patients care.

Involvement of people using services

We spoke to patients and carers who told us that the trust did involve them in their care. In some of the services, information was provided in accessible ways for particular patient groups. Care plans were in formats that were suitable for the patient group they were written for. At Butler Green hospital, we saw a communication book for families to make comments in. Messages that had been left by families had been actioned.

In the learning disability service there were established partnership boards made up of patients, carers, local authority, colleges, and voluntary sector and trust managers from the services. The trust held a conference in March 2015 with people with a learning disability giving a presentation. Staff used iPad and pictures to help patients communicate. The learning disability service had a separate recruitment policy, where patients were involved in the interview process. Staff were using different communication strategies for example, Makaton, (a sign language developed for people with learning disabilities) to communicate.

In some services there was a patient forum called the circle of influence that the service worked with, to support the patient's needs. On the wards around the trust we found that the patients were fully involved in their care and were encouraged to give feedback. In the child and adolescent service there was a young people's council and patients were delivering group therapy alongside staff.

On the older peoples wards patients and families were involved in their care planning feedback from wards was mainly positive. However, feedback from two carers on Saffron ward told us that there was a problem with communication from the ward. There was a training programme available in dementia awareness for patients, who spoke about it in very positive terms.

In the forensic service the trust were introducing the triangle of care to the service this year, a national initiative led by the carers trust. Some patients during the visit, complained about the information given to them on admission. We made the service managers aware of this at the time of our visit.

In the community adults service we found that patients were referred to an expert patient course and that was facilitated by people with or have had long-term conditions. We observed staff involving patients and carers in their care and treatment. The staff had completed Sage and Thyme training, in advanced communication skills, to help patients in a distressed and confused state.

Are services responsive to people's needs?

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

Summary of findings

Our findings

Service Planning

The trust were working with patients, local authorities, GP's, commissioners and other local providers and third sector agencies to provide services to people. The trust operated in a complex commissioning arena, with six commissioning groups and a number of local authorities. The commissioners had a positive working relationship with the trust and had joint action plans to address areas of concern. Commissioners told us that work that was underway in relation to data quality and assurance. They told us that the trust provided care for patients from out of the district. They also told us that the trust planned effectively for providing services for very difficult groups of patients, enabling them to stay within district.

We spoke to the board of governors who told us of their work and input with the trust. They told us that the process of tendering for services frequently removed the trust staff members from attending meetings as they were required to cover the workplace. The governors told us of the public engagement strategies and feel this remains challenging due to the uptake from the public in getting involved. The Service User and Carer Forum hold regular meetings and have a joint working relationship with the trust as well as other third sector and statutory agencies. We looked at minutes of meetings detailing joint working initiatives with the trust including a redesign of a community mental health service.

The street triage service was a partnership with the trust staff, the police and paramedics to provide this service to vulnerable people.

In the children, young people and families' service, due to commissioning arrangements some services were provided by other providers. Not all services had formalised service level agreements in place when care had been transferred to other healthcare providers.

Access and Discharge

A bed occupancy rate of below 85% is considered ideal by The Royal College of Psychiatrists to ensure the orderly running of the ward and hospital.

- The trust provided bed occupancy details of 98% for 31 wards from 1 August 2015 to 31 January 2016

- Out of the 31 wards 14 had bed occupancy rates of over 100%

- Of the 31 wards 30 had bed occupancy of 85% and above

- Adult acute mental health and psychiatric intensive care wards had an average occupancy rate of 103%. Saxon suite had the highest bed occupancy rate with 127%

- Older people's mental health wards had an average occupancy rate of 102%. Davenport had the highest occupancy rate of 121%, with Summers being the lowest at 93%

- The only ward below 85% occupancy was Horizon ward on the children's and adolescent in patient service

- There were 19 re-admissions to eight older people's wards within 90 days of discharge. The ward with the highest number was Davenport with six re-admissions.

This showed that the bed occupancy for inpatients service was considerably higher than the Royal College of Psychiatrists ideal level. Staff on the wards we visited commented on the pressures around bed availability. Patients who went on leave did not always have a bed to return to when they got back, due to new admissions. From 15 March 2016 to 16 June 2016 there were seven females and five males admitted to out of area psychiatric beds due to bed pressures. When patients required transferring to a psychiatric intensive care unit, this was not always available due to high occupancy on Cobden Unit. Staff told us they offered advice to acute wards until a bed became available. Patients sometimes had to be admitted to a bed in another part of the trust or out of area. There were no female psychiatric intensive care beds within the trust. All discharge planning meetings were attended by the specialist secure commissioner and the multidisciplinary team. From 1 December 2015 to 31 May 2016, there were 16

Are services responsive to people's needs?

delayed discharges across all wards. Mooreside had the highest with eight delays, main reason being waiting for placements. From 1 August 2015 to 31 January 2016, there were 255 readmissions within 90 days across the adult acute and psychiatric intensive acre wards.

The Quarterly Mental Health Community Teams Activity return data collected on the number of patients on the Care Programme Approach who are routinely followed up seven days post discharge. The Trust recorded 95% of patients followed up in quarter four 2015 to 16, this is below the England average of 97%.

The single point of access service provided a single point for referrals into the mental health services. There were five teams across the trust in, Oldham, Rochdale, Bury, Stockport and Tameside. Stockport, however, also accepted self-referrals. Urgent referrals were seen the same day, priority referrals within five days and routine within 10 days. None of the teams we visited had a waiting list. All teams had a discharge pathway, including summaries being sent to the GP on discharge. The trust figures show that in quarter 4 2015/16, 96% of patients on the care programme approach were followed up within seven days. We saw some differences in the way the teams operated in the different localities in terms of local protocols.

All the patients detained under section 136 were taken to the dedicated 136 suites and not to other locations. This was in line with the Mental Health Crisis Care Concordat and best practice. Between 1 January 2016 and 31 March 2016 there were:

- There were 578 episodes of the use of the section 136 suites

- The highest was Stockport with 187 episodes

- Rochdale was the lowest with 64

- The number of under 18 year olds using the 136 suites was 61

- The number of patients detained under section 2 or 3 of the Mental Health Act following detention was 16%

- Whilst the number of patients informally admitted to hospital following detention under section 136 was 26%.

- The number of patients discharged without follow up under section 136, across the trust was 34%. Patients from Rochdale were more likely to be discharged without follow up at 48%, whilst at Tameside this was 25%.

In the community services there were differences across the teams in target times for referral to assessment, treatment and in the way the teams operated in the same service. Some teams were working towards the National Institute for Health and Care of a two-week referral to assessment and allocation of a care co-ordinator. Waiting times varied across the services from 10 days in Stockport early intervention team to 102 days in Heywood, Rochdale and Middleton community mental health team. Patients told us that their care co-ordinators were assessable and responded quickly. We saw how staff attempted to engage with patients who failed to attend appointments. In the substance misuse service there was an open access assessment system. Flexibility was offered to clients to enable them to attend appointments at times to suit them. Patients were given contact numbers for use out of hours.

In the community health inpatients services, patients could be admitted to the rehabilitation units at any time, but ideally not after 8pm. Patients were assessed within 24 hours of admission by the nursing staff.

In the community adults service the trust monitored waiting times with many services failing to meet the target. From January 2015 to May 2016 the majority of stroke patients referred to the Oldham service did not meet the two-week target for first appointment. The target was 95% and was met on four occasions, with the average number of patients receiving a timely service between nought percent and 33% of the time.

The facilities promote recovery, comfort, dignity and confidentiality

Most of the places we visited were clean and comfortable. There were a range of rooms available for the patient's needs across the locations. The community locations all had a range of leaflets available regarding the particular condition.

The Cambeck Close short-term breaks and supported living, was particularly well appointed with equipment. All of the learning disability locations were accessible for

wheelchairs. The community bases were variable in design and layout and some shared with other teams. However, none of the interview rooms were soundproofed, which could cause issues with patient confidentiality.

On the older people wards while most wards were accessible and located on the ground floor, Ramsbottom ward was an exception. On the acute wards for adults and psychiatric intensive care, the outside space was variable across wards. There was no direct access to outside space on Northside ward, the access was through Southside ward. We saw a therapeutic garden attached to Norbury ward, a vegetable garden and activity space on North ward. The child and adolescent mental health units both had access to a tree house called the Woodland Retreat, for quiet space and therapeutic activities.

On the wards staff were able to provide snacks and drinks for patients throughout the day.

Meeting the needs of all people who use the service

The trust have produced the Pennine Care FT Annual Equality Publication 2015-2016, setting out the following priorities from the 2012-2016 plan:

- Collection of equality data from people completing patient experience surveys and making complaints

- Incorporating protected characteristics on PARIS

- Introduction of sexual orientation and transgender monitoring for service users from 2016

- Collection of disability data

- Sexual orientation and mentoring training and transgender awareness training.

The trust had an overall rate of 95% of staff having completed equality and diversity training in May 2016. The trust had developed an equality and diversity action plan, identifying key priorities. It is monitored in conjunction with the commissioners and feeds into the trust Quality Group for further discussion.

We saw information leaflets available in community locations that were available to patients. They included information on how to make a complaint. They were available in accessible information format in the learning disability bases. Some teams did not have leaflets in

different languages, but displayed a poster advising them to speak to staff. The poster has printed in 11 languages and offered leaflets in other languages, large print and audio.

Staff within teams were aware of the diverse cultures of the localities they worked in. There was evidence that teams linked in with local community resources aimed at specific needs. In the learning disability service, we found that the electronic systems called CIAS did not allow the recording or monitoring of ethnicity. This meant the trust did not know if the proportion of their learning disability patients reflected the make-up of the local population.

Team bases were compliant with the Disability Discrimination Act requirements regarding access for people with limited mobility. The substance misuse service had access for disabled people, but not designated parking. We saw that teams had access to translators if they needed both in person and via the phone, and could obtain information in braille if needed. We saw information about the service on notice boards and leaflets available on the wards. Staff could print off leaflets in other languages from the internet as needed.

Access to spiritual support was available on the wards if patients wanted this. There was a choice of food to meet dietary and religious needs was available on the wards.

In the children, young people and families' service staff were aware of the diverse populations they served and identified if English was not the first language of the patient at referral. The teams also used translation services as needed.

Learning from concerns and complaints

The trust had dedicated complaints team that had trust wide responsibility and a well-developed strategy. Complaints could be raised in many forms and are assessed for risk and seriousness before being allocated for investigation.

The investigation process follows a framework and is reported to the board via the dashboard system. People are given contacts and the details of the ombudsman if they wish to make a further complaint. Complainants will be contacted by phone for a first response and will be offered a face-to-face meeting. The complainant will be informed by letter of any outcomes. After the response letter the complaints department offer feedback to staff to enable any learning to be implemented from this.

Good ⬤

Are services responsive to people's needs?

In 2014 and 2015, the trust received 272 written complaints this was down from 324 the previous year. The number of complaints that have been up-held has come down from 42% to 38% during the same period.

From the period 20 March 2015 to 24 February 2016 there have been:

- 11 complaints referred to the Ombudsman

- Of these six were not up-held, one was partially upheld and three are on-going

The trust also submitted information to NHS England regarding the complaints received for the period 1 April 2014 to 31 March 2015 this data identified the following:

- Mental health services have had the highest number of complaints with 58% of the total number received

- Professions supplementary to medicine have the next highest with 15% of complaints.

Patients we spoke to during the inspection told us they would feel able to make a complaint if they needed to.

Information was available on the wards and friends and family test cards for patients to use. Where there may be negative comments, these were discussed at staff meetings in a lessons learned format. A small minority said they did not know how to make a formal complaint. Patients who said they did not know how to make a formal complaint said that they would feel able to raise complaints with staff if they wished.

Staff on the wards understood the process for complaints and their role in this. However, staff at Bury community mental health teams told us they did not routinely provide information for patients on how to complain.

Information about how to complain was displayed on notice boards, leaflets and the trust web site. We noted that some wards and community teams had comment boxes where patients could post their comments. Complaints were reported on the monthly dashboard and reviewed at key governance meetings.

Are services well-led?

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

Summary of findings

Our findings

Vision, values and strategy

The trusts vision was "to deliver the best care to patients, people and families in our local communities by working effectively with partners, to help people to live well"

The trust had developed 10 principles of care to meet their vision. The 10 Principles of Care were:

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

The trust had a capital investment plan in place with identified areas for improvement across the sites. The financial director presented a finance and performance dashboard at board of directors meetings, including an update on the trusts progress of achieving the cost improvement plans. The trust had achieved their combined cost improvement plan for 2015-16. The trusts quality account for 2015-16 focused on patient safety, effectiveness of care and patient experience. The account also identified the Commissioning for Quality and Innovation payments framework they adhered to and the target payments if achieved.

Staff across the trust were aware of the vision and values, posters displaying them were displayed in bases we visited. Staff told us that they received regular updates about the vision and goals of the trust via an email called 'Pennine Care Connected'.

Most of the staff we spoke to were aware of who the senior managers were and said they had visited the teams. In the older persons service the senior managers attended a bi monthly planning group.

In the Children's, Young Peoples and Families service, staff were unable to show us their service strategy. However, there had been a major tendering process in each borough recently, which had resulted in some major changes.

Patients told us that they reviewed two 'you said, we did' posters. They told us this was how they knew things were being dealt with.

The trust had a board assurance framework in place, which was reviewed quarterly. There were five strategic goals:

- 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.

Good governance

At the start of the announced inspection period, the trust gave a presentation, which described what the trust did well and what the challenges were and where improvements were needed.

The staff we spoke to had a good understanding of their roles and accountability. They could tell us the structure for reporting and escalating concerns and their role in this. Staff received training that was both mandatory and relevant to their role, however, not all areas had achieved the trust targets.

The governance structure of the trust had five subcommittees that reported directly to the board of directors, they were:

- finance strategy committee
- audit committee
- appointments and remuneration committee
- charitable funds committee
- performance and quality assurance committee.

Are services well-led?

The performance and quality assurance committee sought to assure the board of the operational performance of the trust. There were four meetings that reported into the performance and quality assurance committee:

- trust-wide quality group
- integrated safeguarding strategy group
- mental health law and scrutiny group
- divisional quarterly assurance panels.

Minutes reviewed confirmed actions and lessons learned were shared within the meetings. Executive directors met four times a year and fed directly into the board of directors.

The head of nursing and safeguarding ensured directorate leads for safeguarding disseminated learning and built links with local authority leads for safeguarding in the different regions. Seven minutes briefings had been introduced in 2015 to provide staff within teams a brief overview of the learning from a specific safeguarding incident, ideally the briefing would be shared within team meetings. The briefing included background of a case, the safeguarding concerns, nature of the incident, the review, findings, and recommendations and how to implement change. Some staff within teams were aware of the briefing and gave positive feedback. However, we found that in some areas staff had not acted upon areas identified in monthly reports.

Staff attended safeguarding adults and children training. The head of nursing and safeguarding also had overall responsibility for Prevent (safeguarding people and communities from the threat of extremism and terrorism), training was provided to staff with overall attendance at 86% and directorate representatives sat on the regional Prevent panels.

The trust held weekly patient safety improvement meetings to review serious incidents within the trust, information from these meetings fed into the quality group by exception.

The trust had introduced continuous learning forums in early 2016. The forums were established in order to discuss issues and lessons that could be learned from incidents that required external investigation. The trust had held two meetings, each focusing on a different case. Senior staff and ward managers had attended the meetings to disseminate this to staff.

The trust had a team manager and a clinical lead for the Mental Capacity Act and Mental Health Act. Systems were in place to ensure the trust adhered to the requirements of the Mental Health Act, we spoke with the independent hospital managers who felt supported by the trust with clear systems in place, and however, they identified the need for more independent hospital managers due to the demand for their service. They were aware of their role and gave examples where they discharged patients from hospital. The trust did not provide mandatory training to staff in the Mental Health Act and Mental Capacity Act.

The financial director, staff at a senior level and staff within teams were aware of the financial pressures. The trust used quality impact assessments to ensure that services were not compromised. The trust gave examples where a business case had been submitted to commissioners with a positive outcome of additional funding.

The system in place for clinical audit included a calendar of audits to be completed for each quarter for 2015-16. The trust had introduced a new role of lead in clinical audit and effectiveness from April 2016. They have created the clinical audit programme for 2016 to 17 to include what they must do. This would be fed into the quality account and from there identify what they should do. From this locally identified priority clinical audits will be identified leading to what they want to achieve. This in turn leads to locally identified clinical audits that are not identified as a priority, including clinician interest audits. The quality groups meets bi monthly and had membership from senior managers across the trust. National Institute for Health and Care Excellence implementation was discussed at the quality group from February 2016 and other areas of clinical audit were regularly reviewed at the meeting.

Staff at all levels could contribute to the risk registers locally by adding the risks via the electronic incident reporting system. Risks were also discussed at team meetings and escalated to service managers. We reviewed four examples of team risks that included clear mitigation and risk management plans. High level risks raised locally were also on the trust risk register. This meant staff were able to escalate risks within the trust. However, in the crisis service and section 136 suites and the learning disability community service did not have a local risk register.

We received feedback from 11 commissioners, the trust had a positive relationship with commissioners and had created action plans to address areas of concern including

Are services well-led?

data quality across the trust, waiting lists for child and adolescent services, paediatric speech and language therapy and also children and young people community services. In the forensic service, the secure commissioners attended six weekly performance meetings. They also provided a link between the trust and other forensic mental health service providers.

While some services worked well across different boroughs, we did find some differences with some services functioning separately across the boroughs. This meant there were limited opportunities for teams to share learning across. On the older peoples wards some of the managers had visited their counter parts on other units to share learning and good practice.

In the crisis and health-based places of safety, there were inconsistencies in governance arrangements between the teams. The health-based places of safety did not ensure that care plans and risk assessments were updated on admission. Existing monitoring arrangements had not identified the lack of updated care plans and risk assessments. There was a lack of evidence to demonstrate the effective use of performance indicators and audits to guide improvements in the service.

The services we visited had business continuity plans in place, the one for Bury Healthy Young Minds had been put into practice last year due to floods.

During a review of the personnel files we found personal confidential information about candidates who had applied for a senior position within the trust stored within the successful applicants file.

Fit and Proper Person Requirement
The Fit and Proper Person Requirement is a regulation that applied to all NHS trusts, NHS foundation trusts and special health authorities from 27 November 2014. Regulation 5 says that individuals, who have authority in organisations that deliver care, including providers' board directors or equivalents, are responsible for the overall quality and safety of that care. This regulation is about ensuring that those individuals are fit and proper to carry out this important role and providers must take proper steps to ensure that their directors (both executive and non-executive), or equivalent, are fit and proper for the role.

Directors, or equivalent, must be of good character, physically and mentally fit, have the necessary qualifications, skills and experience for the role, and be able to supply certain information (including a Disclosure and Barring Service check and a full employment history).

The trust had a guidelines document "guidelines on implementing the fit and proper persons requirements for directors, 30 March 2016" within the document it stated that the fit and proper persons requirement and checks would only apply to directors appointed after 27 November 2014, this was confirmed by staff from the human resources department.. We reviewed six directors' files including some in post prior to 27 November 2014 and found that only one file included a search of the registers, disqualified company directors and bankruptcy. In one file the disclosure and barring check was received and approved three days after the director started in post. One directors file also contained confidential information of other candidates that had applied for their post.

Leadership and culture
Sickness rates across the trust varied in the services we visited, with some higher than the national average.

The trust provided a staff wellbeing service that offered support to employees to help reduce stress and improve mental wellbeing.

There is a national requirement to appoint a Speak Up Guardian, this position has yet to be filled. We found that there had been six whistle blowing incidents this year.

Staff we spoke to were aware of the whistleblowing policy and how to use it.

Morale was variable across the different services we visited and sometime between different wards and community teams within the same service. Some staff told us that they had been tendered out as a service and had found this a very stressful experience. This included restructuring of posts and a re-organisation of skill mix, staff involved in these services were unhappy with the proposals.

In the NHS Staff Survey 2015, the trust scored worse than the national average for the questions:

- staff recommendation of the organisation as a place to work or receive treatment
- percentage of staff suffering work related stress in last 12 months.

Are services well-led?

The trust scored favourably and in line with national average for the questions:

- percentage of staff reporting good communication between senior management and staff
- percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.

The trust produce an annual detailed equality publication, areas for development identified in the 2015 publication include to review the diversity of the board composition, particularly in relation to age and ethnicity.

We reviewed 25 recruitment files and found the trust was following their recruitment and selection policy.

We examined five disciplinary investigation files and found that they were comprehensive and thorough. We found the outcomes were proportionate and reasonable.

We reviewed the complaints and compliments policy, approved and issued June 2015 and found there were no set timescales for the completion of investigations into complaints. The timescales were flexible and the complaints manager advised it was dependent on the individual investigating the complaints and their workload. We examined 10 complaints files and found in two examples teams were investigating their own complaints. We found that one complex complaint had taken a year to conclude their investigation. We also found that the trust policy allowed managers to conduct investigations into their own areas. This would leave the trust vulnerable to accusations of impartiality.

The trust had Duty of Candour guidance for staff including the expectation of holding a meeting with the patient and their family to discuss the incident and apologise then follow up with a written apology and summary of the meeting. However, if the family or patient refused to meet with the trust, the trust guidance does not state that they should write to the family and patient anyway with their enquiries, findings and apology. Within the trust wide team, we reviewed six of the most recent incidents where the duty of candour applied. All met the trusts completion deadline, had thorough investigations completed and had action plans in place. However, we noted that in three of the incidents reviewed the trust had not written to the family formally apologising.

Engaging with the public and with people who use services

We have seen from the services we inspected that in the vast majority of cases, staff have included patients and carers views into account when planning their care and treatment. The trust had developed, in December 2015 a trust-wide forum to seek feedback from patients and carers called patient experience steering group. The group was at the scoping phase and had aims to widen the membership to include patients and carer representatives. There were also localised service user and carer forums including the mental health involvement forum, which we observed. Patients reported being involved in recruitment of staff. Examples were given where the trust did not appoint a candidate from the feedback from patients. Items discussed included volunteering and the friends and family test results. This meant patients and carers were involved in the decision making of the organisation and reported feeling valued and that they made a difference.

Quality improvement, innovation and sustainability

The trust participates in national quality initiatives in some services:

- The forensic service participates in the quality network for forensic mental health services. Recommendations from the reviews have been incorporated in the services

- In the crisis and psychiatric intensive care service had undertaken a two year research 'Restrain Yourself', a two year programme in partnership with locals universities

- The Stockport home treatment team had implemented the productive team initiative
- In the learning disability service four of the teams had completed audits against the National Learning Disability Professional Senate
- In the older peoples service Rosewood ward were taking part in the advancing quality initiative

- In the child and adolescent mental health wards both had taken part in the inclusion quality mark. Both had been reviewed by the Royal College of Psychiatrists as part of the quality network. Psychology staff were working jointly with Manchester University in developing a new outcome measure tool

- The Bury health visiting service has achieved UNICEF Baby Friendly Initiative stage three

Are services well-led?

- In 2015 staff at Butler Green House were shortlisted for the Principles of care award.

The trust participated in the following national audits:

- National diabetes foot care audit
- National audit of intermediate care
- National Chronic Obstructive Pulmonary Disease audit
- Sentinel Stroke National Audit Programme
- Early intervention into psychosis
- National audit of schizophrenia
- National audit of psychological therapies for anxiety and depression
- National Learning Disability Professional Senate audit.

The quality account included a review of four of the national audits and clear actions the trust had in place.

The trust had four services which had received national accreditations:

- Quality Network for Forensic Mental Health services at Prospect Place. Overall, Prospect Place fully met 85% of low secure standards
- Quality Network for Forensic Mental Health services at Tatton Unit. Overall, the Tatton Unit fully met 83% of low secure standards, meeting 100% of criteria in six standard areas; Admission, Physical Healthcare, Discharge, Physical Security, Workforce and Governance
- Quality Network for Inpatient Child and Adolescent Mental Health services at Hope Unit. The Hope Unit is accredited until 15th July 2017
- Quality Network for Inpatient Child and Adolescent Mental Health services at Horizon Unit. The Horizon Unit is accredited as excellent until 15th July 2017.

The trust had received national awards:

- The Paediatric Diabetes Specialist Nurse has been awarded the title of Queens Nurse following demonstration of excellent care for children, young people and their families as part of the "Sugar Cube" project.

The trust had several initiatives in the older persons service including, the advancing quality initiative on Rosewood

ward. However, none of the wards had signed up to The Royal College of Psychiatrists accreditation for older peoples mental health wards. The child and adolescent mental health community teams had been part of Manchester University research project in self-harm therapies. Some areas, however, were not taking part in any recognised initiatives.

The trust used heat maps to identify areas for improvement within the trust, targeted resources appropriately and revisited areas of concerns to monitor progress made. Records reviewed confirmed progress within services.

The trust had internal monitoring and auditing taking place called integrated quality matrix. The integrated quality matrix combines three different quality frameworks (Essence of Care, North West Quality Accreditation Scheme and the CQC standards) into an integrated matrix aimed at reducing the amount of data collection required of ward staff, eliminating duplication of evidence provision and action planning, and clarifying priorities for service improvement. The integrated quality matrix framework consists of 10 domains:

- Nutrition, Food and Drink
- Medicine Management
- Communication
- Person Centred Care
- Therapeutic Intervention
- Personal Care and Comfort
- Physical Health
- Safety and Security
- Protecting Vulnerable People
- Infection Prevention and Control

Each ward receives a one-day visit by a team of people including matrons, clinical peers, support staff and PALs representatives, who, collect evidence, analyse this and scores allocated to each indicator. Scores and comments are entered directly into electronic tools contained in separate spreadsheets of an Excel workbook. The database is available to the ward manager and any member of staff he or she wishes to have access.

During 2015/16, Pennine Care was involved in the conduct of 69 clinical research studies. For 2015/16 Pennine Care achieved all clinical research targets set by the National Institute of Health Research.

This section is primarily information for the provider
Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met:** In the acute mental health wards for working age adults: • Patients were not always being provided with person centred care due to high bed occupancy, the delegation of the bed management role out of hours and associated administrative tasks. This meant that staff were not always meeting the needs of the patients in a timely manner. • Patients did not always have a bed to return to upon return from leave. This meant that the continuity of care was disrupted as patients were sometimes admitted to a bed in other parts of the trust or out of area. • Care plans across the wards were not always personalised. • On the wards for older age adults: • Patients on Cedars ward did not receive person centred care that met their needs, as there was a lack of meaningful activities, limited occupational therapy. • The care people received was not adapted to provide effective care to people who have dementia because there was minimal training to nursing assistant staff about providing dementia care. In Tameside home care and treatment team, only four of the eight records had a care plan. In Bury, only three out of eight records had an up to date care plan and only two a current one. Care plans were not person centred or recovery focused. In the home treatment teams, out of 39 care records, only eight had evidence of on-going physical health checks and nine had evidence of physical health checks. In the home treatment teams, there was no evidence of recording of allergies in the 39 care records looked at.

Patient's medication was inconsistently recorded across the home treatment teams.

In Tameside and Bury, home treatment teams, risk assessments were not routinely completed or updated at point of transfer to other services.

Patients had no means of communicating with staff whilst secluded in the health-based place of safety.

In Bury and Trafford Healthy Young Minds teams patients were waiting longer that 12 weeks for assessment and longer than 18 weeks for treatment.

In Tameside home treatment team, only four of the eight records had a care plan and in Bury, only three of the eight records had a care plan of which two had been updated. The care plans were not individual or recovery focussed in these teams. For example, in Bury, two care plans were almost identical despite the two patients having very different needs.

We looked at 39 care records across the home treatment teams. There was evidence of physical health assessments in only nine records and of on-going monitoring of physical health in eight.

Patients' allergies were not recorded in any of the 39 care records we looked at.

Patients' medication was inconsistently recorded across the teams.

In Tameside and Bury, risk assessments were not routinely completed or updated by the home treatment team staff at point of transfer into the service.

This was a breach of Regulation 9 (1) (3) (a) (b) (c)(e)

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 **How the regulation was not being met:** On Northside ward patients had to go through Southside ward to get to their outdoor space. This meant that privacy and dignity of patients on both wards was compromised.

Northside, Southside and Hollingworth, working age adult's wards and Summers, Rosewood and Cedars, older persons wards did not comply with the Department of Health guidance on eliminating mixed sex wards.

On Northside and Southside wards, male and female bedrooms were next to each other.

On Summers, Rosewood and Cedars ward's there was only one functional bath on each ward, this meant that males using the bath on each ward would have to pass female bedrooms to use it.

On Hollingworth ward, there was a designated female bathroom on a mixed sex corridor. This meant that females would have to pass through areas where there were men to get to it.

On Cedars ward there was a designated female only lounge, but it was closed at the time of the inspection and not accessible to patients.

In the learning disability offices, environments did not ensure the confidentiality of patients. Visitors had to walk through or past staff desks to get to interview rooms.Conversations held in interview rooms were audible in adjacent rooms.

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 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met:** We found that the registered person did not act in accordance with the Mental Capacity Act 2005. This was due to staff on Saffron ward not considering the need for a legal framework where persons over the age of 16 who lack capacity were subject to restrictions which may account to a deprivation of liberty such as full consideration of best interests as detailed in the Mental Capacity Act Code of Practice, the Mental Health Act or the Deprivation of Liberty Safeguards.

This section is primarily information for the provider
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The trust had not ensured that staff at the Meadows had not been provided with updated training on the Mental Capacity Act and mental health law such as the precedent case law; Cheshire West and Chester Council v P.

This was a beach of Regulation 11 (13)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** On the acute mental health wards for working age adults: On Southside ward, there were six days of missing dosages of anticoagulant medication in a patient's record. On the Cobden unit, the clinic room temperature was above 25 degrees. On Southside and South ward's, the fridge temperature was not monitored properly. Pharmacological care plans were not in place to describe the use of 'when required' medicines. Doctors did not always follow trust policy when cancelling medicines on a patients chart on Southside ward. In the health-based places of safety: The health-based place of safety at Stockport was particularly dirty. The toilet was heavily stained, the shower base was dusty and the sink was blocked with tissue. The furniture was stained and dirty. The service was unable to provide assurance that the toilet in the health-based place of safety at Stockport was flushed when not in use, in line with trust policy to prevent the risk of legionella disease. This was an unavoidable risk to patients.

There were no completed cleaning schedules available for scrutiny at the time of the inspection for the health-based place of safety at Stockport. It was not possible to determine when the suite was cleaned or how often. This posed an avoidable risk to patient health.

Patients using the health-based places of safety were unable to see staff in the staff room. Staff locked the en suite door in the room if a patient was using the room. However, here was no intercom system or other way for a patient to communicate with staff, summon staff assistance or know that staff were present in the staff room.

The health-based places of safety were sparse, not welcoming and resembled a seclusion room. The rooms did not contain a bed where patients could comfortably lie down. There were no sheets, pillows or blankets in the rooms.

One health-based places of safety at Tameside did not have blinds on the window which could be overlooked from the outside. This could affect a patient's privacy and dignity.

In the children, young people and families service at Milnrow Health Centre we found:

- Evidence that the service could not guarantee the cold chain storage of vaccines.
- Maximum/minimum fridge temperatures were not recorded in line with the provider's policy on the storage of vaccines and the manufacturers guidelines.
- Maximum/minimum thermometers were not available for use in cool bags for transferring vaccines to and from school clinics. We found no evidence that the maximum/minimum temperatures of cool bags were recorded.
- Vaccine stocks held in the fridge were untidy. This increased the risk that new stock could be used before older stock, leading to the possibility of older vaccines going out of date.
- We found date expired needles and syringes in the emergency anaphylaxis kit.
- Medicines disposal record showed that three ampoules of adrenalin were identified as out of date in November 2015, but were not removed from stock and disposed of until June 2016.

- We found no evidence for an expiry date check rota for Levonelle.

The provider's subsequent audit of the medicine fridges at five of the Heywood, Middleton and Rochdale school nurse service location against its storage, handling, distribution and disposal of vaccines policy found full compliance with the policy in only 10 out of 21 standards.

In the Community health service for adults:

Care and treatment must be provided in a safe way for patients.People who use services and others were not protected against the risks of infections, including those that are health care associated.

People who use the service were not protected against the risks associated with medications, by the proper and safe management of medicines.

In the learning disability community services:

Staff did not routinely carry out risk assessments of all patients.

Out of 32 care records we reviewed, seven patients did not have any risk assessment.

This was a breach of Regulation 12 (1)(2) (a) (b) (d) (e) (f) (g) (h)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** Some patients had been cared for in the extra care areas. On one occasion, we found that staff had not adhered to the Mental Health Act code of practice or the trust policy and did not provide the necessary safeguards. This is a breach of regulation 13 (5)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The trust did not have established systems in place to assess, monitor and improve the quality of the service provided because; In the crisis service and health based places of safety: The quality and local governance arrangements within each team was inconsistent. The issues with 136 suites, care plans and risk assessments had not been identified through existing arrangements. There was lack of evidence to demonstrate effective use of performance indicators and audits to drive improvements in the crisis service teams. There were inconsistencies across the crisis teams regarding: • staff skill mix • compliance with mandatory training • access to supervision • access to appraisals • team meetings • the quality of risk assessments • the quality of care plans • the implementation of the electronic care record system. The teams did not have access or oversight of the risk register for the service. In the Oldham's children's nutritional and dietetics service we found: In the five sets of records we saw we found poor recordkeeping. This meant that staff did not keep contemporaneous, accurate and complete records. They would not always know what had happened in previous contacts with the service. This raised risk issues to the safety of children using the service. The records had missing cover sheets, lack of page numbering, pages and letters not stored in order, entries not always signed or initialed.

In two records it was not clear what action had been taken by staff following reviews. One child was on the child protection register, the other had not been seen for a year due to missed appointments.

In the community based mental health service for adults:

Staff did not maintain an accurate, complete and contemporaneous record for patients.

Out of 43 records we reviewed, 11 patients did not have a current risk assessment and two risk assessments had not been updated for over twelve months.

We found 15 out of 43 care records that did not have a plan of care for patients who were receiving treatment.

In the end of life service:

There was no overarching governance structure for end of life services within the trust. End of life services were not subject to assessment, monitoring and quality improvement at trust level. There was no assessment, monitoring and mitigation of risks relating to the health and welfare of service users, relating to the low staff numbers in Bury Specialist Palliative Care Team.

In the community health service for adults:

Systems or processes were not established and operated effectively to ensure the registered person is enabled to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services)

This is a breach of Regulation 17 (1) (2) (a) (b) (c)

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 **How the regulation was not being met:** In the acute wards for working age adults:

Supervision was not always completed in line with trust policy. In some supervision files we could not see any evidence that supervision had taken place at all and in some supervision had not taken place for up to two years.

Staff in Trafford Healthy Young Minds team were not receiving supervision in line with trust policy.

In the acute wards for working age adults:

Mandatory training was under the trust target on some wards. On some wards, less than 75% of staff had completed basic life support training and on some wards, less than 75% of staff had completed intermediate life support. This meant that patients might be at risk should they require life support in an emergency.

In the crisis and health-based places of safety:

Compliance with mandatory training across the service was inconsistent and compliance with some training was much lower than the NHS target of 75% in some teams.

The service was not meeting the NHS target of compliance in six out of 14 mandatory training courses across the core service.

In the community mental health service for adults:

Staff were not up to date with basic life support and fire safety training.

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

This is a breach of Regulation 18 (1) (2) (a)