Pennine Care NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Community health services

Urgent Care

Facts and data about this service

Information about the sites and teams, which offer urgent care services at this trust, is shown below:

Location / site name	Team/ward/satellite name	Services provided	Address (if applicable)
Bury Walk in Centre	Outpatients Service (Bury Walk in Centre)	Outpatients Service	Moorgate PCC, 22 Derby Way, Bury
Prestwich Walk in Centre	OP Service (Prestwich Walk in Centre)	OP Service	Fairfax Road, Prestwich , Manchester, Greater Manchester

Is the service safe?

Mandatory training

Mandatory Training completion

The trust set a target of 95% for completion of mandatory training.

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)
Equality And Diversity	10	10	100%	95%	Yes
Conflict Resolution Level 1	10	10	100%	95%	Yes
Health and Safety Level 1	10	10	100%	95%	Yes
Fire Safety Level 1	9	10	90%	95%	No
Infection Control Level 1	9	10	90%	95%	No
Mental Capacity Act	6	7	86%	95%	No
Medicines Management	6	7	86%	95%	No
Preventing Radicalisation	8	10	80%	95%	No
Moving And Handling Level 1	8	10	80%	95%	No
Information Governance Level 1	8	10	80%	95%	No
Child Safeguarding Level 1	8	10	80%	95%	No
Basic Life Support	5	7	71%	95%	No
Intermediate Life Support	5	7	71%	95%	No
Paediatric Life Support	5	7	71%	95%	No
Child Safeguarding Level 2	5	7	71%	95%	No
Adult Safeguarding Level 1	7	10	70%	95%	No
Infection Control Level 2	3	7	43%	95%	No
Moving And Handling Level 2	1	7	14%	95%	No

In urgent care services the 95% target was met for three of the eighteen mandatory training modules for which staff were eligible.

All of the staff for which mandatory training was reported within urgent care services were qualified nursing staff. For the year to date (May 2017 – April 2018) data was also only provided in relation to Bury Walk in Centre. Data regarding Prestwich Walk in centre was provided for previous years.

The provider did not have a clear understanding of staff learning needs. While staff had completed ongoing training in the past, including specialist training for their role, and more training was being introduced, mandatory training had not been delivered to meet the trusts target.

There was one paediatric nurse employed at the walk-in centre. In the light of this, nursing staff had requested training in the care of children; this was currently being provided. The operations manager was aware that staff training needed to be reviewed and had a plan to address this.

The operations manager had met with each nurse to discuss their training needs. Protected weekly learning time was now in place although this was not yet embedded.

Safeguarding

Safeguarding Training completion

The trust set a target of 95% for completion of safeguarding training. Safeguarding training was classified as non-mandatory and between 1 May 2017 and 30 April 2018 the 95% target was met for none of the three courses.

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Child Safeguarding Level 1	8	10	80%	95%	No
Child Safeguarding Level 2	5	7	71%	95%	No
Adult Safeguarding Level 1	7	10	70%	95%	No

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust told us that they do not record safeguarding referrals as they do not currently have a mechanism for this.

The provider had systems to safeguard children and vulnerable adults from abuse. Policies were reviewed and were accessible to all staff. A safeguarding flowchart and other safeguarding information was available outlining the procedure to follow in the event of a safeguarding concern being raised. The information supplied from the trust did not highlight that any member of staff working within urgent care had received children's or adults safeguarding training at level 3 as

such there was no indications that any individual would be able to undertake an appropriate lead for safeguarding.

Staff could give examples of how to protect patients from harassment and discrimination.

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate. This included working in partnership with other agencies. There was a lead nurse for managing children's safeguarding.

A whistleblowing policy was in place. All staff had received recent up-to-date safeguarding and safety training appropriate to their role.

The children's and adult's safeguarding incident form was evidenced on line. Feedback from safeguarding concerns raised was not always provided to staff for learning. The operations manager was aware of this issue and had an action plan to address this.

Cleanliness, infection control and hygiene

There was an effective system to manage infection prevention and control. Staff adhered to infection control principles, including handwashing. Hand hygiene audits were recently introduced, although results were not visible in the department. A cleaning rota for the walk-in centre was now in place. There were systems for safely managing healthcare waste.

The practice had safety policies, including Control of Substances Hazardous to Health and Health and Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. A sharps injury policy was visible in consultation rooms.

A new system of audits and checks had recently been introduced. This was to ensure that facilities such as clinical rooms were well organised, equipment was safe to use and maintained according to manufacturers' instructions.

Environment and equipment

The provider had carried out health and safety checks in relation to fire safety, testing small electrical appliances and calibrating medical equipment to ensure it was safe to use.

Staff did regular risk assessments of the care environment.

Clinic rooms were well-equipped with the necessary equipment to carry out physical examinations. All areas were clean, had good furnishings and were well-maintained.

Staff maintained equipment well and kept it clean.

Assessing and responding to patient risk

Clinical staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.

Staff used a recognised risk assessment tool in order to ascertain and manage risks to patients.

Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

Staffing

Planned v Actual Establishment

The trust did not provide planned staff numbers, as such the staffing rate cannot be calculated.

Vacancies

The trust set a target of 7.5% for the vacancy rate. From 1 April 2017 to 31 March 2018, the trust reported an overall vacancy rate of 22% in urgent care services. This did not meet the trust's target. Across the service overall vacancy rates for qualified nursing staff was 36% and for allied health professionals was 5%.

A breakdown of vacancy rates by staff group in urgent care services at core service level and by team is below:

Urgent care total

Staff group	Total number of establishment staff March 2018	Number of vacancies March 2018	Total % vacancies overall (excluding seconded staff)
NHS Infrastructure Support Staff	3.5	0.0	1%
Qualified Allied Health Professionals	2.7	0.1	5%
Qualified Nursing and Health Visiting Staff	19.1	6.9	36%
Support to Doctors and Nursing Staff	2.9	0.9	32%
Support to Scientific, Therapeutic and Technical Staff	1.0	-1.6	-164%
All staff	**29.1**	**6.3**	**22%**

Qualified Nursing staff by site

Site name	Total number of establishment staff	Number of vacancies	Total % vacancies overall (excluding seconded staff)
Bury Urgent Treatment Centre	5.9	11.5	51%

Bury Rapid Response and Intermediate Care	1.0	2.8	36%
Rapid Response	0.0	4.8	0%
Grand Total	**6.9**	**19.1**	**36%**

Allied health professional by site

Site name	Total number of establishment staff	Number of vacancies	Total % vacancies overall (excluding seconded staff)
Bury Rapid Response and Intermediate Care	2.7	0.1	5%
Grand Total	**2.7**	**0.1**	**5%**

No information was provided relating to vacancies for medical staff within urgent care services.

Turnover

The trust did not provide the details of a target for turnover rates. From 1 May 2017 to 30 April 2018, the trust reported an overall turnover rate of 34% in Community health services - Urgent care. Across the trust overall turnover rates for qualified nursing staff were 16%; for medical staff were 15% and for allied health professionals were 15%.

Data for was only provided relating to Qualified nursing & health visiting staff for Urgent care services.

A breakdown of turnover rates by staff group in urgent care services at core service level and by team for the year ending 30 April 2018 is below:

Urgent care total

Staff group	Total number of substantive staff (April 2018)	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Qualified nursing & health visiting staff (Qualified nurses)	7.3	2.7	34%
Grand Total	**7.3**	**2.7**	**34%**

Nursing staff by team

Site name	Total number of substantive staff (April 2018)	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Bury Walk in Centre	7.3	1.7	30%
Prestwich Walk in Centre	0	1	44%
Grand Total	**7.3**	**2.7**	**34%**

Sickness

The trust set a target of 5% for sickness rates. From 1 May 2017 to 30 April 2018, the trust reported an overall sickness rate of 5.5% in community health services - Urgent care. This did not meet the trust's target. Across the trust overall sickness rates for nursing staff were 5.5%; for medical staff were 3% and for allied health professionals were 4%.

Data for was only provided relating to Qualified nursing & health visiting staff for Urgent care.

A breakdown of sickness rates by staff group in urgent care services at core level and by team between 1 May 2017 and 30 April 2018 is below:

Urgent care total

Staff group	Total available permanent staff days	Total permanent staff sickness days	Total % permanent staff sickness overall
Qualified nursing & health visiting staff (Qualified nurses)	2875	157	5.5%
Grand Total	**2875**	**157**	**5.5%**

Nursing staff by site

Site name	Total available permanent staff days	Total permanent staff sickness days	Total % permanent staff sickness overall
Bury - Bury Walk in Centre	2042	114	5.6%
Bury - Prestwich Walk in Centre	833	42	5.1%

Grand Total	**2875**	**157**	**5.5%**

Nursing – Bank and Agency Qualified nurses

From 1 May 2017 to 30 April 2018, of the 41943 total working hours available, 0.1% were filled by bank staff and 8% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

The main reason for bank and agency usage for the teams was vacancies.

In the same period, 66% of available hours were unable to be filled by either bank or agency staff.

Data was only provided for Qualified nurses within Urgent care services.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Bury - Bury Walk in Centre	22389	39	0.2%	2447	11%	10165	45%
Bury - Prestwich Walk in Centre	19554	7	<0.1%	820	4%	17618	90%
Core service total	**41943**	**46**	**0.1%**	**3267**	**8%**	**27783**	**66%**

Medical locums

Data was not provided for medical locums at a core service level for Urgent care services.

Suspensions and supervisions

During the reporting period from 30 April 2017 to 1 May 2018, urgent care services reported that there were two cases where staff have been either suspended or placed under supervision. In both cases staff were suspended.

A breakdown of all cases can be seen in the table below.

Outcome	Number of cases
Suspended	2
Total	**2**

The provider had determined safe staffing levels. However, the review of staffing levels implemented was ad-hoc, with the staffing requirements set by the trust regularly not met. Staffing

levels did not take account of the shift system. For example, four nursing were determined as required each day at the inspection two nursing staff were available.

An effective system was not in place to monitor, review and manage clinical staffing levels where there were periods of understaffing which are not addressed quickly. Cover arrangements for sickness, leave, vacant posts did not ensure patient safety. The system for dealing with surges in demand was to signpost patients to other services. On the day of the inspection there were two nursing staff on duty. Under these circumstances, patients were signposted to other services, such as NHS 111, back to their GP or to an urgent care centre

The service used locum/bank/agency staff appropriately. It was confirmed by staff and in records that the agency staff used were regular staff and were familiar with the walk-in centre systems and routines. We were informed that appropriate checks were carried out on the staff to ensure they were suitable for their role.

Over a three-year period staffing levels, including administration staff had reduced from 28 to 5.

Managers did not have in place risk management or staffing tools, formal risk tools were being introduced to monitor staffing levels. These had not been implemented nor embedded at this inspection.

A recent recruitment drive was unsuccessful in recruiting any new nursing staff. Turnover levels for nursing staff remained high. The service at both walk-in centres have been subject to closure for the past three years.

Quality of records

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and in an accessible form. That included when patients moved between teams.

A new communications IT portal had been set up so that staff had access to a range of relevant information including incident referrals and complaints.

Health care information was available to clinicians, for example, information was available about the vital signs to look out for in children. Emergency telephone numbers were available for dentists and direct access to ambulance services.

Medicines

The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment and vaccines minimised risks.

Processes were in place for checking medicines and staff kept accurate records of medicines.

Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Patients were referred to their GP for monitoring and follow-up care and treatment.

The Patient Group Directions had recently been signed and authorised and were available for staff. (PGDs are written instructions to help supply or administer medicines to patients, usually in planned circumstances and are a legal requirement).

Fridge temperatures were monitored. However, the fridge did not have a thermometer which monitored the minimum and maximum temperature which would ensure medicines were stored safely.

Two of the nursing staff were independent nurse prescribers. They were trained for their role and received support from the Clinical Commissioning Group medicine management team.

Staff worked with the services medicines management team to ensure improvements. A pharmacy technician audited the walk-in centre and set up new systems where shortfalls were identified. They would continue to work at the walk-in centre to ensure changes were embedded into staff working practices.

Safety performance

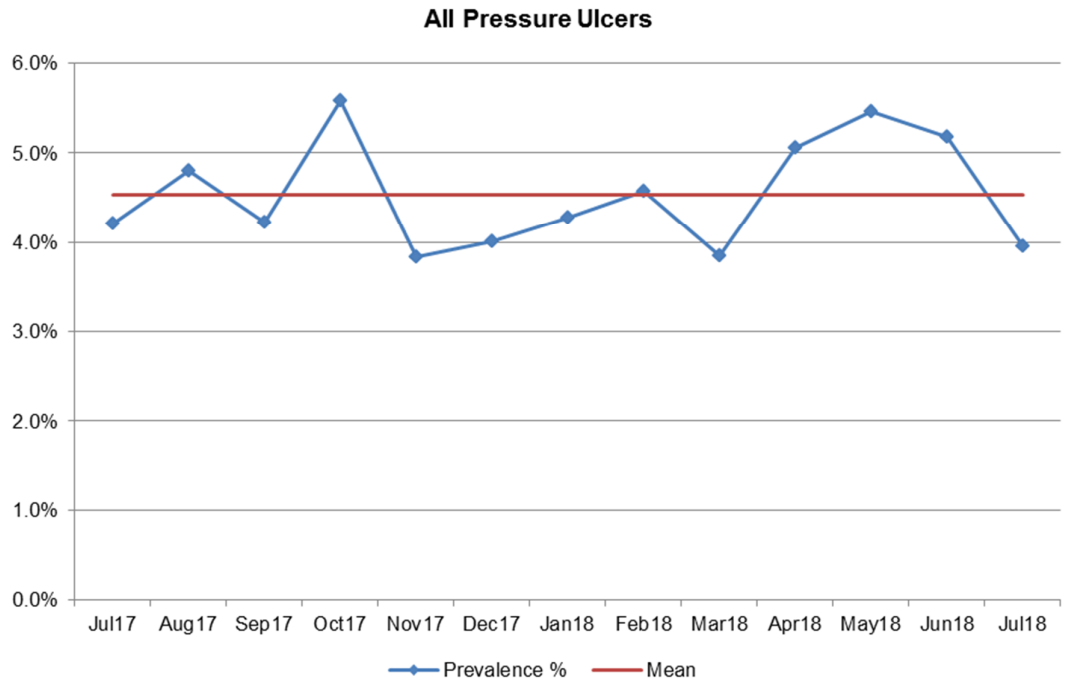
Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

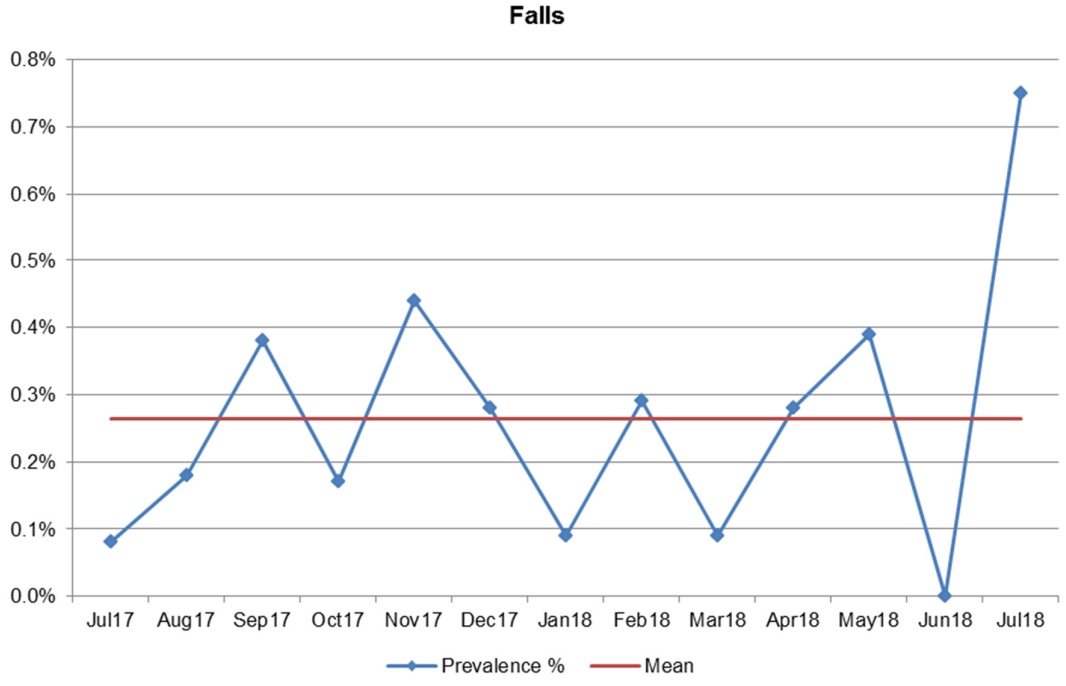
Data from the Patient Safety Thermometer showed that the trust reported 650 pressure ulcers, 37 falls and 14 catheter urinary tract infections from July 2017 to July 2018 within community health settings as a whole (not specific to urgent care).

All pressure ulcers



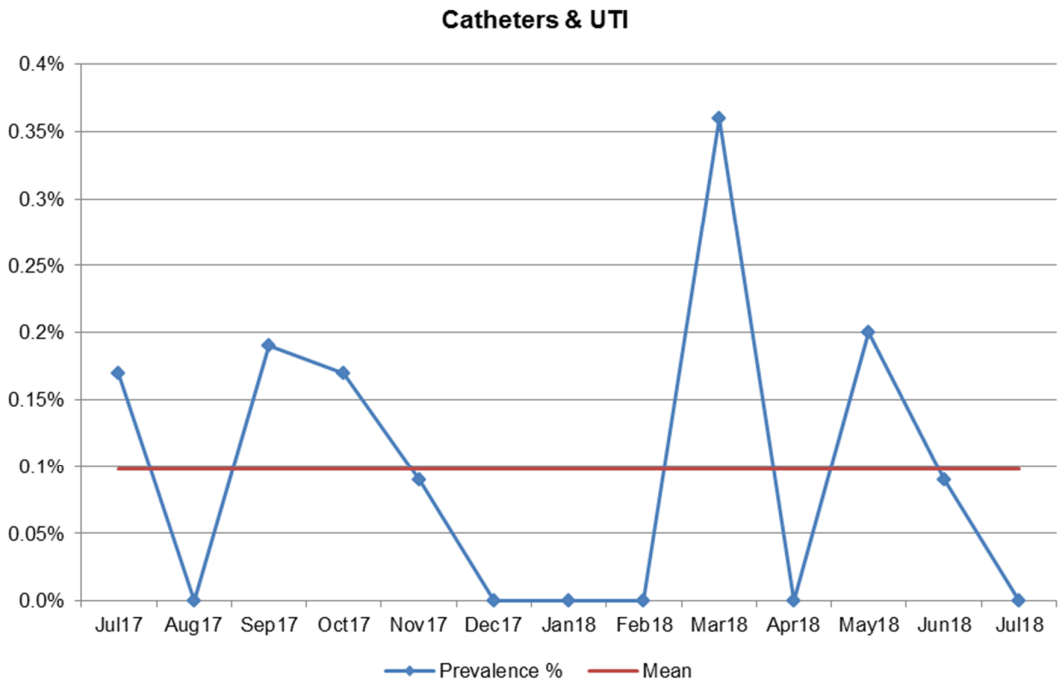
Month	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18
%	4.2	4.8	4.2	5.6	3.8	4.0	4.3	4.6	3.9	5.1	5.5	5.2	4.
No.	50	54	45	64	44	43	50	47	43	54	56	58	42

Total Falls



Month	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18
%	0.1	0.2	0.4	0.2	0.4	0.3	0.1	0.3	0.1	0.3	0.4	0.0	0.8
No.	1	2	4	2	5	3	1	3	1	3	4	0	8

Total CUTIs



Month	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18
%	0.2	0	0.2	0.2	0.1	0	0	0	0.4	0	0.2	0.1	0.0
No.	2	0	2	2	1	0	0	0	4	0	2	1	0

Incident reporting, learning and improvement

Serious Incidents (SIRI) – Trust data

From 1 May 2017 to 30 April 2018, trust staff within urgent care services reported no serious incidents.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been twelve prevention of future death reports sent to Pennine Care NHS Foundation Trust. None of these related to this core service.

There was a system for recording reviewing, investigating and acting on significant events, alerts and incidents. However, these were not consistently managed or adhered too.

Staff understood their duty to raise concerns and report incidents and near misses. While staff were supported by managers to do this, the operations manager had identified that incidents were not always reported in line with the trust policy. The operations manager had an action plan to address this issue. Training sessions were being provided so that staff knew how to raise incidents correctly and accurately. Staff meetings were planned for discussing and learning from significant events.

Staff reported that they did not consistently receive feedback from investigation of incidents both internal and external to the service.

There were no arrangements in place for staff met to discuss feedback and learning from investigations, significant events, alerts and incidents. Meetings were in the process of being set up between the operations manager and the nursing staff so they had opportunity to discuss work related issues and share information for learning. However, these had not yet been implemented.

There was evidence of change having been made because of feedback. As an example, following an incident when the incorrect amount of medicine was administered to a patient, the trust introduced a new syringe to the walk-in center to ensure the correct dose of medicine was measured before being administered.

Staff understood the duty of candour. They were open and transparent, and explained to patients and families a full explanation when something went wrong.

Is the service effective?

Evidence-based care and treatment

The provider had some systems to keep clinicians up to date with current evidence based practice.

Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients need could not be met by the service, staff redirected them to the appropriate service for their needs.

Care and treatment was delivered in a non-discriminatory manner. Staff developed care records that met the needs identified during assessment. Care records were updated and personalised as needed.

Arrangements were in place to deal with repeat patients. Contact was made with the patient's

GP informing them that their patient was regularly attending the walk-in centre.

Best Practice

Staff provided a range of care and treatment interventions suitable for the patient group. There were no systems in place to ensure that these interventions were those recommended by the

National Institute for Health and Care Excellence guidance. This was because the service did not have a comprehensive programme of quality improvement activity to monitor the effectiveness and appropriateness of the care provided. However, the newly appointed operations manager did have an action plan to develop this part of the management of the walk-in centre as yet this was not developed or embedded.

Patient outcomes

Audits – changes to working practices

The trust has participated in five clinical audits in relation to this core service as part of their Clinical Audit Programme. All of these were provider wide audits.

Audit name	Area covered	Key Successes	Key actions
National audit of intermediate care	Community intermediate care providers	Average response time from referral to assessment in IMC crisis response services is 2 hours. Over 60% of service users are discharged from crisis response services to their own home. The average waiting time from referral to commencement of intermediate care is less than two days, and less than 10% of patients wait more than two days.	The clinical effectiveness and quality improvement team have planned to meet the IMC teams to review both national and local level results and discuss actions for improvement.
Hand hygiene observation audit	All teams delivering clinical care	•99.6% of staff used the correct hand washing procedure •99% of staff used the correct alcohol gel procedure •98% of staff were bare below the elbows •97% of staff could name the 5 moments of hand hygiene	•Audit reports are shared with the relevant IP& C lead and discussed at the IP&C committee •IP&C leads disseminate individual summary results to relevant teams so concerns can be addressed
IP&C Community environmental inspection of community buildings	All community clinic rooms from which PCFT delivers clinical care	•Most standards have been maintained or have improved since the previous audit	•A copy of the audit report has been shared with the IP&C leads for

		•All clinical/treatment rooms have foot operated pedal bins, and most have a cleaning schedule in place for medical equipment •Utility/sluice rooms have a wash basin and a foot operated pedal bin	discussion at the IP&C Committee. •IP&C leads disseminate individual reports to relevant services areas highlighting areas that need to be addressed, and will monitor progress of improvement.
Trust wide record keeping audit - paper health records	All relevant clinical teams	•The majority of health records include a demographics sheet and reason for referral. •There has been improvement since the previous audit, in including the service user NHS number on clinical correspondence. •Clinical notes are generally written in chronological order, are concise and factual and written in terms a service user can understand. •In the majority of cases, assessments are completed, and individual plans of care to address service users' needs problems and issues are put in place. •Where there has been a significant event, the majority of cases include a chronology of significant events. •The condition of the health record is generally good.	•A copy of the report has been shared with the Associate Director of Nursing and Healthcare Professionals, the Trust Records Manager and relevant leads. •Services have been provided with a copy of their local results and are required to develop action/improvement plans to address any concerns. •The Associate Director of Nursing and Healthcare, and the Trust Records Manager will oversee strategic actions to ensure they are delivered. •The audit is included on the Trust annual clinical audit programme.

Trust wide record keeping audit - electronic health records	All relevant clinical teams	•The majority of records include up to date patient demographics and the reason for referral to the service. •Most cases do show evidence that entries are written in terms that service user can understand and are concise and factual. Where a significant event has been identified, chronologies of significant events are recorded. •When consent is required for a child, there is evidence that most cases do have the forms in service users' records. •In the majority of cases have evidence that risk formulations are completed to reflect the risks identified in risk assessments.	•A copy of the report has been shared with the Associate Director of Nursing and Healthcare Professionals, the Trust Records Manager, and relevant leads. •Services have been provided with a copy of their local results, and are required to develop action/improvement plans to address any concerns. •The audit is included on the Trust annual clinical audit programme.

Competent staff

Clinical Supervision

The trust provided the following information about their clinical supervision process:

Community Services Bury: a clear Supervision Framework has been launched across the Division (including posters distributed on each site). We held a number of engagement events for staff over the year to support and educate on requirements around supervision both management and clinical.

Clinical supervision compliance is discussed in 1:1 meetings; it's a regular standing item on 1-1 and following feedback from CQC re-reminded staff to ensure they recorded any clinical supervision on the 1-1 template.

(Previously the plan was for this to be submitted to a central point, but this has been changed to give line managers more responsibility/ownership – what happens now is that evidence of the

clinical and management supervision is documented within the agreed template and this is kept by the line manager in the member of staff's supervision files and the member of staff also keeps a copy. A reminder of this system with the relevant framework has been sent out to staff.)

Managers did not provide staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) of their work performance. Nursing staff were not provided with formal clinical supervision although verbal supervision had been provided in the interim. Administration staff were not provided with formal supervision to support them in their role. The operations manager was aware of these issues and had an action plan to introduce a new model of clinical support for nursing staff so their competency could be assessed and with meetings being arranged for all staff.

Appraisal rates

From 1 April 2017 to 31 May 2018, 50% of permanent non-medical staff within the urgent care services core service had received an appraisal compared to the trust target of 85%.

Within Urgent care services data was only provided for Qualified nursing and health visiting staff working within the Bury Walk in Centre. There were no staff eligible for appraisals at the Prestwich centre.

Urgent care total

Staffing group	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Qualified nursing & health visiting staff	5	10	50%	85%	No
All staff	**5**	**10**	**50%**	**85%**	**No**

Staff observations demonstrated that staff had the skills, knowledge and experience to carry out their roles. However, the service did not ensure that all staff worked within their scope of practice as a competency framework was not in place.

We were informed that staff were provided with regular informal support by the area manager. There was a mixed response from staff about the level of support provided. Some staff said they received good ongoing support while other said they received minimal support. The operations manager was aware of this issue and had an action plan to address this through team meetings and informal discussions.

The percentage of staff that had had an annual appraisal in the last 12 months had increased to 100%.

Multidisciplinary working and coordinated care pathways

Staff worked together, and worked with other organisations to deliver effective care and treatment.

Staff spoken with said they would involve other health care professionals and different teams in assessing, planning and delivering care and treatment. Staff did not have access to a GP for advice on more serious clinical issues.

Patients were generally seen on a first come first served basis, although the service had a triage system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived. The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. Staff would consult with clinical staff for advice through instant messaging if they had a concern or query. The operations manager was aware this system needed to be improved and had an action plan to address this.

Staff communicated with patient's registered GP's so that they were aware of the need for possible further action. Staff also referred patients back to their own GP to ensure continuity of care where necessary.

The service ensured that care was delivered in a coordinated way and considered the needs of different patients, including those who may be vulnerable because of their circumstances.

Health promotion

Staff supported patients to manage their own health.

The service identified patients who may need extra support, for example, patients with a learning disability.

Where appropriate, staff gave patients advice so they could self-care.

Where patients need could not be met by the service, staff redirected them to the other appropriate service.

Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given. For example, contact would be made with the patients' GP for follow on care.

Health care promotion leaflets were available in the patient waiting area.

A senior member of staff was currently undertaking work for a local homeless project. This entailed collecting blankets, hats and scarves in the winter to give to patients who were homeless when they came to the walk-in centre.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust set a target of 95% for completion of Mental Capacity Act training.

From April 2017 to December 2017 the trust reported that Mental Capacity Act (MCA) training had been completed by 86% of staff within Community health services - Urgent care. Whilst this did not meet the trust's 95% target, this related to one of the seven eligible staff not receiving training. Information was only provided for Qualified nursing & health visiting staff within this core service.

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)
Mental Capacity Act	6	7	85%	95%	No

Deprivation of Liberty Safeguards

From 1 May 2017 to 30 April 2018 the trust reported that 214 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority. None of which were pertinent to Community health services - Urgent care.

The service obtained consent to care and treatment in line with legislation and guidance.

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Staff were trained on the Mental Capacity Act and Deprivation of Liberty safeguarding.

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to decide.

The service does not undertake care and treatment that would require a Deprivation of Liberty Safeguard (DoLS) application to be made.

Is the service caring?

Compassionate care

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it.

We observed staff being kind, friendly and compassionate towards patients. Patient safety and comfort was continually assessed throughout any treatment.

The service gave patients timely support and information. Feedback received from patients was all positive about how kind the staff were. They commented that staff were friendly, caring and helpful.

At all clinics we visited we witnessed staff speaking to patients using language that was appropriate to patients' age or level of understanding.

Privacy and confidentiality were always maintained. We observed that surgery doors were kept shut and when staff were dealing with patients at the reception area this was done discreetly

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs.

Staff supported patients to understand and manage their care, treatment or condition.

Staff directed patients to other services when appropriate and, if required, supported them to access those services.

Patients said staff treated them well and behaved appropriately towards them.

Staff maintained the confidentiality of information about patients.

Emotional support

Staff were clear on the importance of emotional support needed when delivering care. Patient commented that staff were supportive and reassuring all through treatment.

Staff respected patients' confidentiality.

Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's capacity to decide for themselves.

Staff involved patients in care planning and risk assessment.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.

Staff involved patients when appropriate in decisions about the service.

Staff enabled patients to give feedback on the service they received. The practice invited patients to complete the NHS Friends and Family test (FFT) when attending the walk-in centre. The FFT gave every patient the opportunity to feed back on the quality of care they had received. Results from the patient responses received in July 2018 showed most patients would be 'extremely likely' to recommend the practice to friends and family.

Understanding and involvement of patients and those close to them

Staff helped patients be involved in decisions about their care and treatment.

Staff informed and involved families and carers appropriately and provided them with support when needed.

Communication systems to meet patients' needs could be made available as needed.

For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.

Staff helped patients and their carers find further information and access community services.

Staff carried out a full assessment of patients' needs so they could make an informed decision about their care and treatment. For example, whether a patient had a mental health need.

Staff helped patients and their carers find further information and access community services.

The operations manager was aware that further work needed to be carried out in relation to obtaining patients feedback on the standard of care they received and had an action plan to address this. As yet these actions had not been fully developed or embedded in the practice of the service.

Is the service responsive?

Planning and delivering services which meet people's needs

The service had clear criteria for which patients would be offered a service. The criteria did not exclude patients who needed treatment and would benefit from it.

The service did not have a set and monitored target for time from assessment to treatment. Staff monitored waiting times informally daily. Where patients were waiting a long time for an assessment or treatment there were arrangements in place to manage the waiting list and to support patients while they waited. Where patient's needs could not be met by the service, they were informed about anticipated waiting times and redirected to the appropriate service for their needs. For example, patients were directed to NHS 111 or an urgent care centre. A formal risk tool to monitor waiting times was not used.

The operations manager was aware of this issue and was currently looking to formalise this process with the introduction of an effective monitoring system that could be used daily by the staff team.

The team could see urgent referrals quickly and non-urgent referrals within an acceptable time. The service did not operate overnight.

The team responded promptly and adequately when patients telephoned the service.

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

The facilities and premises were appropriate for the services delivered.
The service made reasonable adjustments when patients found it hard to access the service. For example, interpretation services were available for patients whose first language was not English. Leaflet information was not always available in formats that meet individual needs.

There was no formal system of closing the walk-in centre at the end of the shift. Staff worked additional hours and patients were signposted to other services such as the urgent care centre.

The services are under review to make sure that the provider can deliver these to meet the needs of patients and the community.

Staff communicated with patients in a way that they could understand, for example, there was a hearing loop.

Meeting the needs of people in vulnerable circumstances

The service made adjustments for patients needs for example, by ensuring disabled patients access to premises and by meeting patients' specific communication needs.

Staff ensured that patients could obtain information on treatments, local services and patients' rights.

The information provided such as leaflets could be requested in a form accessible to the patient group. However, this was not readily available and needed to be ordered.

Managers ensured that staff and patients had easy access to interpreters and/or signers.

Access to the right care at the right time

Accessibility

The largest ethnic group within the trust catchment area is White - British with 79% of the population.

	Ethnic minority group	Percentage of catchment population (if known)
First largest	White - British	79.00%
Second largest	Black or Black British - African	5.60%
Third largest	Asian of Asian British - Pakistani	2.70%
Fourth largest	White - English	1.70%

Referrals

No information was provided regarding referrals relating to urgent care services. This is because the service is as needed for patients and therefore referrals are not made.

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

Patients could access the service either as a walk in-patient, via the NHS 111 service or by referral from a healthcare professional. Patients did not need to book an appointment.

Patients could access care and treatment at a time to suit them. The service operated from: Monday to Friday from 7am to 3pm in one location and Monday to Friday 12.00 to 8.00pm in another.

Learning from complaints and concerns

Complaints

From 1 May 2017 to 30 April 2018 there were two complaints about urgent care services, neither complaint was upheld. The trust took between 5 and 50 days to investigate and close complaints. The trust currently do not set targets for closing complaints, this issue was highlighted in a recent well-led review.

A summary of complaints within urgent care services by subject and site is below:

Urgent care Total

Subject	Number of complaints
Patient Care	1
Access to treatment or drugs	1
Total	**2**

Urgent care – Bury Walk in Centre

Subject	Number of complaints
Access to treatment or drugs	1
Total	**1**

Urgent care – Prestwich Walk in Centre

Subject	Number of complaints
Patient Care	1
Total	**1**

Compliments

From 1 May 2017 to 30 April 2018 the trust received 569 compliments. Of these three related to urgent care services, which accounted for 0.5% of all compliments received by the trust as a whole.

Team	Number of compliments
Bury Walk-in Centre	2
Prestwich WIC	1
Total	**3**

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

Patients knew how to complain or raise concerns. Information about how to make a complaint or raise concerns was available and staff referred patients to the Patient Advice and Liaison Service. The complaint policy and procedures was displayed on the walk-in centre's website.

When patients complained or raised concerns, they received feedback. Complaints were monitored by senior managers for trends and patterns although staff reported they did not always receive feedback on complaint investigations.

Staff protected patients who raised concerns or complaints from discrimination and harassment Staff treated patients who made complaints compassionately.

Staff reported they were not always provided with feedback following complaint investigations, although we did see records that reflected feedback was taking place.

Is the service well led?

Leadership

The manager of the Bury walk-in centre had recently been redeployed to another location within the Trust and in the light of this an operations manager had been appointed to take over the running of the service. On the day of the inspection the operations manager had been in post for two weeks. In this time, they had reviewed the management of the centre and identified many shortfalls in all parts of the running of the service. They had developed an action plan to address these shortfalls.

The leadership, senior management and governance of the walk-in centre did not always assure the trust regarding the delivery of high-quality, safe and person-centred care. The shortfalls in the running of the walk-in centre had been identified and were being addressed, by the trust. However, the trust could not be fully assured that the arrangements for governance and performance were fully embedded and operated effectively.

Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and had a plan to address them although this was not in place or embedded as yet.

Leaders had the experience and skills to deliver the service strategy and address risks to it although did not have the capacity due to the uncertain future of the service.

The newly appointed manager was visible and approachable and worked closely with staff to make sure they prioritised inclusive leadership.

Vision and strategy

The service had a vision and strategy to deliver high quality care and promote good outcomes for patients, however, the shortfalls identified by the Trust did not support this strategy. Staff knew and understood the provider's vision and values and how they were applied in the work of their team. However, they were unclear as to how this could be supported and delivered.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. The operations manager had provided support to the staff over the recent changes and actions going forward. It was acknowledged by the staff and the operations manager that there was significant uncertainty about the future of the services.

There had been a recent review of the governance arrangements which had brought about strengthening the vision and strategy for this service. Plans had been developed and some actions

completed to deliver the strategy. However, the longer-term plans were uncertain and actions taken were not yet measurable as to their impact on the vision and strategy.

Staff reported they now had clear lines of accountability and support.

The operations manager now ensured that staff were aware of the vision and set of values.

Culture

Staff reported that morale at the walk-in centre had now improved. The staff spoken with said they received regular support from the newly appointed operations manager. Staff said they now felt respected, supported and valued.

The operations manager spoke highly of the staff team and praised them for their hard work and support in bringing about change in a short period of time.

Staff spoken with said the new operations manager had improved the department immensely and brought about changes which resulted in a safer working environment. Staff said the operations manager was open to listening to new innovations.

Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

All staff said they were considered valued members of the team. They were now given protected time for professional development and evaluation of their clinical work.

The service focused on the needs of patients.

Staff we spoke with told us they could raise concerns and were encouraged to do so. They were now more confident that these would be addressed.

There were now planned processes for providing all staff with the development they need. All staff had received an annual appraisal in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

There was an improved emphasis on the safety and well-being of all staff.

The service promoted equality and diversity.

There were positive relationships between individuals and teams.

Governance

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

Systems had been introduced in relation to monitoring health and safety, good medicines management, staff training and reviewing and monitoring staffing levels. Staff were clear on their roles and accountabilities in these areas.

Policies and procedures were in place for staff to refer to.

Staff were receiving training on dealing with incidents and significant events so these were managed in line with the Pennine Trust policy guidelines.

Formal risk tools were being introduced to monitor staffing levels and waiting times.

Standard operating procedures were in place, although no hard copies were available for agency nursing staff to refer to.

Formal support systems were in the process of being introduced for both nursing and administration staff.

There were clear responsibilities, roles and systems of accountability to support good governance and management.

The operation manager had a plan in place which would ensure the provider that they were operating as intended.

Management of risk, issues and performance

Staff concerns matched those on the risk register and identified by the operation manager.

There were improved processes for managing risks, issues and performance. The operations manager had further plans to monitor identify, and understand current and future risks including risks to patient safety. However, not all these plans were in place, embedded or could provide assurance to the service that risks were safely managed.

Information management

Staff had completed training in information governance and were aware of the importance of protecting patients' personal information.

Care records were a mix of computerised and paper records. We saw computers were password protected and were told these were backed up to secure storage. Any paper records were stored in lockable cabinets. We saw staff locked computers when they moved away from their workstations.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed.

Engagement

The service involved patients about their views on the standard of the service they received.

The service invited patients to complete the NHS Friends and Family test (FFT) when attending the walk-in centre. The FFT gave every patient the opportunity to feed back on the quality of care they had received. The operations manager was aware that further work needed to be carried out in relation to giving patients an opportunity to provide feedback on the standard of care they received. There was an action plan to address this.

Staff had completed a quality assurance questionnaire recently and regular staff meetings were planned so that staff had an opportunity to talk about their work and express their views and ideas about the development of the service.

Learning, continuous improvement and innovation

Accreditations

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

No details of Urgent care services which with accreditations were provided.

There were systems and processes for learning and continuous improvement. The operations manager had a clear risk rated plan of the areas of required improvement.

There was a focus on continuous learning and improvement at all levels within the service. For example, protected learning time was now in place.

Staff knew about improvement methods and had the skills to use them.

Meetings were planned to improve communication amongst the staff team.

There was a lead nurse for managing children's safeguarding.

Staff were appointed lead roles in their work.

Support systems were being set up to provide nursing staff with clinical supervision and competency assessments these were not yet sufficient to provide the trust with reassurance that staff were receiving appropriate support.

Formal supervision was planned for administration staff.

Safety equipment was checked to ensure it was working properly.

Staffing levels were being closely monitored.

Community Dental

Facts and data about this service

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

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

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

Information about the sites and teams, which offer Community Dental at this trust, is shown below:

Location / site name	Team/ward/satellite name	Services provided	Address (if applicable)
Moorgate	Bury Dental Services	Dental	22 Derby Way, Bury
Moorgate	Bury Dental Services	Dental	Church Street West, Radcliffe, Lancashire
Fairfield hospital	Adult Special Care Dentistry - General Anaesthetic Service	Adult Special Care General Anaesthetic	Rochdale Old Rd, Bury
Oldham Integrated Care Centre	Oldham Community Dental Services	Dental	New Radcliffe Street, Oldham
HMP Buckley Hall	HMP Buckley Hall	Dental	Buckley Farm Ln, Rochdale
Rochdale Pheonix Centre	Community Dental Services	Dental	Church Street, Heywood
Nye Bevan House	Community Dental Services	Dental	Maclure Road, Rochdale

Location / site name	Team/ward/satellite name	Services provided	Address (if applicable)
Whitehall Street	Community Dental Services	Dental	Whitehall Street, Rochdale
Oldham Integrated Care Centre	Oldham Urgent Dental Care	Dental	New Radcliffe Street, Oldham
Bolton Hospital	Community Dental services	Community Dental services	Bolton Hospital , Minerva Rd, Bolton
Alder Hey Hospital	Community Dental services- General anaesthetic services	Community Dental services- General anaesthetic services	East Prestcott Rd, Liverpool
Lancashire schools	Epidemiology screening programme	Dental , schools selected for inspections according to random allocation	various

Is the service safe?

Mandatory training

Mandatory Training completion

The trust set a target of 95% for completion of mandatory and statutory training.

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)
Child Safeguarding Level 2	82	82	100%	95%	Yes
Infection Control Level 1	85	85	100%	95%	Yes
Moving And Handling Level 1	84	85	99%	95%	Yes
Child Safeguarding Level 1	84	85	99%	95%	Yes
Health and Safety Level 1	82	85	96%	95%	Yes
Information Governance Level 1	80	85	94%	95%	No
Conflict Resolution Level 1	80	85	94%	95%	No
Moving And Handling Level 2	72	77	94%	95%	No
Equality And Diversity	79	85	93%	95%	No

Infection Control Level 2	76	82	93%	95%	No
Preventing Radicalisation	78	85	92%	95%	No
Paediatric Life Support	70	78	90%	95%	No
Basic Life Support	70	78	90%	95%	No
Intermediate Life Support	68	77	88%	95%	No
Adult Safeguarding Level 1	74	85	87%	95%	No
Fire Safety Level 1	73	85	86%	95%	No
Medicines Management	9	14	64%	95%	No

In Community Dental the 95% target was met for 12 of the 17 mandatory and statutory training modules for which staff were eligible.

A breakdown of compliance for mandatory training courses from 1 May 2017 to 30 April 2018 for Qualified Scientific, Therapeutic and Technical staff in Community Dental is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Moving And Handling Level 1	81	82	99%	95%	Yes
Health and Safety Level 1	79	82	96%	95%	Yes
Information Governance Level 1	77	82	94%	95%	No
Moving And Handling Level 2	72	77	94%	95%	No
Fire Safety Level 1	70	82	85%	95%	No

In Community Dental the 95% target was met for two of the five mandatory training modules for which Qualified Scientific, Therapeutic and Technical staff were eligible.

A breakdown of compliance for mandatory training courses from 1 May 2017 to 30 April 2018 for 'support to doctors and nurses' staff in Community Dental is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Moving And Handling Level 1	3	3	100%	95%	Yes
Infection Control Level 1	3	3	100%	95%	Yes
Health and Safety Level 1	3	3	100%	95%	Yes
Adult Safeguarding Level 1	3	3	100%	95%	Yes
Information Governance Level 1	3	3	100%	95%	Yes
Child Safeguarding Level 1	3	3	100%	95%	Yes
Preventing Radicalisation	3	3	100%	95%	Yes
Conflict Resolution Level 1	3	3	100%	95%	Yes
Fire Safety Level 1	3	3	100%	95%	Yes
Equality And Diversity	2	3	67%	95%	No

In Community Dental the 95% target was met for all 10 of the mandatory and statutory training modules for which 'support to doctors and nurses' staff were eligible.

No data was provided for either qualified nursing staff or medical staff within this core service.

Bury Dental (including Epidemiology)

A breakdown of compliance for mandatory training courses from 1 May 2017 to 30 April 2018 for Qualified Scientific, Therapeutic and Technical in Community Dental at Bury Dental (including Epidemiology) is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Infection Control Level 1	28	28	100%	95%	Yes
Moving And Handling Level 1	28	28	100%	95%	Yes
Child Safeguarding Level 1	28	28	100%	95%	Yes
Child Safeguarding Level 2	28	28	100%	95%	Yes
Conflict Resolution Level 1	27	28	96%	95%	Yes
Health and Safety Level 1	27	28	96%	95%	Yes
Preventing Radicalisation	26	28	93%	95%	No
Equality And Diversity	26	28	93%	95%	No
Fire Safety Level 1	26	28	93%	95%	No
Information Governance Level 1	26	28	93%	95%	No
Moving And Handling Level 2	23	25	92%	95%	No
Paediatric Life Support	23	26	88%	95%	No
Infection Control Level 2	24	28	86%	95%	No
Basic Life Support	22	26	85%	95%	No
Intermediate Life Support	21	25	84%	95%	No
Adult Safeguarding Level 1	22	28	79%	95%	No

HMR Dental (including Epidemiology)

A breakdown of compliance for mandatory training courses from 1 May 2017 to 30 April 2018 for Qualified Scientific, Therapeutic and Technical in Community Dental at HMR Dental (including Epidemiology) is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Infection Control Level 2	22	22	100%	95%	Yes
Moving And Handling Level 2	22	22	100%	95%	Yes
Moving And Handling Level 1	22	22	100%	95%	Yes

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Child Safeguarding Level 1	22	22	100%	95%	Yes
Child Safeguarding Level 2	22	22	100%	95%	Yes
Infection Control Level 1	22	22	100%	95%	Yes
Information Governance Level 1	21	22	95%	95%	Yes
Conflict Resolution Level 1	21	22	95%	95%	Yes
Preventing Radicalisation	21	22	95%	95%	Yes
Health and Safety Level 1	21	22	95%	95%	Yes
Equality And Diversity	21	22	95%	95%	Yes
Adult Safeguarding Level 1	21	22	95%	95%	Yes
Basic Life Support	19	22	86%	95%	No
Intermediate Life Support	19	22	86%	95%	No
Paediatric Life Support	18	22	82%	95%	No
Medicines Management	9	14	64%	95%	No
Fire Safety Level 1	14	22	64%	95%	No

Oldham Dental (including Epidemiology)

A breakdown of compliance for mandatory training courses from 1 May 2017 to 30 April 2018 for Qualified Scientific, Therapeutic and Technical in Community Dental at Oldham Dental (including Epidemiology) is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Infection Control Level 1	32	32	100%	95%	Yes
Child Safeguarding Level 2	32	32	100%	95%	Yes
Moving And Handling Level 1	31	32	97%	95%	Yes
Child Safeguarding Level 1	31	32	97%	95%	Yes
Health and Safety Level 1	31	32	97%	95%	Yes
Paediatric Life Support	29	30	97%	95%	Yes
Basic Life Support	29	30	97%	95%	Yes
Fire Safety Level 1	30	32	94%	95%	No
Infection Control Level 2	30	32	94%	95%	No
Equality And Diversity	30	32	94%	95%	No
Information Governance Level 1	30	32	94%	95%	No
Intermediate Life Support	28	30	93%	95%	No

Conflict Resolution Level 1	29	32	91%	95%	No
Moving And Handling Level 2	27	30	90%	95%	No
Adult Safeguarding Level 1	28	32	88%	95%	No
Preventing Radicalisation	28	32	88%	95%	No

Epidemiology - Dental

A breakdown of compliance for mandatory training courses from 1 May 2017 to 30 April 2018 for Support to doctors and nursing staff at Epidemiology is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Moving And Handling Level 1	3	3	100%	95%	Yes
Infection Control Level 1	3	3	100%	95%	Yes
Health and Safety Level 1	3	3	100%	95%	Yes
Adult Safeguarding Level 1	3	3	100%	95%	Yes
Information Governance Level 1	3	3	100%	95%	Yes
Child Safeguarding Level 1	3	3	100%	95%	Yes
Preventing Radicalisation	3	3	100%	95%	Yes
Conflict Resolution Level 1	3	3	100%	95%	Yes
Fire Safety Level 1	3	3	100%	95%	Yes
Equality And Diversity	2	3	67%	95%	No

Mandatory training for staff included Intermediate Life Support (ILS), safeguarding children level one and two, safeguarding adults level one, information governance, infection control and fire safety. Training was a mix of online training and study days. We were told that training was beneficial, however, it was not always specifically relevant to dentistry. Staff told us they had good access to training which could be booked through the trusts intranet and were provided with protected time to complete the training. Staff demonstrated the use of the training booking system to us.

Staff were encouraged to complete mandatory and this was actively monitored by management. We were told that staff received an e-mail four months prior to when the training was required. This was then followed up with another reminder when it was due.

Updated records as of August 2018 showed that mandatory training for community dental services was 97%.

Safeguarding

Safeguarding Training completion

The trust set a target of 95% for completion of safeguarding training. Safeguarding training was classified as mandatory and between 1 May 2017 and 30 April 2018 the 95% target was met for two of the three courses.

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Child Safeguarding Level 2	82	82	100%	95%	Yes
Child Safeguarding Level 1	84	85	99%	95%	Yes
Adult Safeguarding Level 1	74	85	87%	95%	No

Trust wide

A breakdown of compliance for safeguarding training courses from 1 May 2017 to 30 April 2018 for qualified scientific, therapeutic and technical staff in Community Dental is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Child Safeguarding Level 2	82	82	100%	95%	Yes
Child Safeguarding Level 1	81	82	99%	95%	Yes
Adult Safeguarding Level 1	71	82	87%	95%	No

In Community Dental the 95% target was met for two of the three safeguarding training modules for which qualified scientific, therapeutic and technical staff were eligible.

Bury Dental (including Epidemiology)

A breakdown of compliance for safeguarding courses from 1 May 2017 to 30 April 2018 for qualified scientific, therapeutic and technical staff in Bury Dental (including Epidemiology) is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Child Safeguarding Level 2	28	28	100%	95%	Yes
Child Safeguarding Level 1	28	28	99%	95%	Yes
Adult Safeguarding Level 1	28	22	87%	95%	No

HMR Dental (including Epidemiology)

A breakdown of compliance for safeguarding courses from 1 May 2017 to 30 April 2018 for qualified scientific, therapeutic and technical staff in HMR Dental (including Epidemiology) is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Child Safeguarding Level 2	22	22	100%	95%	Yes
Child Safeguarding Level 1	22	22	100%	95%	Yes
Adult Safeguarding Level 1	21	22	95%	95%	Yes

Oldham Dental (including Epidemiology)

A breakdown of compliance for safeguarding courses from 1 May 2017 to 30 April 2018 for qualified scientific, therapeutic and technical staff in Oldham Dental (including Epidemiology) is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Child Safeguarding Level 2	32	32	100%	95%	Yes
Child Safeguarding Level 1	31	32	97%	95%	Yes
Adult Safeguarding Level 1	28	32	88%	95%	No

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust informed us that they do not record safeguarding referrals as they don't currently have a mechanism to do this.

A trust safeguarding policy existed and staff were familiar with how to access this. There were details of the local children's social care team and the safeguarding board. The trust had a dedicated safeguarding team with a lead nurse who could provide advice and support to the dental team. Staff were aware of the trust's safeguarding team and how to contact them.

As part of the mandatory training all staff are required to complete safeguarding children levels one and two and safeguarding adults.

Staff were knowledgeable about the signs and symptoms of abuse. These included modern day slavery, human trafficking, radicalisation and Female Genital Mutilation (FGM). They were also aware of the issues relating to children who presented with high levels of dental decay that could indicate that a child could be suffering from neglect and patients who were not brought treatment.

Staff would liaise with patients GP's, health visitors and school nurses when dealing with suspected safeguarding issues. If a child was on a protection plan this would be recorded in their dental care records.

Cleanliness, infection control and hygiene

An offsite decontamination unit was used for the reprocessing of contaminated dental instruments and equipment for most locations we visited. A process to scan instruments in and out was in

place which enabled them to track a package of instruments to an individual patient. Clean instruments were returned in sterile pouches and were stored in a non-clinical environment until they were ready to be used. There was a process in place for the service to notify the decontamination unit if there were any issues with the instruments, for example, missing items or unclean instruments.
At Moorgate primary care centre and Oldham integrated care centre local decontamination was carried out for the reprocessing of contaminated dental instruments and equipment. These clinics were meeting best practice Health Technical Memorandum HTM 01 05 (guidelines for decontamination and infection control in primary dental care) for infection prevention and control. Best practice HTM 01 05 was met because the decontamination units at each site we inspected had a separate room for processing contaminated dental instruments, an automated washer disinfector for pre-sterilisation cleaning and separate room for storing the processed instruments. Staff described to us the end to end procedure for the processing of used instruments and equipment through the on-site decontamination rooms. This was in line with guidance laid down in HTM 01 05. We observed the daily, weekly and three-monthly checks were carried out on the equipment used for the decontamination and sterilisation of used instruments. These were consistent with guidance in HTM 01 05.
Hand washing facilities and alcohol hand gel were available throughout the clinic areas. Personal protective equipment (PPE) such as gloves and masks were readily available throughout the clinics. We observed staff followed the “arms bare below the elbow” guidance.
We saw that there were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps. Safer sharps use was in accordance with the European Directive for the safer use of sharps.

Infection prevention and control audits were carried out every six months as described in HTM 01-05. The latest audits showed that they were meeting the required standards. We noted that the same audit was used all locations where off-site decontamination and local decontamination were used. This audit did not go into sufficient detail about the decontamination process and more focussed on the premises and storage of instruments.

There were processes in place to reduce the risks associated with Legionella. We were told that at all locations external contractors were used to monitor water temperatures monthly. We saw evidence of these. Staff described how they managed the dental unit water lines. This included flushing them at the beginning of a session, between patients and at the end of a session. We saw an external Legionella risk assessment which had been carried out at Whitehall Street Clinic. This had identified there were some dead legs within the water system. The risk assessment stated that these should be removed and were considered a medium risk. We asked staff about this and they were unaware of them. They advised us that they had not seen the Legionella risk assessment before. We were later told by the Head of Operational Estates that they had sought a second opinion about these dead legs and they had deemed them to be of a lower risk as they had temperature gauges on them and the high temperatures in these pipes would not allow Legionella to develop. However, staff had not been informed about this and felt they should have been told about this.

Environment and equipment

We observed that dental equipment was clean and generally well maintained. There was sufficient equipment to support safe and effective care. These included dental handpieces and other dental instruments.

We reviewed evidence of servicing and maintenance of equipment. Equipment involved in the decontamination and sterilisation of dental instruments at Moorgate primary care centre and Oldham integrated care centre (where local decontamination was carried out) had been serviced and maintained appropriately.

At Oldham integrated care centre, we asked to see evidence of the servicing of the compressors. We were told there had recently been some issues with these compressors. We were shown the latest service had been carried out on 22 May 2017. It was due to be serviced again 22 May 2018. This had not been done. We saw evidence of checks carried out on the compressors by an external contractor. These had deemed the compressors to be “beyond economical repair”. We were told that new compressors had been ordered in June 2018. However, as of the day of inspection these compressors had not arrived. We saw evidence that members of staff had raised their concerns about this with the estate team. They had not had any feedback about any progress about the compressors.

We found that at each site we inspected equipment was present for dealing with medical emergencies. This included an automated external defibrillator (AED), emergency medicines and medical oxygen. There were also separate medical emergency kits for staff to take on domiciliary visits. Emergency medicines and equipment were in line with guidelines issued by the British National Formulary (BNF) and the Resuscitation Council UK.

A radiation protection folder was maintained at each location which we visited. This included records in relation to dental X-ray equipment and registration with the Health and Safety Executive as required with the Ionising Radiation Regulations (IRR 2017). A radiation protection advisor (RPA) and radiation protection supervisor (RPS) had been appointed. We noted that the most recent routine test of the Orthopantomogram (OPG) had identified it was producing more radiation that expected. We asked if this had been addressed and staff were unable to demonstrate to us that it had. On the day of inspection, the dose was adjusted to reflect the recommendations of the routine test. If this affected the quality of the images produced then they would contact the RPA for further guidance.

When X-rays were taken they were justified, reported on and quality assured every time. Dental care records which we reviewed supported this. This ensured that the service was acting in accordance with the Ionising Radiation (Medical Exposure) regulations IR(ME)R and protected staff and patients from receiving unnecessary exposure to radiation.

The service carried out domiciliary visits for when patients could not attend the clinic. There was a policy in place to support these visits. A risk assessment was carried out on the premises which they were visiting. This took the form of an initial risk assessment and then a more detailed risk assessment on-site. We were told the medical emergency medicines and equipment were taken on domiciliary visits.

Assessing and responding to patient risk

Throughout our inspection, we looked at examples of dental treatment records. We found that the clinicians always recorded patient safety alerts. For example, medical histories were always taken by the clinicians and updated when patients attended for treatment. These medical histories included any allergies and reactions to medication such as antibiotics.

We observed a general anaesthetic session at Alderhey Hospital. We witnessed that the dental and theatre staff involved in the treatment of two patients carried out in full, the World Health Organisation safer surgery check list to prevent incidents such as a never events from occurring. In addition, a huddle was done at the beginning of the session where all staff were introduced, roles identified, and any complex cases discussed. Complex cases would include the need for premedication or any medical conditions which could affect the general anaesthetic.

Staff ensured that patients and carers received appropriate pre and post-operative instructions about treatments. This minimised the risk of the patient suffering from post-operative complications such as post extraction haemorrhage or infections. Information leaflets were given to patients and chaperones with details about what to do after having treatment under conscious sedation.

Staff were aware of the process to follow if a patient became acutely unwell in dental services including demonstrating signs of sepsis. If a patient required emergency resuscitation, this would be carried out by trained members of staff, an ambulance would be contacted, and the patient transferred to hospital if required.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

Mercury and blood spillage kits were readily available at all locations which we visited.

The service had a process for receiving national patient safety alerts such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA). Where relevant, these alerts were shared with all members of staff at staff meetings.

Staffing

Planned v Actual Establishment

Year 1 section:

Details of staffing levels within Community Dental by staff group as at 31 March 2018 are below. Data was only provided for the number of actual staff for support to doctors and nursing staff.

Community dental total

Staff group	Planned staff WTE	Actual Staff WTE	Staffing rate (%)
Support to doctors and nursing staff	-	18.0	-
Grand Total	**-**	**18.0**	**-**

Year 2 section:

Details of staffing levels within Community Dental by staff group as at 19 June 2018 are below.

Community dental total

Staff group	Planned staff WTE	Actual Staff WTE	Staffing rate (%)
Support to doctors and nursing staff	-	18.8	-
Grand Total	**-**	**18.8**	**-**

Vacancies

The trust set a target of 7.5% for vacancy rate. From 1 April 2017 to 31 March 2018, the trust reported an overall vacancy rate of 6% in Community Dental. This was under the trust's target. Across the trust overall vacancy rates for medical staff were 23% and for support to Doctors and Nursing staff were -1%. Negative values indicate that there are staff in place above the number of planned establishment posts.

A breakdown of vacancy rates by staff group in Community Dental at core service level and by team is below:

Community dental total

Staff group	Total number of substantive staff	Number of substantive vacancies	Total % vacancies overall (excluding seconded staff)
Medical & Dental Staff - Hospital	18.9	4.3	23%
Support to Scientific, Therapeutic and Technical Staff	11.0	0.5	5%
Support to Doctors and Nursing Staff	25.7	-0.2	-1%
NHS Infrastructure Support Staff	1.0	-1.1	-107%
All staff	**56.6**	**3.6**	**6%**

Medical and Dental staff by site

Site name	Total number of substantive staff	Number of substantive vacancies	Total % vacancies overall (excluding seconded staff)
Dental Vocational Trainee Bury	3	2	67%
Minor Oral Surgery Bury	0.6	0.2	33%
Dental Bury	6.59	1.78	27%

Dental H W A Oldham	8.24	0.3	4%
Dental Epidemiology	0.5	0	0%
Grand Total	**18.9**	**4.3**	**23%**

Support to Scientific, Therapeutic and Technical Staff

Site name	Total number of substantive staff	Number of substantive vacancies	Total % vacancies overall (excluding seconded staff)
Dental Bury	3.4	0.3	10%
Dental H W A Oldham	7.6	0.2	3%
Grand Total	**11.0**	**0.5**	**5%**

Support to doctors and nursing staff by site

Site name	Total number of substantive staff	Number of substantive vacancies	Total % vacancies overall (excluding seconded staff)
Dental Epidemiology	0.5	0.5	100%
Minor Oral Surgery Bury	1.8	0.35	19%
Dental Bury	12.09	-0.5	-4%
Dental H W A Oldham	11.3	-0.53	-5%
Grand Total	**25.69**	**-0.18**	**-1%**

NHS Infrastructure Support Staff

Site name	Total number of substantive staff	Number of substantive vacancies	Total % vacancies overall (excluding seconded staff)
Dental Epidemiology	0	-0.15	-
Dental H W A Oldham	1	-0.92	-92%
Grand Total	**1**	**-1.07**	**-107%**

Turnover

The trust did not set a target for turnover rates. From 1 May 2017 to 30 April 2018, the trust reported an overall turnover rate of 18% in Community Dental. Across the trust overall turnover rates for Qualified Scientific, Therapeutic & Technical staff were 20% and for Support to doctors and nursing staff were 7%.

A breakdown of turnover rates by staff group in Community Dental at core service level and by

team for the year ending 30 April 2018 is below:

Community dental total

Staff group	Total number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Other Qualified Scientific, Therapeutic & Technical staff	53.1	11.5	20%
Support to doctors and nursing staff	20.8	0.9	7%
Grand Total	**73.9**	**12.4**	**18%**

Qualified scientific, therapeutic & technical staff by site

Site name	Total number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Bury - Dental (including Epidemiology)	25.8	5.1	17%
Oldham - Dental (including Epidemiology)	27.3	6.4	22%
Grand Total	**53.1**	**11.5**	**20%**

Support to doctors and nursing staff by site

Site name	Total number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Dental Management	6.4	0.0	0%
Epidemiology - Dental	2.0	0.0	0%
Dental Admin	12.4	0.9	20%
Grand Total	**20.8**	**0.9**	**7%**

Sickness

The trust set a target of 5% for sickness rates. From 1 May 2017 to 30 April 2018, the trust reported an overall sickness rate of 7.5% in Community Dental. This did not meet the trust's target. Across the core service the sickness rates for qualified scientific, therapeutic & technical staff were 8.3%; for support to doctors and nursing staff were 3.0%.

A breakdown of sickness rates by staff group in Community Dental at core service level and by team between 1 May 2017 to 30 April 2018 is below:

Community dental total

Staff group	Total available permanent staff days	Total permanent staff sickness days	Total % permanent staff sickness overall
Qualified scientific, therapeutic & technical staff	21464	1790.2	8.3%
Support to doctors and nursing staff	4198	127.1	3.0%
Grand Total	**25662**	**1917.2**	**7.5%**

Qualified scientific, therapeutic & technical staff by site

Team name	Total available permanent staff days	Total permanent staff sickness days	Total % permanent staff sickness overall
Bury - Dental (including Epidemiology)	10935	886.48	8.1%
Oldham - Dental (including Epidemiology)	10529	903.7	8.6%
Grand Total	**21464**	**1790.2**	**8.3%**

Support to doctors and nursing staff by site

Team name	Total available permanent staff days	Total permanent staff sickness days	Total % permanent staff sickness overall
Dental Management	2303	20	0.9%
Epidemiology - Dental	334	14	4.2%
Dental Admin	1561	93.1	6.0%
Grand Total	**4198**	**127.1**	**3.0%**

Nursing - Bank and Agency Qualified nurses

From 1 May 2017 to 30 April 2018, the trust reported zero total working hours available for qualified nurses, however, 34 hours were filled by bank staff.

The main reason for bank and agency usage within this core service was vacancies. In the same period the trust reported that zero shifts were filled by agency staff and -34 shifts were unfilled. This indicates that shifts were filled above the planned amount.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Oldham – Dental (including Epidemiology)	0	34	-	0	-	-34	-
Core service total	0	34	-	0	-	-34	-

Nursing - Bank and Agency Non-Qualified nurses

From 1 May 2017 to 30 April 2018, the trust reported zero total working hours available for qualified nurses, however, 34 hours were filled by bank staff.

The main reason for bank and agency usage within this core service was vacancies. In the same period the trust reported that zero shifts were filled by agency staff and -456 shifts were unfilled. This indicates that shifts were filled beyond the planned amount.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Bury – Dental (including Epidemiology)	0	31	-	0	-	-456	-
Oldham – Dental (including Epidemiology)	0	7	-	0	-	-7	-
Core service total	0	38	-	0	-	-463	-

Medical locums

Data on the use of medical locums was not provided at a core service level. The trust reported that they used medical locums to cover emergency services for general adult and older people, community services and trust inpatient services.

The trust told us that:

“We are currently advertising all vacant posts on a rolling basis on NHS Jobs. We have now created the facility of a Trust bank to allow a flexible for available workers. We are utilising the offer of relocation packages to support those out of the area. We are also the creation of non-medical roles to support the gaps including AP's and nurse consultants. We have used the raising the research and development profile of the trust as a method of attraction to the trust. We are currently in the planning and scoping stages for international recruitment.

Medical Workforce Strategy to be presented to Workforce Committee in October 2018.”

Suspensions and supervisions

During the reporting period from 30 April 2017 to 1 May 2018, Community Dental reported that there was one case where staff have been either suspended or placed under supervision. The member of staff was suspended.

Outcome	Number of cases
Suspended	1
Total	**1**

We were told that there was currently an issue with a lack of dentists working for the service. This was on the directorates risk register. We were told that they were actively recruiting for new dentists. However, this lack of dentists did not appear to be adversely affecting the safety or quality of patient care.

There were sufficient numbers of suitably qualified dental nurses to support the dentists in providing care. In the event of absence or sickness then dental nurses could be moved to other clinics to provide chairside support.

The service rarely used agency or bank staff as there was some resilience within the work force to cover holiday or sickness.

Appropriately trained dental nurses supported the dentists carrying out sedation. All staff had completed immediate life support training.

The appointment diaries at each location we visited showed that sufficient time was booked for patient assessment and treatments. The dentists could choose how long they required for appointments therefore had sufficient time to treat patients safely and effectively.

Quality of records

Dental care records were mainly computerised. Computers were password protected and backed up to secure storage to keep patient details safe. If domiciliary visits were carried out then the dentists would record their notes on paper and then transfer them to the computer system when they returned to the clinic.

Audits of record keeping were carried out. The latest audit showed that the clinicians were meeting nationally recognised guidance. However, where issues had been identified an action plan was formulated to continuously improve. The dentists confirmed that results of record keeping audits were discussed with them during staff meetings.

The dental care records which we looked at were clear, concise and accurate and provided a detailed account of the treatment patients received. They also included an oral examination, consent and agreement for treatment and a treatment plan. Patient safety alerts such as medical or physical conditions were recorded on patient's records. These included allergies and reactions to medication such as antibiotics.

Medicines

Medical gasses used for the provision of inhalation sedation were stored securely in a manifold. Staff carried out daily checks of these to ensure they had not been tampered with and there was sufficient flow of medical gasses.

Medicines used in the provision of intravenous sedation (Midazolam) were stored securely in locked wall mounted metal cabinets. A controlled drug log was maintained by staff. This showed the amount used on each patient and the volume which was disposed of. Midazolam was disposed of safely using denaturing kits.

NHS prescription pads were stored securely at all times. A log was maintained for the prescription pads. This enabled the service to actively monitor the use of prescriptions and ensure none had been taken.

Audits of prescribing were carried out. The most recent audit showed a reduced compliance with nationally recognised guidance. The dentists were aware of this as they had been informed during staff meetings. Dentists were aware of nationally recognised guidance with regards to the prescribing of antibiotics.

Incident reporting, learning and improvement

Never events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From 1 May 2017 to 30 April 2018, the trust reported no never events relating to Community Dental.

Serious Incidents

From 1 May 2017 to 30 April 2018, trust staff within Community Dental reported no serious incidents.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been twelve prevention of future death reports sent to Pennine Care NHS Foundation Trust. None of these related to this core service.

There had been no never events at the community dental services in the previous 12 months. Staff were familiar with the concept of a never event and told us of a never event which had occurred several years ago.

Staff described to us how incidents and accidents are reported. We were shown the trusts electronic reporting system. Staff had good access to computers to report incidents. Incidents were graded according to their severity and investigated. If the incident was graded at more than a three then a root cause analysis would be carried out. Staff received feedback about incidents which they had reported. We were shown and told of significant events which had occurred at the service within the last 12 months. These had been investigated and actions taken as appropriate. Significant events formed part of the regular staff meetings and staff confirmed that this was the case.

Is the service effective?

Evidence-based care and treatment

The dentists used national guidelines to ensure patients received the most appropriate care. This included the guidance produced by the British Society for Disability and Oral Health, the National Institute for Health and Care Excellence and the Royal College of Surgeons. Dentists we spoke with were knowledgeable about these guidelines and the standards that underpinned them. Dental care records which we looked at confirmed this.

Inhalation sedation was carried out according to the standards set out by the Royal Colleges of Surgeons and the Royal College of Anaesthetists 'Standards for Conscious Sedation in the Provision of Dental Care' 2015. We were shown evidence of patients' dental care records who had received conscious sedation either under intravenous and inhalational sedation. These demonstrated that the dentists followed these standards.

The dentists used rubber dam when carrying out root canal treatment in line with guidance from the British Endodontic Society.

Nutrition and hydration

Patients undergoing general anaesthesia were given appropriate information by staff of the need to fast before undergoing their procedure. The patient, parent or carer were given a pre-operative instruction sheet emphasising the importance of fasting prior to the procedure.

Children having treatment under inhalation sedation were advised to eat and drink normally but ensure the meal before the appointment should be kept small and at least two hours before the appointment. This was detailed in the instruction sheet provided to patients.

Pain relief

The dentists assessed patients on an individual basis to determine the best form of pain relief or anaesthesia. They considered patient age, co-operation and the complexity of treatment required. For example, for a nervous, young child requiring multiple extractions where local anaesthesia was not possible then a general anaesthetic was used as an alternative. Different types of pain relief were discussed with the patients and carers to ensure they obtained full informed consent.

Patient outcomes

Audits – changes to working practices

The trust has participated in five clinical audits in relation to this core service as part of their Clinical Audit Programme.

Audit name	Area covered	Key Successes	Key actions
National audit of intermediate care	Provider wide	Average response time from referral to assessment in IMC crisis response services is 2 hours. Over 60% of service users are discharged from crisis response services to	The clinical effectiveness and quality improvement team have planned to meet the IMC teams to review both

Audit name	Area covered	Key Successes	Key actions
		their own home. The average waiting time from referral to commencement of intermediate care is less than two days, and less than 10% of patients wait more than two days.	national and local level results and discuss actions for improvement.
Hand hygiene observation audit	Provider wide	•99.6% of staff used the correct hand washing procedure •99% of staff used the correct alcohol gel procedure •98% of staff were bare below the elbows •97% of staff could name the 5 moments of hand hygiene	•Audit reports are shared with the relevant IP& C lead and discussed at the IP&C committee •IP&C leads disseminate individual summary results to relevant teams so concerns can be addressed
IP&C Community environmental inspection of community buildings	Provider wide	•Most standards have been maintained or have improved since the previous audit •All clinical/treatment rooms have foot operated pedal bins, and most have a cleaning schedule in place for medical equipment •Utility/sluice rooms have a wash basin and a foot operated pedal bin	•A copy of the audit report has been shared with the IP&C leads for discussion at the IP&C Committee. •IP&C leads disseminate individual reports to relevant services areas highlighting areas that need to be addressed, and will monitor progress of improvement.
Trust wide record keeping audit - paper health records	Provider wide	•The majority of health records include a demographics sheet and reason for referral. •There has been improvement since the previous audit, in including the service user NHS number on clinical correspondence. •Clinical notes are generally written in chronological order, are concise and factual and written in terms a service user can understand. •In the majority of cases, assessments are completed, and individual plans of care to address service users' needs	•A copy of the report has been shared with the Associate Director of Nursing and Healthcare Professionals, the Trust Records Manager and relevant leads. •Services have been provided with a copy of their local results, and are required to develop action/improvement plans to address any concerns. •The Associate Director of Nursing

Audit name	Area covered	Key Successes	Key actions
		problems and issues are put in place. •Where there has been a significant event, the majority of cases include a chronology of significant events. •The condition of the health record is generally good.	and Healthcare, and the Trust Records Manager will oversee strategic actions to ensure they are delivered. •The audit is included on the Trust annual clinical audit programme.
Trust wide record keeping audit - electronic health records	Provider wide	•The majority of records include up to date patient demographics and the reason for referral to the service. •Most cases do show evidence that entries are written in terms that service user can understand and are concise and factual. Where a significant event has been identified, chronologies of significant events are recorded. •When consent is required for a child, there is evidence that most cases do have the forms in service users records. •In the majority of cases have evidence that risk formulations are completed to reflect the risks identified in risk assessments.	•A copy of the report has been shared with the Associate Director of Nursing and Healthcare Professionals, the Trust Records Manager, and relevant leads. •Services have been provided with a copy of their local results, and are required to develop action/improvement plans to address any concerns. •The audit is included on the Trust annual clinical audit programme.

The service used quality assurance processes to improve patient outcomes and ensure quality and safety were not compromised. These took the form of regular audits. We saw audits of X-rays, dental care records and antibiotics prescribing. Results of audits were discussed with staff during meetings. Staff were spoke with confirmed this and were aware of the recent audit results with regards to the prescribing of antibiotics. We noted the X-ray audit did not follow nationally recognised guidance. It was not clinician specific and only X-rays which were graded as a three were flagged up.

In addition to the mandatory audits, the service was auditing the pre-assessment for children prior to a general anaesthetic and one about the compliance with recall intervals as dictated in NICE guidance. They were awaiting the results of these audits.

Competent staff

Clinical Supervision

The trust was unable to provide information on the frequency of clinical supervision as there are varying positions across different services within the trust. Some services provide combined clinical and managerial supervision, others do separate sessions. The majority of services offer 4-6 weekly clinical supervision, with some offering sessions on a monthly basis. As well as clinical supervision, some services also offer peer, informal and/or group supervision.

Appraisal rates

From 1 April 2017 to 31 March 2018, 75% of permanent non-medical staff within the Community Dental core service had received an appraisal compared to the trust target of 85%.

Community dental total

Staffing group	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	67	89	75%	85%	No
Support to doctors and nursing staff	18	25	72%	85%	No
All staff	**85**	114	75%	85%	No

Qualified Scientific, Therapeutic & Technical staff by site / location

Site or location	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Oldham - Dental (including Epidemiology)	29	34	85%	85%	Yes
HMR - Dental (including Epidemiology)	19	27	70%	85%	No
Bury - Dental (including Epidemiology)	19	28	68%	85%	No
Grand Total	**67**	**89**	**75%**	**85%**	No

Support to doctors and nursing staff by site

Site or location	Number of staff appraised	Sum of Individuals required	Appraisal rate (%)	Trust target (%)	Target met (Yes/No)
Dental Admin	12	15	80%	85%	No
Dental Management	5	8	63%	85%	No
Epidemiology - Dental	1	2	50%	85%	No
Grand Total	**18**	**25**	**72%**	85%	No

Staff were encouraged to complete additional training relevant to their roles. This was to assist with the ever-increasing complexity of patient which they were seeing.

All staff involved in the provision of conscious sedation had completed immediate life support techniques which was an appropriate level of training for a service that provided conscious sedation.

Some of the dentists were on the General Dental Council's specialist register for special care dentistry.

The service used dental therapists to carry out some treatments. Dental hygiene and therapists are qualified dental professionals who can carry out treatments such as fillings, extraction of deciduous teeth and periodontal treatment. Some of the dental hygiene and therapists had completed training in inhalation sedation which enabled them to treat nervous children.

Many of the dental nurses had completed additional training to provide extended duties. These included oral health promotion, fluoride varnish application, radiography and sedation. The dental nurses told us they were encouraged to complete these additional courses and were able utilise these skills.

Staff had regular one to ones with their team lead, a six monthly Individual Development & Performance Review (IDPR) and an annual appraisal. Staff told us this process was worthwhile and felt they benefited from the support which was provided. The appraisal process also helped to develop the staff members personal development plan.

Multidisciplinary working and coordinated care pathways

Multidisciplinary working was embedded within the culture of the service. Multidisciplinary team (MDT) meetings were held as part of best interest decision making.

Staff provided numerous examples of when they worked with other healthcare professionals to improve outcomes for patients. For example, for special care patients they would liaise with the patients GP, consultant or the local community disability team to see if any other procedures such as a blood test, podiatry treatments or a hair cut were required if the patient needed a general anaesthetic for treatment. In the event of a child in the mixed dentition requiring extraction of permanent teeth then the opinion of an orthodontist would be sought. This ensured that any possible future orthodontic treatment would not be compromised.

Referrals were received into the service through an online referral management service. These came from dentists, GPs or community nurses. Referrals were initially triaged by a dental nurse to check all the required information was available. Referrals for oral surgery were triaged by the

clinician. Once a course of treatment had been finished, a letter was sent back to the referring clinician advising them that the patient had been discharged back to their care.

Health promotion

Oral health promotion was at the heart of the service being provided. Dental staff used the Department of Health's 'Delivering Better Oral Health' toolkit 2013 when providing preventative advice to patients on how to maintain a healthy mouth. This is an evidence-based tool kit used for the prevention of the common dental diseases. Staff we spoke with were familiar with this toolkit. We saw evidence in dental care records that oral hygiene advice, toothbrushing instruction and smoking cessation advice were given to patients in line with the toolkit. Patients who were smokers were also signposted to local smoking cessation services if required. High fluoride toothpaste was prescribed to those patients at risk of developing dental caries. There were numerous patient information leaflets available in the surgeries and waiting areas to assist patients.

An oral health promotion group worked out of Moorgate Primary care centre. There was a dedicated member of staff who provided this service and they visited local care homes and helped educate the carers about good oral hygiene regimes. Staff would give demonstrations to the carers about how to care for resident's mouths. This is in line with guidance published I July 2016 from NICE namely "Oral health for adults in care homes". They would also visit special schools where they would speak to the children and the teachers about maintaining a healthy mouth.

The service had recently been awarded a contract from Heywood, Middleton and Rochdale council to provide fluoride varnish to children. There were three full time nurses who have completed the fluoride application course allocated to this role. These nurses would visit local nurseries and reception age children to apply fluoride varnish with the consent of the children's parents or carers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Mental Capacity Act training was not mandatory for this core service. Across the remainder of the trust Mental Capacity Act training was mandatory and renewed every three years.

Deprivation of Liberty Safeguards

From 1 May 2017 to 30 April 2018 the trust reported that 214 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority. None of which were pertinent to Community Dental.

Staff understood the importance of obtaining and recording patients' consent to treatment. The dentists told us they discussed treatment options and the associated risks and benefits of each treatment. We saw evidence of this in the dental care records we saw. Consent for treatment under sedation was obtained at a pre-assessment appointment following standards set out by the Royal Colleges of Surgeons and the Royal College of Anaesthetists 'Standards for Conscious

Sedation in the Provision of Dental Care' 2015. This was then re-confirmed on the day of treatment.

Staff described to us the use of NHS consent forms 1, 2, 3 and 4. They told us the different scenarios in which they would be used. We saw evidence of completed NHS consent forms which had been signed by patients to indicate that they understood the treatment which had been agreed.

Staff understood the legal requirements of the Mental Capacity Act 2005. They explained how they carried out a mental capacity assessment and that a best interest's decision would be made in those cases where the patient lacked capacity to consent for treatment. Staff had completed training about the Mental Capacity Act 2005 as part of their safeguarding training.

The dentists were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Is the service caring?

Compassionate care

We observed staff being kind, friendly and compassionate towards patients. Patient safety and comfort was paramount and this was continually assessed throughout any treatment.

Feedback received from patients was all positive about how kind the staff were. They commented that staff were friendly, caring and helpful.

We observed staff interacting with the parents of children prior to undergoing a general anaesthetic. This was done in a caring and compassionate manner. At all clinics we visited we witnessed staff speaking to patients using language that was appropriate to patients' age or level of understanding.

Privacy and confidentiality were maintained at all times. We observed that surgery doors were kept shut and when staff were dealing with patients at the reception area this was done discreetly

Staff respected peoples' individual preferences, habits, culture, faith and background.

Emotional support

Staff were clear on the importance of emotional support needed when delivering care. Patient commented that staff were supportive and reassuring all through treatment.

Appointment times and lengths were tailored to individual needs. For example, we were told that nervous patients would normally prefer wither early or late appointments. These were arranged, and staff ensured these patients were not kept waiting. In addition, the dentists were able to choose how long they required for each treatment. For example, for treatments under inhalation sedation a longer appointment would be booked to ensure they were not rushed and could provide support to the patient. If the dentists were ever running late then the patient would be informed about this and given the option to either wait or re-book for another time.

Understanding and involvement of patients and those close to them

Patients and their families were appropriately involved in and central to making decisions about care options and the support needed. Patients confirmed that they were fully involved in decision about treatment all through the process.

Staff descried to us how they informed and involved patients or their carers in decisions about treatments. Staff would describe the different treatment options available including the associated risks and benefits. The dentists told us they used different adjuncts to help patients fully understand treatments. These included models, X-rays and animations available on the computerised record system. There were numerous leaflets about treatments offered by the service readily available. These included child friendly leaflets about inhalation sedation. In addition, we noted there were intraoral cameras available in two surgeries at Moorgate Primary care centre. These were used to take up close photographs of teeth. These were useful in showing patients areas of their mouth which they could not normally see such as back teeth.

Is the service responsive?

Planning and delivering services which meet people's needs

The dental service was commissioned by NHS England. Services were planned to meet the needs of people who could not access primary dental care services. These included patients with medical, physical or social issues and patients with dental anxiety.

Reasonable adjustments had been made at all the locations which we visited. These included step free access, automatic doors, accessible toilets and lowered reception desks. The service also had access to a wheelchair tipper and a bariatric chair. Hoists were also available at some of the locations. Staff told us they had been fully trained in the use of these pieces of equipment.

Translation services were available for patients who did not have English as a first language. We saw notices in the reception areas, written in languages other than English, informing patients translation service were available. In addition, hearing loops were readily available at each location which we visited.

There were adequate seating facilities in the waiting areas at all clinics.

The service was also contracted to provide "in hour" emergency dental services at Moorgate Primary care centre, Oldham integrated care centre and Whitehall Street Clinic. This service was for patients who did not have their own dentist or who could not get an appointment with their own dentist. These appointments were booked through the NHS 111 service.

Meeting the needs of people in vulnerable circumstances

The whole service was configured to reflect the needs of vulnerable people. It was a referral service providing either continuing care or a single course of treatment to children or patients with special needs due to physical, mental, social and medical impairment.

Domiciliary visits were carried out by the service. These visits were reserved for patients who could not access the service due to medical, physical or social issues.

The service also provided treatment at HMP Buckley Hall. This is a male category C prison. They offer dental services for eight sessions a week.

The oral health promotion group reached out to vulnerable groups living in local care homes and to children in special schools. They provided oral health education and training to carers and teachers to improve the oral health of their residents and students.

Access to the right care at the right time

Accessibility

The largest ethnic group within the trust catchment area is White - British with 79% of the population.

	Ethnic minority group	Percentage of catchment population (if known)
First largest	White - British	79.0%
Second largest	Black or Black British - African	5.6%
Third largest	Asian of Asian British - Pakistani	2.7%
Fourth largest	White - English	1.7%

Referrals

No information was provided relating to referral times to assessment or treatment was provided.

General dental practitioners and other health professionals could refer patients for short-term specialised treatment as well as long term continuing care to the community dental service. Once a course of treatment had been completed the patient was referred to primary dental care for ongoing care with their own dentist if appropriate.

Internal referral systems were in place, should the dental service decide to refer a patient on to other services either internally or externally. One of the dentists described the process for referring patients. If a patient was for example referred on for a general anaesthetic the service would track the referral until completion of treatment and the dentist would be informed of the outcome.

During the inspection we observed that appointments ran smoothly and patients were not kept waiting. Staff told us that patients would be kept informed if there were going to be any delays with their appointment.

Learning from complaints and concerns

Complaints

From 1 May 2017 to 30 April 2018 there were no complaints about Community Dental.

Compliments

From 1 May 2017 to 30 April 2018 the trust received 569 compliments. Of these eight related to Community Dental, which accounted for 1% of all compliments received by the trust as a whole.

Team	Number of compliments
Bury Community Dental Service	3
Community Dental - Bury	2
Community Dental - Oldham and DAC HMR	1
Dental Access Centre - Bury	1
Dental Access Centre - HMR	1
Total	8

The service took complaints and concerns seriously. There was a trust wide complaints policy and procedure providing guidance to staff on how to handle a complaint. The service had a low level of complaints. There were details of how a patient could complain displayed in the waiting room as both a poster and a leaflet. There were also details about how to complain on the trusts website.

Patients wishing to make a complaint were signposted to the Patient Advice and Liaison Service (PALS). The complaint would be acknowledged. Next, the complaint would be allocated to a senior member of staff who would investigate the complaint. If the complaint was regarding clinical treatment, then this would be investigated by one of the dentists. A formal response would be sent to the complainant once the investigation had been completed.
We looked a complaint which the service had received. This had been dealt with in line with the trusts policy and gave an open and honest response to the patient.

Is the service well-led?

Leadership

There had recently been a re-structuring of the management arrangements at the service. The new management arrangements were currently becoming embedded.

The director of dentistry provided the clinical leadership and support to the clinicians across the directorate. The managing director of Heywood, Middleton and Rochdale services was responsible for the overall governance for the directorate. They were supported by a governance and quality manager, dental nurse team lead and dental administrative team lead. Several members of staff had individual lead roles and this had led to a culture of individual responsibility and accountability within the service.

Most staff felt valued and appreciated in their role and said local management were approachable, supportive and visible.

Vision and strategy

The service was currently looking at re-vamping its vision and strategy to align with the new governance and management arrangements. The services current vision was to provide safe and quality treatment to the local community. It was clear that staff all subscribed to this vision.

The trusts values were “Compassionate”, “Accountable”, “Responsive”, “Effective” and “Safe”. We saw evidence that during the inspection that staff considered the trusts values when providing care for patients.

Culture

Staff were passionate and proud to be working within the service and providing high quality care to their patients. They continuously strived to provide high quality treatments in a caring and compassionate manner for their patients.

Staff morale was generally good across all sites which we visited. We observed a calm working environment at all sites which was conducive to compassionate patient care.

Staff felt empowered and were aware of their responsibility to raise concerns if the need arose. There was a whistleblowing policy and process which was available on the trusts intranet and staff were aware of this and felt confident to use it. They were aware of the requirements of the Duty of Candour.

Governance

There were governance procedures in place to assist with the smooth running of the service. There were policies and procedures which were readily available on the trusts intranet. Staff were familiar with how to locate these polices. Policies included safeguarding children and vulnerable adults, infection prevention and control and radiation protection.

Dental directorate meetings were held on a monthly basis. These covered topics such as performance, significant events, complaints and health and safety. This enabled managers to discuss these and have oversight of the service as a whole.

There were regular staff meetings at each location. At these meetings information from the dental directorate meetings were disseminated. An Integrated Assurance Framework was distributed to all staff during this meeting. This included the integrated governance dashboard for the community dental services. This covered a breakdown of significant events, the risk register, complaints and compliments. All staff were e-mailed a copy of the Integrated Assurance Framework.

Quality assurance processes were used within the service. These included audits of infection prevention and control, record keeping and radiography. We noted the radiography audit did not fully reflect current guidance. The audit was not practitioner specific and therefore could not identify any issues with individual clinicians.

There was a disconnect between some other teams within the trust and the dental directorate. This was highlighted by the fact that the staff (including management) were unaware of the Legionella risk assessment at Whitehall Street Clinic. They told us that this was important to them and they should have been made aware of it. In addition, staff working at the Oldham integrated care centre had not been kept informed of the issues relating to the compressors. Staff felt the communication between other teams within the trust and themselves could be improved.

Management of risk, issues and performance

The service maintained a risk register which was reviewed and discussed on a regular basis. This was used to monitor known risks associated with the service. There were currently two risks identified on the risk register. These related to staffing levels and ageing equipment. We saw that actions had been taken to reduce the identified risks. For example, the service was proactively recruiting dentists through dental journals and dental conferences. The risk register was discussed at the monthly dental directorate meeting to discuss any changes to current risk or any new emerging risks.

Information management

Staff had completed training in information governance and were aware of the importance of protecting patients' personal information.

Dental care records were a mix of computerised and paper records. We saw computers were password protected and were told these were backed up to secure storage. Any paper records were stored in lockable cabinets. We saw staff locked computers when they moved away from their workstations.

Engagement

The director of dentistry was the chair of the local managed clinical network (MCN). MCNs are groups of professionals from primary, secondary and tertiary care who work together to ensure the equitable provision of high quality effective services. These networks enable the clinicians to engage with general dental practitioners and other providers of secondary care about how services can be improved.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. Feedback from the FFT was collated by the trust and then passed to the dental directorate. Patient feedback was discussed at monthly staff meetings and formed part of the Integrated Assurance Framework.

The service had a dental core trainee (DCT) working from Bury. DCT is a period of postgraduate development which extends from the end of Dental Vocational (Foundation) Training to the start of Specialty Training, specialist or general practice or other possible career options. The DCT would visit the medical trainees to provide advice to them about how to triage patients presenting at A and E with signs and symptoms of dental pain or emergencies.

Learning, continuous improvement and innovation

Accreditations

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

No information on accredited services relating to this core service were provided.

Many dental nurses had completed additional qualifications including radiography, fluoride varnish application and oral health education. The service had identified an issue with regards to the national availability of training for inhalation sedation for dental nurses. As a result of this they had developed a training course for the dental nurses for inhalation sedation. This course had been formally accredited.

The service provided training and supervision of a DCT. The DCT scheme provides newly qualified dentists with experience and supports their development in specialities such as paediatric and special care dentistry.

The service was currently working with Public Health England to carry out epidemiology surveys. The current survey was to assess the dental health of five-year olds in the local area.

The service had recently been awarded a contract from Heywood, Middleton and Rochdale council to provide fluoride varnish to children. There were three full time nurses who have

completed the fluoride application course allocated to this role. These nurses would visit local nurseries and reception age children to apply fluoride varnish with the consent of the children's parents or carers.

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

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Bury Mental Health Services	North ward (used to be called Irwell unit / admission assessment unit)	24 beds	Mixed
Bury Mental Health Services	South Ward (used to be called AAU & Enhanced Care Ward - ECW)	24 beds	Mixed
Heathfield House	Cobden Unit - Psychiatric Intensive Care	10 beds	Male
Oldham Mental Health Services	Aspen Ward (used to be called Southside Ward)	22 beds	Female
Oldham Mental Health Services	Oak Ward (used to be called Northside Ward)	22 beds	Male
Rochdale Mental Health Services	Moorside Ward	24 beds	Mixed
Rochdale Mental Health Services	Hollingworth Ward, John Elliott Unit	18 beds	Mixed
Stockport Mental Health Services	Arden Ward	24 beds	Mixed
Stockport Mental Health Services	Norbury Ward	23 beds	Mixed
Tameside Mental Health Services	Saxon Suite (was called Ward 36)	23 beds	Mixed
Tameside Mental Health Services	Taylor Ward (was called Ward 35)	22 beds	Mixed

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Staff did regular risk assessments of the care environment and ligature risk assessments were in place for all the wards we visited.

Ward layouts allowed staff to observe all parts of the ward on most wards. Saxon suite, Aspen, Arden and North ward had some blind spots that hindered the line of sight. Mirrors were positioned on these wards to improve the lines of sight but there were still some blind spots on these wards. These were managed with increased observations and allocation of staff throughout the ward to mitigate the risks where needed.

Staff had easy access to alarms and patients had easy access to nurse call systems (in wards where this was necessary).

Over the 12-month period from 1 May 2017 to 30 April 2018 there were 87 mixed sex accommodation breaches within this core service. The three wards which saw the highest number were 35 on Norbury Ward, 27 on Arden Ward and 13 on Hollingworth Ward.

The trust produced a managing mixed sex accommodation report in December 2017. This detailed the phased approach the trust intended to take to eliminate mixed sex accommodation over three phases, covering all five regional areas where the acute wards were located.

Staff, patients and carers have been consulted with about the implications and pros and cons of having single sex and mixed sex wards. The trust informed us they would report on the outcome of the consultation before making any final decisions regarding the elimination of single sex wards throughout the trust.

The wards provided single bedroom accommodation apart from Moorside ward. This had four dormitory style bedrooms accommodating four patients in each in the male and female area of the ward. The dormitory bays were separated by partitioned walls.
Aspen, Oak and Cobden wards had single sex accommodation. All the other wards had mixed sex accommodation. Taylor ward was not consistently managing the risks to patients on a mixed sex ward. All the other wards had implemented changes onto the wards to separate mixed sex patients and to manage the risks toward patients. Breaches of mixed sex accommodation were incident reported and commissioners were notified.

There were ligature risks on all 11 wards within this core service, details of an additional assessment for the Arden family room was also provided as there were risks present. The trust had undertaken ligature risk assessments on all 11 wards from 11 July 2017 onwards.

All the wards presented a relatively higher level of risk due to the nature of the patients using the unit. The Arden family room presented a lower level of risk due to the nature of others being present when it was in use.

The trust had taken actions to put control measures in place against all identified risks to mitigate ligature risks.

Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were well-maintained.

Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly.

Staff adhered to infection control principles, including handwashing and all wards had access to hand sanitisers on entering the wards.

For the most recent patient-led assessments of the care environment assessment (2018) the locations scored higher than similar trusts for cleanliness. Three sites also scored above the average for 'condition, appearance and maintenance', 'dementia friendly' and 'disability'. However, Birch Hill Hospital scored below the England average for these three aspects.

Site name	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
Birch Hill Hospital	98.7%	92.6%	87.2%	84.0%
Fairfield General Hospital	99.2%	96.4%	90.1%	96.6%
Heathfield House	98.5%	98.3%	93.0%	96.4%
Royal Oldham Hospital	100.0%	96.9%	90.6%	92.7%
Trust overall	**99.3%**	**95.6%**	**87.1%**	**90.6%**
England average (Mental health and learning disabilities)	**98.4%**	**95.4%**	**88.3%**	**87.7%**

Seclusion room

There was one seclusion room on Cobden ward. The seclusion room allowed clear observation and two-way communication, and it had toilet facilities and a clock.

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well and records were completed.

Safe staffing

Nursing staff

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	30 April 2018	317.6	N/A
Total number of substantive staff leavers	1 May 2017 – 30 April 2018	53	N/A
Average WTE* leavers over 12 months (%)	1 May 2017 – 30 April 2018	17%	N/A

Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	31 March 2018	65	N/A
Total vacancies overall (%)	31 March 2018	17%	7.5%
Total permanent staff sickness overall (%)	30 April 2018	4.1%	5%
	1 May 2017 – 30 April 2018	5.2%	5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	31 March 2018	152	N/A
Establishment levels nursing assistants (WTE*)	31 March 2018	198	N/A
Number of vacancies, qualified nurses (WTE*)	31 March 2018	38	N/A
Number of vacancies, nursing assistants (WTE*)	31 March 2018	29	N/A
Qualified nurse vacancy rate	31 March 2018	25%	7.5%
Nursing assistant vacancy rate	31 March 2018	15%	7.5%
Bank and agency use			
Hours bank staff filled to cover sickness, absence or vacancies (Qualified nurses)	1 May 2017 – 30 April 2018	27457	N/A
Hours filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 May 2017 – 30 April 2018	17181	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 May 2017 – 30 April 2018	24086	N/A
Hours filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	155677	N/A
Hours filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	36139	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	-107716	N/A

*Whole-time Equivalent

This core service reported an overall vacancy rate of 25% for registered nurses at 31 March 2018 and 15% for registered nursing assistants.

This core service has reported a vacancy rate for all staff of 17% as of 31 March 2018.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Adult OT Tameside	0.0	0.0	100%	3.5	5.5	64%	3.2	7.5	43%

	Registered nurses			Health care assistants			Overall staff figures		
Taylor Ward TGH	3.5	12.3	28%	8.7	22.6	39%	11.2	35.7	31%
Cobden Unit – PICU	5.2	14.5	36%	3.1	13.7	23%	8.4	28.1	30%
North Ward	6.7	15.1	44%	0.0	15.6	0%	7.7	34.4	22%
Saxon Suite TGH Adult Inpatients	2.2	11.8	18%	5.5	21.4	26%	6.7	34.2	19%
Moorside Ward	4.9	13.9	35%	2.2	16.5	13%	6.3	33.8	19%
Hollingworth Ward	4.4	14.4	31%	0.6	12.1	5%	5.1	27.9	18%
South Ward	3.4	13.8	24%	1.2	13.7	9%	5.1	31.0	16%
Arden Ward Stepping Hill	1.8	13.6	13%	3.7	23.6	16%	5.4	38.6	14%
Oak Ward	1.0	13.0	7%	1.4	15.0	9%	3.6	30.0	12%
Norbury Ward Stepping Hill	2.0	13.3	15%	3.2	22.5	14%	3.2	36.8	9%
Adult Inpatients OT Stockport	0.0	0.0	100%	0.2	2.0	8%	0.3	3.8	8%
Tameside Working Age Medical	0.6	2.0	32%	-	-	-	0.4	9.6	4%
Stockport Working Age Medical	0.0	1.0	0%	-	-	-	0.3	10.9	3%
Aspen Ward	2.2	13.4	16%	-4.2	13.8	-30%	-2.0	28.2	-7%

	Registered nurses			Health care assistants			Overall staff figures		
Core service total	**38**	**152**	**25%**	**29**	**198**	**15%**	**65**	**391**	**17%**
Trust total	**230**	**1703**	**14%**	**105**	**932**	**11%**	**464**	**4081**	**11%**

NB: All figures displayed are whole-time equivalents

Between 1 May 2017 and 30 April 2018, bank staff filled 173361 of available hours to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 70461 of available hours for qualified nurses. 24086 of available hours were unable to be filled by either bank or agency staff.

After querying the data with the trust they have stated that, “the reason some of the data is in negative figures is because the team/service have overspent on their budgets. This could be due to vacancies, short or long- term sickness, maternity leave or (for wards) high levels of observations.” This has meant we cannot calculate the percentage of hours worked by bank or agency staff because the number of available hours is not a true reflection of the hours worked by staff.

Ward/Team	Total hours available / establishment	Bank use (hours)	Agency use (hours)	Total hours NOT filled by bank or agency staff
Cobden Unit - PICU	29331	2776	162	2449
Bury - North Ward	25937	3643	4977	3101
Bury - South Ward	26970	3036	1764	2754
Oldham - Oak Ward (Formally Northside Ward)	25420	2487	336	-124
Oldham - Aspen Ward (Formally Southside Ward)	26202	2010	214	360
HMR - Hollingworth & ECT Costs	24736	4500	1835	1970
HMR - Moorside & ECT Costs	27229	1333	2980	4023
Stockport - Norbury Ward	26059	2115	1296	3489
Stockport - Arden Ward	26773	1123	585	1056

Ward/Team	Total hours available / establishment	Bank use (hours)	Agency use (hours)	Total hours NOT filled by bank or agency staff
Tameside - Saxon Suite	23334	1670	2084	2197
Tameside - Taylor Ward	24051	2764	948	2811
Core service total	**286042**	**27457**	**17181**	**24086**
Trust Total	**3580727**	**173361**	**70461**	**286744**

*Percentage of total hours

Between 1 May 2017 and 30 April 2018, 155677 of available hours were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered 36139 of available hours. 107716 of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available / establishment	Bank use (hours)	Agency use (hours)	Total hours NOT filled by bank or agency staff
Cobden Unit - PICU	26564	12172	5060	-12057
Bury - North Ward	30944	13334	1951	-8516
Bury - South Ward	27519	13598	644	-8702
Oldham - Oak Ward (Formally Northside Ward)	30856	8291	2885	-7737
Oldham - Aspen Ward (Formally Southside Ward)	41787	13980	390	-7716
HMR - Hollingworth & ECT Costs	24253	15404	2323	-13460
HMR - Moorside & ECT Costs	33405	16288	6009	-14933
Stockport - Norbury Ward	42217	19039	8020	-19091
Stockport - Arden Ward	43464	22209	5444	-21257

Ward/Team	Total hours available / establishment	Bank use (hours)	Agency use (hours)	Total hours NOT filled by bank or agency staff
Tameside - Saxon Suite	39343	10142	1623	-2112
Tameside - Taylor Ward	42062	11213	1783	1616
Oldham - Adult Inpatient OT - Rehab Employ	3129	7	0	2
Tameside - Adult OT - Inpatients	6529	0	0	6529
Stockport - Adult OT - Inpatients	3989	0	7	-282
Core service total	**396061**	**155677**	**36139**	**-107716**
Trust Total	**1507115**	**459367**	**84134**	**-332234**

* Percentage of total hours

This core service had 53 (17%) staff leavers between 1 May 2017 and 30 April 2018.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Stockport - Adult OT - Inpatients	3.6	1.8	49%
Bury - North Ward	28.3	7.0	29%
Oldham - Adult Inpatient OT - Rehab Employ	3.6	1.0	28%
Cobden Unit - PICU	22.9	6.0	25%
Tameside - Saxon Suite	27.6	6.6	25%
Oldham - Oak Ward (Formally Northside Ward)	26.3	6.0	22%
HMR - Moorside & ECT Costs	26.9	4.9	16%
Stockport - Norbury Ward	33.2	5.0	16%
Tameside - Taylor Ward	24.0	4.0	15%
Stockport - Arden Ward	32.8	5.2	15%

Bury - South Ward	28.7	3.0	11%
Oldham - Aspen Ward (Formally Southside Ward)	34.9	2.0	6%
HMR - Hollingworth & ECT Costs	20.8	0.5	3%
Tameside - Adult OT - Inpatients	4.0	0.0	0%
Core service total	**318**	**53**	**17%**
Trust Total	**4244**	**662**	**16%**

The sickness rate for this core service was 5.2% between 1 May 2017 and 30 April 2018. The most recent month's data (April 2018) showed a sickness rate of 4.1%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Stockport - Adult OT - Inpatients	0.0%	12.3%
Stockport - Arden Ward	11.4%	7.3%
Cobden Unit - PICU	4.9%	7.0%
Tameside - Saxon Suite	5.3%	6.6%
Tameside - Taylor Ward	3.8%	6.6%
HMR - Hollingworth & ECT Costs	4.1%	6.4%
HMR - Moorside & ECT Costs	2.5%	5.3%
Oldham - Aspen Ward (Formally Southside Ward)	2.2%	5.0%
Oldham - Oak Ward (Formally Northside Ward)	2.0%	4.9%
Oldham - Adult Inpatient OT - Rehab Employ	0.0%	4.7%
Bury - North Ward	4.5%	3.3%
Bury - South Ward	1.2%	2.9%
Stockport - Norbury Ward	3.5%	2.2%
Tameside - Adult OT - Inpatients	0.0%	1.0%
Core service total	**4.1%**	**5.2%**
Trust Total	**4.5%**	**5.4%**

The below table covers staff fill rates for registered nurses and care staff during April, May and June 2018.

There was only one case of a ward having below 90% registered nurses in more than one month. This was Oak Ward which had below 90% of day shifts filled for all three months. Oak Ward also had below 90% of day shifts filled for care staff in May and June and 90.4% of shifts filled in April.

Hollingworth, Moorside Norbury and Arden Wards had over 125% of both day and night shifts filled for care staff across all three months reported. In May 2018 Hollingworth Ward had 548.4% of night shifts filled for care staff.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
	April				May				June			
North Ward	97.8%	111.1 %	146.7%	178.3 %	97.8%	105.4%	148.4%	177.4 %	100.7%	107.3%	156.7%	171.7 %
South Ward	105.5%	93.3 %	126.7%	92.2 %	110.7%	92.5%	145.2%	87.1 %	114.7%	111.1%	136.7%	106.7 %
Oak Ward	80.8%	90.4 %	96.7%	101.7 %	83.5%	89.8%	91.9%	106.5 %	83.6%	89.9%	95.0%	105.0 %
Aspen Ward	107.5%	97.0 %	100.0%	100.0 %	106.5%	96.5%	96.8%	102.4 %	104.2%	102.3%	98.3%	115.0 %
Hollingworth	92.8%	186.9 %	100.0%	236.7 %	96.5%	276.3%	100.0%	548.4 %	70.2%	315.3%	100.0%	348.3 %
Moorside	100.0%	140.1 %	95.0%	181.7 %	80.9%	161.9%	100.0%	179.6 %	76.0%	196.3%	95.0%	295.0 %
Norbury	110.0%	250.5 %	100.0%	247.5 %	115.3%	224.9%	100.0%	212.9 %	115.8%	157.6%	96.7%	156.7 %
Arden	121.7%	200.5 %	100.0%	200.0 %	121.8%	210.6%	100.0%	229.0 %	132.5%	171.9%	100.0%	163.3 %
Saxon Suite	100.0%	100.5 %	96.7%	100.0 %	100.0%	101.4%	100.0%	100.0 %	100.0%	109.5%	96.7%	107.5 %
Taylor Ward	96.7%	107.1 %	100.0%	105.8 %	91.1%	99.1%	100.0%	101.6 %	95.0%	101.0%	100.0%	100.0 %
Cobden Unit	92.2%	119.2 %	93.3%	181.7 %	86.0%	100.0%	93.5%	148.4 %	110.0%	139.2%	100.0%	271.7 %

Trust managers calculated the number and grade of nurses and healthcare assistants required. Managers on all the wards we visited reported they had had their staffing levels increased under the safer staffing model. Recruitment to these posts was underway.

The number of nurses and healthcare assistants was displayed throughout the ward areas and these matched this number on all shifts.

The ward managers and band six nurses in charge of the wards during the inspection could adjust staffing levels daily to take account of case mix and levels of acuity on the wards.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels.

When agency and bank nursing staff were used, those staff received an induction and a ward orientation to familiarise them with the ward.

A qualified nurse was present on the wards always.

However; staffing levels did not always allow patients to have regular one-to-one time with their named nurse. Staff reported that activities and escorted leave were sometimes cancelled due to the levels of acuity on the wards with leave being reinstated as soon as possible.

There were enough staff to carry out physical observations and interventions safely and the managers had the authority to increase staffing levels.

Medical staff

Data on the use of medical locums was not provided at a core service level. The trust reported that they used medical locums to cover emergency services for general adult and older people, community services and trust inpatient services.

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Mandatory training

The compliance for mandatory and statutory training courses at 31 December 2017 was 91%. Of the training courses listed 13 failed to achieve the trust target of 95% and of those, two failed to score above 75%.

The training compliance reported for this core service during this inspection was the same as the 91% compliance in the previous year.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	This core service %	Trust target %	Trustwide mandatory/ statutory training total %
Conflict Resolution Level 2	**98%**	95%	92%
Conflict Resolution Level 1	**98%**	95%	92%
Child Safeguarding Level 1	**98%**	95%	93%
Preventing Radicalisation	**96%**	95%	92%
Infection Control Level 1	**96%**	95%	96%
Moving And Handling Level 1	**95%**	95%	93%
Health and Safety Level 1	93%	95%	92%
Equality And Diversity	93%	95%	88%

Adult Safeguarding Level 1	92%	95%	88%
Child Safeguarding Level 2	91%	95%	90%
Basic Life Support	89%	95%	83%
Information Governance Level 1	89%	95%	86%
Medicines Management	88%	95%	83%
Fire Safety Level 1	87%	95%	92%
Intermediate Life Support	85%	95%	83%
Moving And Handling Level 2	79%	95%	81%
Infection Control Level 2	77%	95%	77%
Mental Health Law	**70%**	95%	65%
Child Safeguarding Level 3	**50%**	95%	90%
Total %	**91%**		**89%**

Staff had received and were mostly up to date with appropriate mandatory training apart from staff on Hollingworth ward. The trust reported only 71% of applicable staff had completed their intermediate life support which was a requirement notice from a previous inspection. These figures did not consider staff on maternity leave or long term sick leave which would make the figure higher than it was. All other outstanding requirement notices in relation to Regulation 18 had been achieved with over 85% compliance. However, child safeguarding level three was only 50% compliant for this core service and mental health law was 70%. Managers told us staff had either completed the mental health law training or had been booked on to complete this.

Assessing and managing risk to patients and staff

Assessment of patient risk

The inspection team examined 50 care records. We found most care records demonstrated good practice in the areas of risk assessment and the formulation of safety plans. However, on North ward and Arden ward the completion of care plans to address a patient's additional needs were incomplete or not available. Staff did a risk assessment of every patient on admission and updated it regularly, including after any incident. However, on Taylor ward staff had not considered nor assessed the risks of a patient being admitted to a mixed sex accommodation as part of the admission process, nor were there any alerts to inform the ward of previous history regarding disinhibited behaviour. There was no reference to this in their risk assessment and no reference to the use of the trust algorithm.

Staff used a trust wide risk assessment tool as well as a risk assessment formulation and safety plan.

Management of patient risk

Staff were aware of and dealt with any specific risk issues, such as significant changes in patients' mental states, historical risk and any current risks.

Staff identified and responded to changing risks to, or posed by, patients. They updated risk issues daily if needed, discussed current patient risks in staff handovers three times a day and discussed individual patient risks within the multidisciplinary meetings held on the wards for each patient weekly.

Staff followed good policies and procedures for use of observation, including to minimise risk from potential ligature points and for searching patients or their bedrooms.

Staff applied blanket restrictions on patients' freedom to access garden areas and fresh air breaks. The trust was not smoke free and they restricted patients to two hourly smoke breaks on all the wards we visited. North ward and Aspen had a restrictive practice board that explained to patients why the restrictive practices were in place. Other wards had notices informing patients they could only order takeaways on certain days and televisions on most wards were turned off at certain times in the week and at weekends to promote healthy sleep.

The trust informed us they had piloted a blanket restriction and restrictive practices audit on North ward and Saxon ward. The data collection tool had been amended and a further pilot was completed on North ward. Data collection was due to finish on 1 October 2018. The trust told us the data would be cleansed and an update would be available with the rationale provided for each identified blanket restriction on the wards.

Once data cleansing was completed and the data analysed, then an initial draft report would be completed and shared with stakeholders. The trust planned to finalise the report once all internal quality checks have been done by 26 November 2018.

Contraband items were included in the inpatient packs and carer information booklets.

Informal patients could leave at will and knew that they had to speak to a staff member first to exit the wards. There were signs throughout the wards advising patients of this.

Records were maintained of all patients leaving and returning to the wards with information of where they were going and expected return times. Staff also kept a record of the clothing they were wearing.

This core service had 852 incidents of restraint (on between 25 and 43 different patients per month) and 111 incidents of seclusion between 1 May 2017 and 30 April 2018.

In comparison to the previous 12 months, there was an increase in the incidences of both restraint (up from 403) and seclusion (up from 81). In both years the highest numbers of restraints and seclusions were within the Cobden Unit.

The below table focuses on the last 12 months' worth of data: 1 May 2017 to 30 April 2018.

Ward name	Seclusions	Restraints	Of restraints, incidents of prone restraint	Rapid tranquilisations
Arden Ward Adult Acute	11	102	2 (2%)	51 (50%)
Norbury Ward Adult Acute	9	94	1 (1%)	45 (48%)
North Ward Adult Acute	0	98	5 (5%)	35 (36%)

Ward name	Seclusions	Restraints	Of restraints, incidents of prone restraint	Rapid tranquilisations
South Ward Adult Acute	2	70	5 (7%)	45 (64%)
Moorside Ward Adult Acute	1	53	3 (6%)	25 (47%)
Hollingworth Ward Adult Acute	0	19	1 (5%)	6 (32%)
Oak Ward Adult Acute	2	53	1 (2%)	14 (26%)
Aspen Ward Adult Acute	0	52	0 (0%)	31 (60%)
Taylor Ward Adult Acute	0	66	2 (3%)	24 (36%)
Saxon Ward Adult Acute	1	39	0 (0%)	35 (90%)
Cobden Unit PICU - RHSD	85	206	10 (5%)	45 (22%)
Core service total	**111**	**852**	**30 (4%)**	**356 (42%)**

There were 30 incidents of prone restraint which accounted for 4% of the restraint incidents.

Over the 12 months the highest number of prone restraints was in October 2017 (5) and November 2017 (6). The number of prone restraint incidences reported during this reporting period was slightly lower than the 34 reported for the previous year.

The number of incidences of restraint resulting in rapid tranquilisation for this core service varied between 16 in September 2017 and 40 in March 2018.

There have been no instances of mechanical restraint over the reporting period.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.

Over the 12 months, the highest number of uses of seclusion was in March 2018, where there was a total of 13 instances.

The number of seclusion incidences during this reporting period (111) was higher than the 81 reported at the time of the last inspection.

Staff used seclusion appropriately and followed best practice when they did so**.**

During the inspection there was one seclusion room for this core service on Cobden ward. There was no one using the room at the time of the inspection. Staff kept records for seclusion in an appropriate manner on Cobden ward. However, we were informed by the managers and nurses in charge that patients were sometimes secluded in their own bedrooms. They informed us that when this happened the seclusion policy was implemented and information documented as an incident.

The trust reported over the past three months (June, July, August 2018) they had 54 incidences of seclusion, of these only one was recorded as in a bedroom area, however 42 of the incidences had no location recorded.

Staff did not always follow National Institute for Health and Care Excellence guidance when using rapid tranquilisation as was referenced within their policy. There was a lack of consistency on Oak ward in recording the minimum frequency for monitoring vital signs following the administration of medication for rapid tranquilisation as per the trust policy updated in March 2018.

The wards in this service were participating in the trusts restrictive interventions reduction programme. Staff used restraint only after de-escalation had failed and used correct techniques.

There have been no instances of long term segregation over the 12-month reporting period which was the same at the time of the last inspection.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust told us that they do not record safeguarding referrals as they do not currently have a mechanism for this.

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. These incidents were recorded on their incident reporting system and safeguarding leads within the trust were informed.

Staff could give examples of how to protect patients from harassment and discrimination. However, for patients with protected characteristics under the Equality Act, for example patients who are gender reassigned, the trust does not have a policy in place.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.

Staff followed safe procedures for children visiting the ward.

Pennine Care NHS Foundation Trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 May 2017 to 30 April 2018) that relate to this core service.

Staff access to essential information

Staff used paper and some electronic patient records. However, the electronic recording for patient records had still not been fully implemented throughout this core service.

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. However, some staff reported there were sometimes delays as not all the nurses had access to the computerised system used to store current risk assessments. Staff told us there were ways to access this information from the ward clerks and the home treatment teams had access as well as the night managers. Some of the wards could access patient paper notes that were stored on site if needed. The paper records did not allow alerts to be applied to inform staff of potentially high-risk issues. Staff informed us they had good links with probation and the police to seek pertinent information if needed

Where staff were expected to record information in more than one system (paper or electronic), this did not cause them any difficulty in entering or accessing information.

Medicines management

We sampled 134 patient medicine records throughout the eleven wards we visited.

Staff followed good practice in medicines management in (transporting, storage, dispensing, administration, medicines reconciliation, recording and disposal) and did it in line with national guidance.

However; staff did not consistently review the effects of medication on patients' physical health regularly and in line with National Institute for health and Care Excellence guidance, especially when the patient was prescribed a high dose of antipsychotic medication.

On Hollingworth ward we looked at 11 records and found one patient prescribed a combined dose of anti-psychotic medicines that were more than twice the dose recommended by the British National Formulary. Staff had not followed trust guidance by recording the rationale or completed the additional monitoring required. The addition of haloperidol was not recorded in the patient's notes. Some monitoring had taken place (test results accessed on-line). T2 forms for two patients on Hollingworth were not filed with the prescription chart. Five patients on Hollingworth did not have capacity and consent to treatment forms filed with the prescription chart.

On North ward of the 20 records we checked one patient was prescribed a high dose antipsychotic (138% British National Formulary dose). British National Formulary provides information and advice on prescribing doses. The treatment rationale was documented in the patient multidisciplinary notes and they had received the necessary physical health checks.

On Saxon ward we checked 20 records, one patient had been prescribed 100% British National Formulary and this had been increased orally by the addition of 'as required' medication. There was no record of the dose being reviewed or stopped. A high dose antipsychotic treatment form was not in place. One T3 form for a patient had not recorded the prescribed medication they were receiving at night.

On Moorside ward we looked at eight records and found one patient of child bearing age was taking sodium valproate which was continued upon admission. There was no record of the patient's history to show consent to treatment, ability to conceive, understanding of adverse effects or that she had been counselled about the current prescribing restrictions.

Allergies were not recorded correctly on two out of eight records on Moorside and T2 forms for two patients on Hollingworth did not match the current prescription.

However, staff were mostly following the trust policy and regular pharmacy input was in place for all the wards. Staff were storing the medicines correctly and checks were in place with errors highlighted and reported accordingly.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 May 2017 and 30 April 2018 there were 14 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was '*Apparent/actual/suspected self-inflicted harm'* with six. The two unexpected deaths reported were instances of '*Apparent/actual/suspected self-inflicted harm'*.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS.

The number of serious incidents reported during this inspection was slightly higher than the 10 reported at the last inspection.

	Number of incidents reported								
Type of incident	Hollingworth Ward	Moorside Ward	Norbury Ward	North Ward	Oak Ward	Saxon Ward	South Ward	Taylor Ward	Total
Apparent/ actual/ suspected self-inflicted harm	1		1	1	1	1			**6**
Disruptive/ aggressive/ violent behaviour							1		**1**
HCAI/ Infection control incident								1	**1**
Abuse/ alleged abuse of adult patient by third party	1	1							**2**
Apparent/ actual/ suspected homicide	1								**1**
Accident e.g. collision/scald (not slip/trip/fall)			1						**1**
Environmental incident						1			**1**
Total	3	1	2	1	1	2	1	1	14

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been 11 'prevention of future death' reports sent to Pennine Care NHS Trust. Four of these related to this core service

The trust should continue to monitor and implement the schedule 5 recommendations for example providing psychological input as a critical treatment to all inpatient wards and to introduce one information technology system which is currently not in place.

There had been five incidents of a sexual nature on three wards. These were reported in the last three months from July 2018 to September 2018. Four of these incidents were directed toward staff and one was where a patient was sexually disinhibited on a ward. These incidents were appropriately managed with increased observations.

All staff knew what incidents to report and how to report them. Staff reported all incidents that they should report.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. They discussed these in team meetings, handover, supervision and staff received a 7-minute briefing of incidents post investigation.

There was evidence that changes had been made because of feedback. On Saxon ward they had made improvements to the observations of patients and had ensured this was shared with all staff during their induction on the ward. Following an incident on the ward they had changed the door openings on the anti-barricade doors.

All the wards were in the process of increasing their staffing levels in response to the safer staffing model. Staff were mindful in managing the mixed sex accommodation when locating patients on to the wards and increasing observations and separating male and female patients' in areas where needed. The trust had developed an algorithm to follow when mixed sex accommodation was required for a patient requiring admission. However, we did not see evidence of this being used during the inspection.

Staff were debriefed and received support after a serious incident.

Is the service effective?

Assessment of needs and planning of care

Fifty care records were examined by the inspection team.

Staff completed a comprehensive mental health assessment of patients in a timely manner at, or soon after, admission.

Staff assessed patients' physical health needs in a timely manner after admission.

Eighteen care records did not demonstrate good practice in the areas reported on below.

Staff did not develop care plans that met the needs identified during assessment.

Care plans were not personalised, holistic and recovery-oriented.

Staff did not update care plans when necessary.

A specific trust 'care plan' document was available for staff and patients to use. These were completed and kept in a designated section of the patient notes marked 'Care Plan'. In eighteen patient care notes, these care plans were not completed, with whole sections left blank and little evidence of patient input. Of the twenty- three patients who were asked about care plans during interviews with inspectors, fifteen said they been involved in writing their care plans. The other eight said they didn't know whether they had a care plan or they didn't remember writing one.

Best practice in treatment and care

Fifty care records and 134 medication charts were examined by the inspection team. Care records did not demonstrate good practice in the areas reported on below.

Staff did not provide a range of care and treatment interventions suitable for the patient group. The interventions should be those recommended by, and be delivered in line with, guidance from the National Institute for Health and Care Excellence. The trust was not able to offer psychological therapies recommended by National Institute for Health and Care Excellence to patients on all wards. National Institute for Health and Care Excellence guidelines recommend patients should have access to cognitive behavioural therapy or family therapy.

Seven out of eleven wards did not offer patients access to a clinical psychologist. Dialectical behaviour therapy (an evidence-based psychotherapy designed to help people suffering from borderline personality disorder, mood disorders, self-harm, suicidal ideation, and substance abuse) was used by staff on Hollingworth ward and a nurse on Oak ward was training to do cognitive behavioural therapy. Of the 134 patient medication charts examined, eight patients were prescribed antipsychotics above the British National Formulary limit. On Hollingworth ward a patient was prescribed an antipsychotic 213% higher than the British National Formulary limit but there was nothing in the patient notes explaining why this was the case.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Staff supported patients to live healthier lives – for example, through participation in smoking cessation schemes, healthy eating advice, managing cardiovascular risks, screening for cancer, and dealing with issues relating to substance misuse. Commissioning for quality and innovation were being assessed for patients on inpatient wards demonstrating improvements to prevent ill health by risky behaviours with alcohol and tobacco.

Staff did not use recognised rating scales to assess and record severity and outcomes (for example, Health of the Nation Outcome Scales). National early warning scores were used by staff on Cobden ward and on other wards we saw evidence of this.

Recognised psychological cognitive assessment tools were occasionally used by occupational therapists and psychologists but not as a matter of routine clinical practice for every patient.

Staff did not follow National Institute for Health and Care Excellence guidance when prescribing medication.

Staff did not use technology to support patients effectively. Patients were not given access to on-line assessments and self-help tools.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. (See table below).

This core service participated in three clinical audits as part of their clinical audit programme 2017 – 2018. Details can be found in the below table:

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Hand hygiene observation audit	All teams delivering clinical care	Provider wide	Infection prevention & control	01/05/2018	•Audit reports are shared with the relevant IP&C lead and discussed at the IP&C committee •IP&C leads disseminate individual summary results to relevant teams so concerns can be addressed
Trust wide record keeping audit - paper health records	All relevant clinical teams	Provider wide	Clinical	01/05/2018	•A copy of the report has been shared with the Associate Director of Nursing and Healthcare Professionals, the Trust Records Manager and relevant leads. •Services have been provided with a copy of their local results, and are required to develop action/improvement plans to address any concerns. •The Associate Director of Nursing and Healthcare, and the Trust Records Manager will oversee strategic actions to ensure they are delivered. •The audit is included on the Trust annual clinical audit programme.
Trust wide record keeping audit - electronic health records	All relevant clinical teams	Provider wide	Clinical	01/05/2018	•A copy of the report has been shared with the Associate Director of Nursing and Healthcare Professionals, the Trust

Records Manager, and relevant leads.

•Services have been provided with a copy of their local results, and are required to develop action/improvement plans to address any concerns.

•The audit is included on the Trust annual clinical audit programme.

Skilled staff to deliver care

The team did not have access clinical psychology on all the wards to meet the needs of patients.

Consultant psychiatrists were ward based in the Bury, Oldham and Rochdale areas. In Tameside and Stockport consultant psychiatrists were not ward-based.

Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group.

Managers provided new staff with appropriate induction (using the care certificate standards as the benchmark for healthcare assistants). The care certificate standards have fifteen core standards. Trust induction only included four of these core standards; Equality and Diversity, Safeguarding Adults, Safeguarding Children, Health & Safety. However, other mandatory training was provided to new staff once they were in post.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance.

Managers ensured that staff had access to regular team meetings.

The trust's target rate for appraisal compliance was 85%. As at 31 May 2018, the overall appraisal rates for non-medical staff within this core service was 73%.

The wards/teams achieving the trust's appraisal target were 'Oldham – Adult Inpatient OT – Rehab Employ' with an appraisal rate of 100%, Tameside - Saxon Suite at 100%, Oldham - Aspen Ward at 92%, Bury - South Ward (87%), Bury - North Ward (86%), Oldham - Oak Ward (86%).

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Oldham - Adult Inpatient OT - Rehab Employ	4	4	100%
Tameside - Saxon Suite	30	30	100%
Oldham - Aspen Ward (Formally Southside Ward)	38	35	92%

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Bury - South Ward	30	26	87%
Bury - North Ward	29	25	86%
Oldham - Oak Ward (Formally Northside Ward)	28	24	86%
Stockport - Arden Ward	34	28	82%
HMR - Moorside & ECT Costs	29	23	79%
Cobden Unit - PICU	23	18	78%
Stockport - Norbury Ward	34	21	62%
HMR - Hollingworth & ECT Costs	20	11	55%
Stockport - Adult OT - Inpatients	5	2	40%
Oldham - Psy Medical Service	19	6	32%
Tameside - Taylor Ward	25	6	24%
Tameside - Adult OT - Inpatients	5	0	0%
Core service total	**353**	**259**	**73%**
Trust wide	**4839**	**3808**	**79%**

There was no data for medical staff for appraisals for this core service.

The trust was unable to provide information on the frequency of clinical supervision as there were varying positions across different services within the trust.

The percentage of staff that received regular supervision was not provided by the trust. Trust policy (GL041) states “each identified individual should receive a minimum of 40 – 60 minutes of clinical supervision every eight weeks”. Staff supervision, appraisals and access to regular team meetings varied across the Trust. However, staff received supervision in other ways through team meetings. Nurses on Aspen ward had a nursing team supervision meeting.

Managers during interviews reported that Norbury Ward offered supervision sessions monthly; whilst on Aspen Ward, staff supervision took place every week. As well as clinical supervision, some services also offer peer, informal and/or group supervision.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge.

Managers ensured that staff received the necessary specialist training for their roles.

Managers dealt with poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multidisciplinary meetings.

Staff shared information about patients at effective handover meetings within the team (for example, shift to shift).

The ward teams had effective working relationships, including good handovers, with other relevant teams within the organisation (for example, care co-ordinators, community mental health teams, and the crisis team).

The ward teams had effective working relationships with teams outside the organisation (for example, local authority social services and GPs).

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

As of December 2017, 70% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training was mandatory for certain staff roles.

Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were.

The provider had relevant policies and procedures that reflected the most recent guidance.

Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Staff did not ensure that patients were able to take section 17 leave (permission for patients to leave hospital) when this has been granted. Patients were not always able to take section 17 escorted leave due to there not being enough staff on the ward to enable them to do this safely.

Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff stored copies of patients' detention papers and associated records (for example, section 17 leave forms) correctly and so that they were available to all staff that needed access to them.

The service displayed a notice to tell informal patients that they could leave the ward freely.

Care plans referred to identified section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Good practice in applying the Mental Capacity Act

The trust confirmed the mental health law mandatory training was role specific training and it covered the Mental Capacity Act and Deprivation of Liberty Act. Figures for this core service were 70%.

Figures were not available for the number of staff who had had training in the Mental Capacity Act. However, staff were aware of capacity issues, how to find out if patients had capacity and there were on-line training courses which they could access.

Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act, including Deprivation of Liberty safeguards.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Staff made deprivation of liberty safeguards applications when required and monitored the progress of applications to supervisory bodies.

The service had arrangements to monitor adherence to the Mental Capacity Act.

Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

The trust told us that three Deprivation of Liberty Safeguard applications were made to the Local Authority for this core service between 1 May 2017 and 30 April 2018.

CQC received no direct notifications from the Trust between 1 May 2017 and 30 April 2018.

Number of DoLS applications made by month

	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	Total
Applications made	1	0	0	0	0	1	0	0	1	0	0	0	**3**
Applications approved	0	0	0	0	0	0	0	0	0	0	0	0	**0**

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

The 2018 patient-led assessments of the care environment score for privacy, dignity and wellbeing at three locations scored higher than similar organisations.

The score for Birch Hill Hospital (85.7%) was lower than the average score for other similar trusts for privacy, dignity and wellbeing.

Site name	Privacy, dignity and wellbeing
Birch Hill Hospital	85.7%

Fairfield General Hospital	93.6%
Heathfield House	95.3%
Royal Oldham Hospital	94.5%
Trust overall	**88.7%**
England average (mental health and learning disabilities)	**91.0%**

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive. We observed staff listening to patients and offering them support and advice. Patients told us staff respected their privacy and we saw stop and knock signs on doors.

Patients told us that staff tried to provide patients with help, emotional support and advice at the time they needed it. However, several patients told us that staff struggled to find the time to provide them with one to one support.

Staff supported patients to understand and manage their care, treatment or condition. Patients were involved in ward rounds and most patients told us they discussed their care with their named nurse.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. Staff worked with community services to help patients get ready for discharge. Staff referred patients for help with benefits, housing and legal issues.

Most patients said staff treated them well and behaved appropriately towards them. However, some patients felt that some staff were caring and helpful while others were not. Several patients told us that the ward could become unsettled when there were agency staff on the ward.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Information was available in different languages although not readily available on the wards. Staff could access an interpreter if patients needed one. The service met patient's religious needs and patients had access to a chaplaincy and Iman service. Patients told us that Halal food was available.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Staff maintained the confidentiality of information about patients.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and to the service. We saw welcome packs in some of the wards. Staff told us about the procedure that helped orient patients to the ward, and we saw displays on the wall providing patients with useful information about the ward.

Staff involved some patients in care planning and risk assessment**.** The care plan templates had space where patients could provide their opinion about their care. Some care plans were filled in with a great deal of involvement from the patient. Other care plans had limited involvement. Where

there was limited involvement it was sometimes unclear that the patient was unwilling or unable to contribute.

Some patients told us that they were involved in their care plan while others did not remember being involved. Many patients told us they did not have a copy of their care plan. Staff recorded that some of these patients had refused a copy. Patients on Oak and Aspen were provided with a self-review record form. This helped them to plan for their ward round. These were distributed to patients at the weekend allowing them time to prepare.

Staff communicated with patients so that they understood their care and treatment. This included finding effective ways to communicate with patients with communication difficulties. Staff supported patients who spoke a different language both with interpreters and by using staff who spoke those languages.

However, we found staff had not put plans in place to meet the communication needs of patients with learning disabilities, including patients on the autistic spectrum.

Staff involved patients when appropriate in decisions about the service – for example, in the recruitment of staff.

Staff enabled patients to give feedback on the service they received. All wards held community meetings. Some wards also had a 'you say we did' board which showed how wards had responded to patient feedback.

Staff enabled patients to make advance decisions (to refuse treatment, sometimes called a living will) when appropriate.

Not all patients were able to access advocacy. Oldham, Oak and Aspen ward only offered advocacy to patients who were detained. Other wards offered advocacy if requested on a case by case basis.

We received 22 comments cards, 15 of the comments we received were positive, two were negative and five cards were a mixture of positive and negative. Many comments related to how caring the staff were and how much patients felt looked after. However, a few patients fed back that were unhappy with some aspects of their care.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. We saw carers information boards and carers leaflets on the wards. Patients told us staff would involve carers but would get consent from the patient first. We saw family rooms away from the wards that patients could book to have private time with family members.

Staff enabled families and carers to give feedback on the service they received. Carers were invited to meetings and involved in patient care.

Staff provided carers with information about how to access a carer's assessment. This information was available to carers in leaflets and on notice boards.

Is the service responsive?

Access and discharge

Beds were not always available when needed for patients living in the catchment area. However, the ward managers and bed managers were always mindful to allocate a bed locally for patients where possible.

There was not always a bed available when patients returned from leave and patients were informed of this before they went on leave if the necessity to use their bed was required.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient.

When patients were moved or discharged, this happened at an appropriate time of day.

A bed was not always available in a psychiatric intensive care unit when a patient required more intensive care. There was no female psychiatric intensive care unit and only one male psychiatric intensive care unit located in Stockport. Beds would be sought out of area and or within the private sector which meant patients were not always sufficiently close to maintain contact with family and friends.

Bed management

The trust provided information regarding average bed occupancies for the 11 wards in this core service between 1 May 2017 and 30 April 2018.

All of the wards within this core service reported average bed occupancies ranging above the benchmark of 85% over this period with the highest rate being an average of 117% on two wards. All wards, with the exception of The Cobden Unit had average rates of over 100%. Rates above 85% can have a detrimental impact on the smooth running of the ward and patient experience. However, during our inspection we found there were some bed vacancies on some of the wards we visited.

We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	Average bed occupancy range (**1 May 2017 – 30 April 2018**) (current inspection)
Bury - North Ward	117%
Stockport - Arden Ward	117%
Bury - South Ward	115%
Tameside - Saxon Suite	111%
Tameside - Taylor Ward	110%
Oak ward	107%
Stockport - Norbury Ward	107%
Rochdale - Moorside Ward	105%
Rochdale - Hollingworth Ward	103%
Oldham - Aspen Ward	102%

Stockport - PICU - The Cobden Unit	86%

The trust provided information for average length of stay for the period 1 May 2017 to 30 April 2018.

We are unable to compare the average length of stay data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	Average length of stay (**1 May 2017 – 30 April 2018**) (current inspection)
Stockport - PICU - The Cobden Unit	74
Oak ward	48
Oldham - Aspen Ward	39
Bury - South Ward	38
Bury - North Ward	37
Rochdale - Moorside Ward	36
Stockport - Arden Ward	36
Tameside - Saxon Suite	33
Rochdale - Hollingworth Ward	31
Stockport - Norbury Ward	28
Tameside – Taylor Ward	26

This core service reported 205 out area placements between 1 May 2017 and 30 April 2018.

As of 14 June 2018, this core service had 24 ongoing out of area placements.

There were three placements that lasted one day, and the placement that lasted the longest amounted to 351 days.

All the placements were due to capacity issues.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements (14 June 2018)
205	0	205	1-351 days	24

This core service reported 269 readmissions within 28 days between 1 May 2017 and 30 April 2018.

Of the readmissions, 105 (39%) were readmissions to the same ward as the patient was discharged.

The average of days between discharge and readmission was 11 days. There were four instances whereby patients were readmitted on the same day as being discharged and there were 16 instances where patients were readmitted the day after being discharged.

Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
269	105	39%	0 - 30	11

Discharge and transfers of care

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

Discharges were sometimes delayed and managers on the wards reported the delayed discharges were due to a lack of appropriate community facilities to meet some patient's individual complex needs.

Between 1 May 2017 and 30 April 2018 there were 2325 discharges within this core service. This amounted to 54% of the total discharges from the trust overall (4336). 1467 of these discharges related to Taylor Ward.

Of the 2325 discharges, 100 (4%) discharges were delayed. The number of delayed discharges varied between 10 in July 2017 to 39 in April 2018.

Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit.

The service complied with transfer of care standards (for example, those set in the national Children and Young People Mental Health Transitions Commissioning for Quality and Innovation).

The trust did not provide any details relating to referral to assessment and treatment times for this core service.

Facilities that promote comfort, dignity and privacy

The 2018 patient-led assessments of the care environment score for ward food at two locations (Birch Hill Hospital and Heathfield House) scored higher than similar trusts. The other two locations (Fairfield General Hospital and Royal Oldham Hospital) scored lower when compared to other similar trusts for ward food.

Site name	Ward food
Birch Hill Hospital	99.4%
Fairfield General Hospital	90.8%
Heathfield House	93.5%
Royal Oldham Hospital	91.9%
Trust overall	**90.6%**
England average (mental health and learning disabilities)	**92.2%**

The food was of a good quality and snack boxes were made available if patients missed their meals.

Patients had their own bedrooms on all the wards apart from Moorside ward. This had two male and female dormitories with four beds allocated in each. These bed areas had a solid wall divider with curtain access. Privacy and dignity notices were displayed throughout the dormitories.

Patients could personalise their bedrooms.

Patients had somewhere secure to store their possessions.

Staff and patients had access to the full range of rooms and equipment to support treatment and care (clinic room to examine patients, activity and therapy rooms). Hollingworth ward did not have enough space and did not have enough dining tables or chairs for all the patients to eat their meals in comfort and to promote social interactions. Oak ward dining room was small and was unable to seat all the patients. All wards apart from Taylor and Saxon had access to a gym area and additionally North and South wards had access to outdoor exercise equipment and a covered football pitch. Staff and patients reported access to these areas was limited due to staff needing to be allocated to facilitate access and some patients needing section17 leave to access the gym.

Patients had access to outside space. However, on most of the wards the outside space was either locked or patients had to be accompanied by staff apart from Norbury ward where patients had access to a small garden freely. North ward, Arden and Hollingworth ward were based on the first floor and staff had to accompany patients to access outside space. North ward patients had to go through South ward to access any outside space.

There were quiet areas on the wards and a room where patients could meet visitors.

Patients could make a phone call in private and had access to their own mobile phones unless this had been risk assessed and a removal of phone form was completed and an incident reported. The patient pay phone was broken on Hollingworth ward.

Patients could make hot drinks and snacks were available However; these facilities could be locked off if there were any patients that posed a risk on the wards.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. All wards apart from Cobden Ward had access to a recovery and inclusion worker.

Staff supported patients to maintain contact with their families and carers.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

The service did not always make adjustments for disabled patients – for example patients with specific communication needs were not care planned for.

There were no positive behavioural plans in place for patients. One patient had additional physical needs and had been allocated an accessible bathroom. However, their specific health condition had not been care planned for. Access to all wards for disabled people was via ramps and lifts. There were identified staff champions allocated on the wards for patients with a disability.

Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain.

The information provided was not always in a form accessible to all patients. For example, in easy-read format.

Staff made information leaflets available in languages spoken by patients. However, these were not routinely available on the wards specific to the local population and ethnic groups.

Managers ensured that staff and patients had easy access to interpreters and/or signers.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups.

Staff ensured that patients had access to appropriate spiritual support.

Listening to and learning from concerns and complaints

This core service received 30 complaints between 1 May 2017 and 30 April 2018. Three of these were upheld, nine were partially upheld and eleven were not upheld. One was referred to the Ombudsman.

Total Complaints	Fully upheld	Partially upheld	Not upheld	Referred to Ombudsman
30	**3**	**9**	11	1

This core service received 14 compliments during the last 12 months from 1 May 2017 to 30 April 2018 which accounted for 2% of all compliments received by the trust as a whole.

Patients knew how to complain or raise concerns. Information was displayed throughout the wards. When patients complained or raised concerns, they received feedback.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to handle complaints appropriately.

Staff received feedback on the outcome of investigation of complaints and acted on the findings.

Is the service well led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide good quality care.

Leaders were visible in the service and approachable for patients and staff. Leaders were aware of their management structure and told us they were available and had visited the wards. Staff were positive about the appointment of the new management and the introduction of the new quality leads for each borough.

Leadership development opportunities were available, including opportunities for staff below team manager level. We found on Aspen ward an advanced practitioner had been successful in becoming a responsible clinician fully supported by the trust.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. This was at ward level as well as in discussion within supervision.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Posters and information boards were displayed throughout the wards. Information was readily available in the patient and carers information booklets which was reflective of the trust visions and values.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff were aware of the changes and could discuss this in their supervision and team meetings. Leaders received feedback from the senior management meetings and cascaded this to their teams.

Staff could explain how they were working to deliver high quality care within the budgets available. Leaders were aware of the budget constraints but told us that the trust responded to risk issues and were increasing staffing levels.

Culture

During the reporting period there were 10 cases where staff were either suspended, placed under supervision or were moved to a different ward. Nine staff were suspended, none were placed under supervision and one was moved ward.

Of the 10 cases, nine involved Band 2 staff group; all nine were suspended.

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

Ward name	Suspended	Under supervision	Ward move	Total
Southside Ward	1	0	0	1
Moorside Ward	1	0	0	1
Decant Ward	1	0	0	1

Hollingworth Ward	2	0	0	2
Arden Ward	1	0	0	1
Taylor Ward	1	0	0	1
South Ward	1	0	0	1
Saxon Ward	1	0	0	1
Cobden Unit	0	0	1	1
Core service total	**9**	**0**	**1**	**10**

Staff felt respected, supported and valued.

Staff felt positive and proud about working for the provider and their team.

Staff felt able to raise concerns without fear of retribution.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Information was available on the wards we inspected.

Managers dealt with poor staff performance when needed.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. Staff we spoke with gave examples of career progression and the creation of the quality leads which many had applied for. There were forums and networks available to staff.

The service's staff sickness and absence was 5.2% between 1 May 2017 and 30 April 2018. The most recent month's data (April 2018) showed a sickness rate of 4.1%. These were similar to the average for the provider at 4.5%.

Staff had access to support for their own physical and emotional health needs through a staff wellbeing service. This provided confidential advice and support for staff.

The provider recognised staff success within the service – for example, through staff awards.

Governance

The trust provided a document detailing their highest profile risks. Those identified as high risk which relate to this core service are summarised below.

Opened	ID	Description	Trend of Risk Rating	Last review date
14/02/2018	1222/02-18	Ward Staffing on adult acute inpatient services - qualified nurse practitioners	Static	13/07/2018

14/02/2017	1103/02-17	Lack of formal physical health monitoring for pts newly prescribed antipsychotic meds	Static	30/09/2018
20/06/2018	1226/03-18	Utilisation of Paris and paper records across the community and physical health pathway	New	-
17/07/2017	1158/07-17	There is a risk of failure of the estate of PCs/laptops/tablets(end user device)	Static	05/07/2018
03/07/2017	1147/07-17	Manual locking systems on bedroom doors on inpatient wards	Static	20/06/2018
30/08/2016	1062/12-16	Not achieving / delivering CQC recommendations / targets	Static	30/06/2018

Governance systems for the core service and wards were mostly effective. There were systems and procedures to ensure that wards were safe and clean. There were enough staff to facilitate clinical care. However, staff and patients reported patients supervised leave, one to one time and access to leisure facilities on site were delayed due to insufficient staff to facilitate this.

Staff were trained and supervised. Patients were assessed and treated well, that the ward adhered to the Mental Health Act and Mental Capacity Act.

The wards did not participate in accreditation schemes relevant to the service.

There were lapses in the management of medicines practice and managers had not ensured there was consistent practice.

Bed management practice meant that patients could not always access a bed in their catchment area. Psychiatric intensive care beds were not always available and the trust had no facility for female patients to access a psychiatric intensive care bed within their trust.

Discharges were planned, incidents were reported, investigated and learnt from.

There were networks and forums available to staff and the trust had altered the way these were managed. There were new quality assurance leads within the trust however, these were not fully imbedded at the time of inspection.

There was a clear framework of what must be discussed at ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

The trust had not fully implemented recommendations from the reviews of deaths. However, lessons from incidents had been shared with staff and changes to practice had been implemented.

Staff undertook or participated in local clinical audits. The trust had implemented an adult inpatient documentation audit. However, this was not sufficient to provide assurance that the collaborative care planning had been fully implemented and that care plans were produced.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required.

Staff concerns matched those on the risk register.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Where cost improvements were taking place, they did not compromise patient care.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff did not always have access to the equipment and information technology needed to do their work. However, some staff reported there were sometimes delays as not all the nurses had access to the computerised system used to store current risk assessments. Staff told us and we saw there were ways to access this information form the ward clerks and the home treatment teams had access as well as the night managers. Some of the wards could access patient paper notes that were stored on site if needed. The paper records did not allow alerts to be applied to inform staff of potentially high-risk issues.

The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, not all staff had full access to the information technology infrastructure.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters and so on.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and carers were involved in decision-making about changes to the service.

Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback.

Directorate leaders engaged with external stakeholders – such as commissioners and Healthwatch.

Learning, continuous improvement and innovation

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

No details of accreditations relating to this core service were provided.

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Clinical staff had co-produced a survival guide handbook, to act as a quick reference guide to staff on inpatient wards.

Staff had opportunities to participate in research. Innovations were taking place in the service. North and South wards had access to a physical health check, drop in clinic additional to the physical health checks on the wards.

Staff used quality improvement methods and knew how to apply them.
Staff participated in national audits relevant to the service and learned from them.
Wards did not participate in accreditation schemes relevant to the service.

Wards for older people with mental health problems

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Bury Mental Health Services	Ramsbottom Ward	12 beds	Mixed
Oldham Mental Health Services	Rowan Ward	12 beds	Mixed
Oldham Mental Health Services	Cedars Ward	10 beds	Mixed
Rochdale Mental Health Services	Beech Ward	14 beds	Mixed
Tameside Mental Health Services	Summers ward	11 beds	Mixed
Tameside Mental Health Services	Hague ward	14 beds	Mixed
The Meadows	Saffron Ward	23 beds	Mixed
The Meadows	Davenport Ward	20 beds	Mixed
The Meadows	Rosewood Ward	10 beds	Mixed

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Staff carried out regular risk assessments of the care environment. A full risk assessment of the environment was carried out annually by staff independent of the area being assessed. Staff also completed risk assessments after significant events, for example, changing the function of a room. All wards had an environmental risk assessment undertaken in the last 12 months. All actions were either completed or ongoing, such as window replacement on Beech ward.

The ward layout did not allow staff to observe all parts of ward; however, staff mitigated the risks of areas they could not observe by using mirrors and CCTV. Staff also managed risk through individual risk assessments and observations.

There were potential ligature points on all nine wards within this core service. The trust had undertaken recent (from 2 July 2017 onwards) ligature risk assessments at all nine locations.

None of the wards presented a high level of ligature risk. The trust reported that all wards presented 'lower risk due to the nature of persons using the unit'. The risks were mitigated because the trust had taken actions to put control measures in place against all identified risks. Staff also managed risks through individual risk assessments and observations.

The wards were not fully compliant with guidance on eliminating mixed-sex accommodation. Over the 12-month period from 1 May 2017 to 30 April 2018 there were 149 mixed sex accommodation breaches within this core service. The highest numbers were as follows: 78 on Cedars ward, 33 on Rosewood and 13 on Hague ward.

However, between 1 May 2018 and 31 August 2018, there were 30 mixed sex accommodation breaches within this core service, an apparent pro rata reduction of just under 40%. The highest numbers were 15 on Cedars ward and 11 on Rosewood.

The trust was unable to provide the reasons for the breaches.

On most of the wards, patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. However, on Ramsbottom ward there were two shared bed bays. The bays were within clear single sex areas of the ward and staff ensured the beds were always occupied by patients of the same gender. The beds were separated by curtains and there was a shared bathroom within each bay.

Staff ensured patients were safe and their privacy and dignity was maintained through observation, bed allocation, understanding patients' needs, escorting patients between areas, carrying out regular checks of the ward areas, good handovers, and individual risk assessment and care planning. There was dementia-friendly signage and clear single gender areas within the wards, including female-only lounges. A programme of work had been agreed and approved by the trust to enhance the single sex status of these areas. The bed management policy provided guidance for staff if a patient had to be admitted into a bed assigned to an alternative gender. There was a mixed sex accommodation algorithm that all inpatient staff utilised when a bed was requested.

In addition to this, Beech and Ramsbottom wards had agreed an individualised staffing model utilising safer staffing monies.

Ramsbottom ward had increased staffing to provide an extra member of staff on each shift to act in the capacity of a privacy and dignity nurse, whose function was to monitor the ward environment to ensure no breaches of mixed sex accommodation occurred.

We saw records of trust board meetings where the consultation process required to address the mixed sex accommodation was discussed.

Staff had easy access to alarms and patients had easy access to nurse call systems. There were also pressure mats that alerted staff, for example, when patients got out of bed at night.

Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were well-maintained.

For the most recent patient-led assessments of the care environment assessment 2018, all the locations scored higher than similar trusts for cleanliness. Fairfield General Hospital and Royal Oldham Hospital also scored higher for 'condition, appearance and maintenance', 'dementia friendly' and 'disability'. Tameside scored higher for 'condition, appearance and maintenance'.

Site name	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
Birch Hill Hospital	98.7%	92.6%	87.2%	84.0%
Fairfield General Hospital	99.2%	96.4%	90.1%	96.6%
The Meadows (Old Age Psychiatry Unit)	98.8%	95.0%	80.0%	88.9%
Royal Oldham Hospital	100.0%	96.9%	90.6%	92.7%
Tameside General Hospital	100.0%	95.9%	84.9%	87.5%
Trust overall	**99.3%**	**95.6%**	**87.1%**	**90.6%**
England average (Mental health and learning disabilities)	**98.4%**	**95.4%**	**88.3%**	**87.7%**

Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly.

Staff adhered to infection control principles, including handwashing.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment. Emergency drugs were not available in all wards. Staff used 999 for acute medical emergencies. Where emergency drugs were kept on the ward, they were sealed and monitored by the trust responsible. Only Hague and Summers wards had crash boxes. These were sealed and dated with a date at the end of October 2018. Staff monitored these and contacted the trust responsible if they were due to expire so they could be replaced before the expiry date.

Staff maintained equipment well and kept it clean. They used 'clean' stickers, which were visible and in date.

However, in all the clinic rooms there were numerous posters additional to those on the noticeboard; in one case an additional 31. All the nursing staff and managers spoken with objected to the "excessive" numbers of posters. They told us that there were too many and that every time there was an issue, rather than dealing with the individuals involved, a new pathway was posted. This, they thought, was a knee jerk reaction. They told us that old information was not removed and that after a while staff did not read the posters as there were too many.

Safe staffing

Nursing staff

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 30 April 2018	185.4	N/A
Total number of substantive staff leavers	1 May 2017 – 30 April 2018	19.5	N/A
Average WTE* leavers over 12 months (%)	1 May 2017 – 30 April 2018	10%	N/A
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31 March 2018	35.9	N/A
Total vacancies overall (%)	At 31 March 2018	15%	7.5%
Total permanent staff sickness overall (%)	At 30 April 2018	8.5%	5%
	1 May 2017 – 30 April 2018	6.6%	5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31 March 2018	92.1	N/A
Establishment levels nursing assistants (WTE*)	At 31 March 2018	120.5	N/A
Number of vacancies, qualified nurses (WTE*)	At 31 March 2018	17.8	N/A
Number of vacancies nursing assistants (WTE*)	At 31 March 2018	14.8	N/A
Qualified nurse vacancy rate	At 31 March 2018	19%	7.5%
Nursing assistant vacancy rate	At 31 March 2018	12%	7.5%
Bank and agency Use			

Hours bank staff filled to cover sickness, absence or vacancies (Qualified nurses)	1 May 2017 – 30 April 2018	20645	N/A
Hours filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 May 2017 – 30 April 2018	5717	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 May 2017 – 30 April 2018	-209	N/A
Hours filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	105989	N/A
Hours filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	27166	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	27166	N/A

*Whole-time Equivalent

This core service reported an overall vacancy rate of 19% for registered nurses at 31 March 2018.

This core service reported an overall vacancy rate of 12% for registered nursing assistants.

This core service has reported a vacancy rate for all staff of 15% as of 31 March 2018.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Saffron The Meadows	0.4	10.1	4%	6.4	22.9	28%	8.8	36.3	24%
Hague Ward TGH	5.5	13.5	41%	0.2	10.0	2%	5.7	24.5	23%
Rowan Ward- EMH Oldham	2.4	9.5	25%	1.3	10.7	12%	4.2	20.7	20%
Beech Ward	2.7	10.0	27%	2.3	13.5	17%	5.0	24.9	20%
Summers Ward TGH	2.3	9.3	25%	2.5	14.2	18%	4.9	24.3	20%
Stockport Older People Medical	-	-	-	-	-	-	0.6	5.8	10%
Cedars Ward-	1.6	8.6	19%	-0.4	8.4	-5%	1.7	17.5	10%

	Registered nurses			Health care assistants			Overall staff figures		
EMH Oldham									
Orchard Hse, Milton St Day Hosp	0.1	1.9	3%	0.7	2.7	25%	0.7	8.0	9%
Ramsbottom Ward	2.4	9.6	25%	-0.6	12.1	-5%	1.8	22.4	8%
Davenport The Meadows	0.4	10.6	4%	1.3	13.7	9%	1.9	25.4	7%
Rosewood The Meadows	0.0	9.0	0%	1.0	12.4	8%	1.0	21.9	5%
Tameside Older People Medical	-	-	-	-	-	-	-0.4	3.8	-11%
Core Service Total	**17.8**	**92.1**	**19%**	**14.8**	**120.5**	**12%**	**35.9**	**235.5**	**15%**
Trust total	**230**	**1703**	**14%**	**105**	**932**	**11%**	**464**	**4081**	**11%**

NB: All figures displayed are whole-time equivalents

Between 1 May 2017 and 30 April 2018, bank staff filled 20645 available hours to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 5717 of available hours for qualified nurses. Two hundred and nine of available hours could not be filled by either bank or agency staff.

After querying the data with the trust, they stated that, “the reason some of the data is in negative figures is because the team/service have overspent on their budgets. This could be due to vacancies, short or long-term sickness, maternity leave or (for wards) high levels of observations.” This has meant we cannot calculate the percentage of hours worked by bank or agency staff because the number of available hours is not a true reflection of the hours worked by staff.

Ward/Team	Total hours available / establishment	Bank use (hours)	Agency use (hours)	Total hours NOT filled by bank or agency staff
Saffron Ward	19769	1628	262	-62
Bury - Ramsbottom Ward and ECT	17103	2825	525	-577
Oldham - Cedar	16856	2060	830	192

Oldham - Rowan Ward & ECT	18720	3956	972	-1354
HMR - Beech Ward & ECT Costs	19554	1527	2617	-64
Stockport - Davenport Ward	20768	756	0	763
Stockport - Rosewood Ward	17599	2167	101	-1682
Tameside - Hague Ward	21907	4077	390	1320
Tameside - Summers Ward	18254	1649	20	1255
Core service total	**170530**	**20645**	**5717**	**-209**
Trust Total	**3580727**	**173361**	**70461**	**286744**

Between 1 May 2017 and 30 April 2018, 105989 available hours were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same period, agency staff covered 27166 available hours. Of the available hours, 114095 could not be filled by either bank or agency staff.

After querying the data with the trust, they stated that, “the reason some of the data is in negative figures is because the team/service have overspent on their budgets. This could be due to vacancies, short or long-term sickness, maternity leave or (for wards) high levels of observations.” This has meant we cannot calculate the percentage of hours worked by bank or agency staff because the number of available hours is not a true reflection of the hours worked by staff.

Ward/Team	Total hours available / establishment	Bank use (hours)	Agency use (hours)	Total hours NOT filled by bank or agency staff
Saffron Ward	42334	6350	705	3857
Bury - Ramsbottom Ward and ECT	20395	18156	4342	-22645
Oldham - Cedar	16393	15162	5948	-21032
Oldham - Rowan Ward & ECT	15545	14971	3510	-17763
HMR - Beech Ward & ECT Costs	21118	24363	5436	-25744

Stockport - Davenport Ward	24767	3698	999	-4067
Stockport - Rosewood Ward	22336	6939	2283	-7320
Tameside - Hague Ward	33	5426	1289	-7080
Tameside - Summers Ward	3929	10924	2654	-12301
Core service total	**166850**	**105989**	**27166**	**-114095**
Trust Total	**1507252**	**459367**	**84134**	**-332234**

Turnover

This core service had 19.5 (10%) staff leavers between 1 May 2017 and 30 April 2018.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Oldham - Cedar	17.2	4.3	25%
Saffron Ward	29.5	5.8	21%
Stockport - Rosewood Ward	20.1	2.6	13%
Tameside - Summers Ward	20.8	2	9%
Stockport - Davenport Ward	23.7	1.8	7%
Tameside - Hague Ward	16.8	1.4	7%
Oldham - Rowan Ward & ECT	16.4	1	6%
Bury - Ramsbottom Ward and ECT	21	0.6	3%
HMR - Beech Ward & ECT Costs	19.9	0	0%
Core service total	**185.4**	**19.5**	**10%**
Trust Total	**4244**	**662**	**16%**

Sickness

The sickness rate for this core service was 6.6% between 1 May 2017 and 30 April 2018. The most recent month's data (April 2018) showed a sickness rate of 8.5% against a trust average of 4.5%.

Ward/Team	Total % staff sickness (April 2018)	Ave % permanent staff sickness (over the past year)
Tameside - Summers Ward	9.2%	9.1%
Oldham - Rowan Ward & ECT	17.7%	8.9%
Bury - Ramsbottom Ward and ECT	11.6%	8.7%
Oldham - Cedar	11.3%	8.2%
Stockport - Rosewood Ward	10.2%	6.3%
Stockport - Davenport Ward	5.1%	6.3%
Saffron Ward	6.5%	5.1%
HMR - Beech Ward & ECT Costs	3.8%	4.1%
Tameside - Hague Ward	3.9%	3.5%
Core service total	**8.5%**	**6.6%**
Trust Total	**4.5%**	**5.4%**

Staff Fill Rates

The table below covers staff fill rates for registered nurses and care staff during April, May and June 2018.

Ramsbottom, Cedar, Rowan and Beech wards had over 125% of care staff shifts filled for both day and night shifts in all three months. The highest percentages were within Cedar ward with up to 533% of shifts filled.

Rosewood ward had below 90% of care staff shifts filled for day shifts in all three months and Summers ward had below 90% of nurses' shifts filled for day shifts in all three months.

Key:

> 125%	< 90%

Day	Night	Day	Night	Day	Night

	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
	April				May				June			
Bury - Ramsbottom Ward	83.3%	254.2%	96.7%	268.3%	93.5%	310.5%	100.0%	301.6%	90.8%	307.5%	100.0%	310.0%
Oldham - Cedar	93.3%	318.3%	100.0%	533.3%	105.4%	285.5%	93.5%	516.1%	110.0%	278.3%	113.3%	510.0%
Oldham - Rowan	107.5%	276.7%	100.0%	256.7%	108.1%	183.1%	100.0%	158.1%	93.3%	221.7%	100.0%	201.7%
Rochdale - Beech	92.5%	221.7%	103.3%	213.3%	97.6%	211.3%	103.2%	209.7%	90.0%	239.2%	103.3%	240.0%
Stockport - P2 (Davenport)	103.3%	96.7%	143.3%	90.0%	112.9%	92.3%	116.1%	100.0%	132.5%	78.7%	103.3%	96.7%
Stockport - Rosewood	166.7%	81.9%	100.0%	101.7%	141.9%	88.0%	100.0%	101.6%	143.3%	87.1%	100.0%	105.0%
Stockport - Saffron	98.3%	98.1%	100.0%	100.0%	99.2%	100.0%	100.0%	98.9%	100.0%	99.3%	100.0%	100.0%
Tameside - Hague Ward	99.2%	127.5%	100.0%	111.7%	98.4%	108.9%	100.0%	101.6%	97.5%	125.0%	100.0%	105.0%
Tameside - Summers	73.3%	188.3%	100.0%	156.7%	65.3%	186.3%	129.0%	166.1%	62.5%	240.8%	100.0%	173.3%

Managers had calculated the number and grade of nurses and healthcare assistants required. They used the safer staffing model to do this. The staffing establishment on each ward was calculated based on the highest acuity of the ward so that it was safe.

We reviewed staffing rotas. The number of nurses and healthcare assistants matched this number on all shifts. The ward manager could adjust staffing levels daily to take account of case mix.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. Wherever possible, for continuity they used the same staff. When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward.

There was always a qualified nurse present in communal areas of the ward.

Staffing levels allowed patients to have regular one-to-one time with their named nurse. This was documented clearly in daily care records.

Staff shortages rarely resulted in staff cancelling escorted leave or ward activities.

There were enough staff to carry out physical interventions safely, for example, observations and restraint, and staff had been trained to do so.

There had been recent investment of safer staffing money and transformation money. The service was recruiting new staff during this inspection including registered nurses, health care support staff, occupational therapy and psychology staff, across the whole core service.

Data on the use of medical locums was not provided at a core service level. The trust reported that they used medical locums to cover emergency services for general adult and older people, community services and trust inpatient services.

The trust told us that:

"We are currently advertising all vacant posts on a rolling basis on NHS Jobs. We have now created the facility of a trust bank to allow a flexible for available workers. We are utilising the offer of relocation packages to support those out of the area. We are also the creation of non-medical roles to support the gaps, including advanced practitioners and nurse consultants. We have used the raising the research and development profile of the trust as a method of attraction to the trust. We are currently in the planning and scoping stages for international recruitment.

Medical Workforce Strategy to be presented to Workforce Committee in October 2018."

Staff on Ramsbottom ward told us that although there was medical cover day and night, there were not always enough medical staff on duty and a doctor could not always attend the ward in a timely manner. This meant patients' care may be compromised. The ward had developed a protocol to provide guidance for staff.

Mandatory training

Most staff had received and were up to date with appropriate mandatory training.

Training data

The training compliance reported for this core service during this inspection was slightly lower than the 90% reported for the previous year.

The compliance for mandatory and statutory training courses at 30 April 2018 was 87%. Of the nineteen training courses listed, 14 failed to achieve the trust target of 95% and of those, one failed to score above 75%. Mental Health Law had a compliance rate of below 75% in each of the past three years. However, when we inspected this core service we found that all staff had either completed Mental Health Law training or were booked onto a course. Some staff told us that accessing training was not always easy as courses did not run very often.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	**This core service %**	**Trust target %**	**Trustwide mandatory/ statutory training total %**
Child Safeguarding Level 3	**100%**	95%	90%
Infection Control Level 1	**99%**	95%	93%
Conflict Resolution Level 1	**98%**	95%	92%
Conflict Resolution Level 2	**97%**	95%	86%
Moving and Handling Level 1	**96%**	95%	93%
Child Safeguarding Level 1	93%	95%	93%
Health and Safety Level 1	93%	95%	92%
Preventing Radicalisation	91%	95%	92%

Medicines Management	90%	95%	83%
Child Safeguarding Level 2	89%	95%	91%
Basic Life Support	85%	95%	83%
Intermediate Life Support	83%	95%	83%
Information Governance Level 1	81%	95%	86%
Moving and Handling Level 2	80%	95%	81%
Equality and Diversity	79%	95%	88%
Adult Safeguarding Level 1	79%	95%	88%
Fire Safety Level 1	78%	95%	92%
Infection Control Level 2	76%	95%	96%
Mental Health Law	**58%**	95%	65%
Total %	**87%**		89%

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 43 sets of care records.

Staff used a locally developed risk assessment tool called the 'trust approved risk assessment'. They carried out risk assessments of every patient within 48 hours of admission.

Management of patient risk

Staff were aware of and dealt with any specific risk issues, such as nutrition, falls or pressure ulcers. Following assessment, staff developed risk management plans for each individual patient, including personal emergency evacuation plans.

There was an inpatient falls steering group and a designated falls lead and manual handling lead on each ward. There was topical training on each ward that included issues such as pressure ulcers.

Staff identified and responded to changing risks to, or posed by, patients. They updated records at least weekly and whenever clinically indicated. At the Meadows, there was a new fire and immediate life support response nurse. Staffing levels had been increased at night. Cedars and Rowan ensured between them that three registered nurses were rostered across the two wards every night. There were specialist advisors available to the wards, for example the managing violence and aggression team to advise on safe and least restrictive practice when patients were presenting with challenging and aggressive behaviours. The wards also had access to a patient safety officer.

Staff followed good policies and procedures for use of observation, including to minimise risk from potential ligature points and for searching patients or their bedrooms.

Staff applied blanket restrictions on patients' freedom only when justified, for example to protect privacy and dignity, and to keep patients safe. However, not all staff had a clear understanding of what constituted a blanket restriction.

Staff adhered to best practice in implementing a smoke-free policy.

Informal patients could leave at will and knew that. There were notices at the ward doors telling patients this.

Use of restrictive interventions

The wards in this service participated in the provider's restrictive interventions reduction programme. All the wards were involved with organisational work at trust level via the clinical effectiveness and audit department to identify all restrictive practices in inpatient areas across the trust footprint. Once completed, it was intended that the audit findings would be progressed via ward and service managers to ensure that all restrictive practices continued to be used appropriately and were regularly reviewed. This was also discussed in the managers' meeting.

There was a marginal downward trend in the numbers of restrictive interventions since we last inspected this core service.

This core service had two incidences of seclusion between 1 May 2017 and 30 April 2018. The number of seclusion incidents was higher than the none reported for the previous 12 months.

There were 307 incidences of restraint (on between 11 and 21 different patients). This was lower than we found at our last inspection when the trust reported 370 incidences of restraint over a 12-month period.

Over the 12 months, the month with the highest number of restraints was November 2017 (44). Twelve of the 14 restraints were related to Cedars ward, which also had the highest number of restraints; however, Rosewood ward had a similar number of restraints (65 compared to 66) and a higher number of rapid tranquilisations (27 compared to 21).

The table below focuses on the last 12 months' worth of data: 1 May 2017 to 30 April 2018.

Ward name	Seclusions	Restraints	Of restraints, incidents of prone restraint	Rapid tranquilisations
Rosewood Ward Older Person	0	65	0 (0%)	27 (42%)
Davenport Ward Older Person	1	25	0 (0%)	9 (36%)
Saffron Ward Older Person	1	8	0 (0%)	1 (13%)

Elderly Therapies	0	1	0 (0%)	1 (100%)
Ramsbottom Ward Older Person	0	55	0 (0%)	25 (45%)
Beech Ward Older Person	0	22	0 (0%)	10 (45%)
Cedars Ward Older Person	0	66	0 (0%)	21 (32%)
Rowan Ward Older Person	0	26	0 (0%)	5 (19%)
Summers Ward Older Person	0	17	0 (0%)	11 (65%)
Hague Ward Older Person	0	22	0 (0%)	9 (41%)
Core service total	**2**	**307**	**0 (0%)**	**119 (39%)**

There were no incidents of prone restraint and no instances of mechanical restraint which was the same reported for the previous twelve months.

The number of incidences resulting in rapid tranquilisation for this core services varied between two (October 2017) and 19 (July 2017), with a total of 119. This was lower than the 128 reported at our last inspection.

There had been no instances of long term segregation over the 12-month reporting period, which was the same reported for the previous 12 months.

The provider could not be assured that staff used restraint only after de-escalation had failed. Staff received training in managing violence and aggression and in moving and handling. All staff were up to date. We saw care records that set out the risks when patients presented with violence and aggression but the resulting care plans were not always clear on the action to take, for example, referring to 'various distraction techniques'.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. There were some restrictions that restricted freedom of movement, such as locked bedroom doors. The entrance doors were also locked. Access to the kitchen was individually risk assessed. These restrictions were justified by the need to keep patients safe and maintain their privacy and dignity. Other than that, there was free movement around the wards. On some wards, the physical environment was more appropriate to promoting independence and wellbeing, such as clear views to outside space, distinctive colours and clear signage, thus helping to avoid situations that might lead to using restraint. Staff knew their patients and understood how to deflect and avoid situations that might require restraint. There was regular discussion between staff and patients. Most care plans contained evidence of patient involvement in discussion except where that was not possible due to their condition. Some care plans contained evidence of proactive approaches to risk, which helps to reduce the potential for use of restraint.

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquillisation. The trust policy 'Short Term Management of Acutely Distressed Patients and Rapid Tranquillisation' incorporated the National Institute for Health and Care Excellence definition

of rapid tranquillisation as the use of parenteral medication. In relation to this core service, it also referenced National Institute for Health and Care Excellence guidance QS154 'Violent and aggressive behaviours in people with mental health problems', NG10 'Violence & Aggression in Short Term Management in Mental Health, Health and Community settings' and CG178 'Psychosis and Schizophrenia in Adults; prevention and management'.

There were no seclusion rooms within this core service and we did not see any evidence that any patients had been nursed away from others in de facto seclusion. The trust reported that there had been no instances of seclusion in this core service in the six months before this inspection. We saw care plans that set out how care should be delivered to avoid a situation where the patient might need to be nursed away from others. One care plan on Cedars ward was a good example of this.

Safeguarding

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust told us that they do not record safeguarding referrals as they do not currently have a mechanism for this.

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. Staff we spoke with explained clearly what action they would take, including contacting the trust safeguarding lead for advice. They were aware of other stakeholders, including acute trusts, care services and social services.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. Equality and diversity training was part of the mandatory programme. Staff explained how they could help address discriminatory behaviour, for example, through whistle blowing and incident reporting, or through speaking to the ward manager and challenging discriminatory behaviour if they encountered it.

Staff followed safe procedures for children visiting the ward.

Serious case reviews

Pennine Care NHS Foundation Trust submitted no details of serious case reviews commenced or published in the last 12 months (1 May 2017 to 30 April 2018) that related to this core service.

Staff access to essential information

Staff used a combination of paper and electronic records. The electronic case recording system was still not embedded across this core service. Staff were expected to record information in more

than one system (paper and electronic). They said this did not cause them any difficulty in entering or accessing information on the ward. However, the records were not easy to navigate and information was fragmented. For example, information regarding the management of covert medicines was held in five different places.

All information needed to deliver patient care was available to all relevant staff, including agency staff, when they needed it and it was in an accessible form. This included when patients moved between teams. However, staff said that using different recording methods meant sharing information was difficult.

Another concern was that staff did not always know about patients' histories on admission and there was no flagging system in the paper records; for example, to alert staff to any potential safeguarding issues they needed to be aware of.

Medicines management

Practice in medicines management in line with national guidance was not consistent across the service. Although we found staff were mostly following policy and that medicines were stored correctly, patients were getting the medicines prescribed, errors were recognised and incidents were being reported, we also found several inconsistencies in relation to the safe administration of medicines.

For example, staff on most wards checked the prescription charts at the end of each shift to ensure that they were completed correctly; however, this was not done on Beech ward.

Thickener for drinks for a patient on Beech ward did not have a prescription and there was no record that it had been administered. Additionally, the patient had recently spent time in hospital in the acute trust. Their medicines were different on discharge and this had not been queried. We fed back to the manager regarding both these issues. They told us they would take immediate action to ensure the patient's medication was administered appropriately and safely. They also told us they would ensure they created an incident form to report this.

The disposal of waste medicines at ward level did not ensure that waste tablets were destroyed and could not be retrieved. This was not in line with best practice guidance.

The trust policy stated that in the north division of mental health services, the administration and recording of recorded drugs must follow the recorded drugs policy of the acute trust.
There was no similar arrangement if the south division. The rationale for this was not clear.

Specific timings and instructions of when certain medicines needed to be administered was not recorded on all prescription charts. On Saffron ward, flucloxacillin, which must be given on an empty stomach was not given before breakfast or two hours after a meal. Aspirin, which must be administered with or after food, was given at the same time as lansoprazole, which must be given half an hour to an hour before food. There was capacity to alter the times and we saw some examples where this had been done but overall, the timing of medication in relation to food was not consistent. This meant the effectiveness of the medication could be compromised or that the patient could possibly experience preventable side-effects.

The spelling of drugs on prescription charts was not checked. We found examples of mis-spelling on Saffron ward. On Rosewood, the controlled drugs book had the same mis-spelling.

The arrangements for covert medicines were recorded in some care plans but were not available in others. We found that doctors did not consistently record the justification for administering

medicines covertly. Best interest meetings had taken place but there was minimal recording of the discussion; generally, there was just a line in the doctors' records stating, "give covert medicines in the patient's best interests".

In five out of seven care records, the record did not explain how the covert medicine was to be given to the individual. It was clearly written in two others. Each of the prescription records contained a photocopied, laminated pro forma for the use of covert medicines. However, this was only a 'sample' care plan taken from the trust policy document and it did not state arrangements for administering covert medicines in any of the individual cases reviewed. The policy stated at section seven that covert medication should be included in each patients' care plan and reviewed weekly. There were no individual care plans that set out how covert medicines should be given to each patient.

None of the care records we reviewed described when medicines prescribed for administration 'as required' should be given. There was no formal monitoring of these. In one case, staff had recorded that they had monitored this once and recorded that it had no effect. In total, 15 doses had been given; none of the other 14 doses had been monitored.

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

On Rowan ward, monitoring records following rapid tranquillisation had not always been fully completed. The ward manager had addressed this and told us they were assured that records would be properly completed in future.

Track record on safety

Serious incidents requiring investigation

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 May 2017 and 30 April 2018 this core service reported 13 STEIS incidents. Of the total number of incidents reported, the most common type of incident was *Slips/Trips/Falls* with five. There was one unexpected death which related to *Treatment Delay*.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS with 13 serious incidents recorded for this core service.

The number of serious incidents reported during this inspection was higher than the five reported at the last inspection.

	Number of incidents reported							
Type of incident reported on STEIS	**Beech**	**Cedars**	**Davenport**	**Rosewood**	**Rowan**	**Saffron**	**Summers**	**Total**
Slips/ Trips/ Falls			1	1	1	1	1	**5**

HCAI/ Infection control incident			1	1		1		**3**
Apparent/ actual/ suspected self-inflicted harm						2		**2**
Abuse/ alleged abuse of adult patient by third party	1							**1**
Treatment delay	1							**1**
Disruptive/ aggressive/ violent behaviour		1						**1**
Total	1	1	2	2	1	4	1	13

Reporting incidents and learning from when things go wrong

'Prevention of future death' reports

The Chief Coroner's Office publishes the local coroner's Reports to Prevent Future Deaths, which all contain a summary of Schedule 5 recommendations made by the local coroners with the intention of learning lessons from the cause of death and preventing future deaths.

In the last two years, there have been 12 'prevention of future death' reports sent to Pennine Care NHS Foundation Trust; however, none related to this core service.

All staff knew what incidents to report and how to report them.

Mostly, staff reported all incidents that they should report. However, on Beech ward, when rapid tranquillisation had been used and the doctor did not attend, staff did not log this as an incident.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation when things went wrong. Duty of candour was included in the incident reporting system.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss that feedback. Feedback was discussed at team meetings, '7-minute briefings', handover meetings and in individual supervision. Cedars ward had introduced 'team talk Thursday' in addition to other meetings.

There was evidence that changes had been made as a result of feedback.

All the wards had made improvements in safety. They had undertaken a series of measures to improve how they managed the risk of the wards not meeting national guidance for single sex accommodation. The clinic room shortfalls noted at the last inspection had been addressed. Changes had been made to improve the safety of the environment, such as dementia friendly signage. Mirrors had been installed to improve lines of sight and eliminate blind spots. In some wards, the layout had been changed to facilitate better observation. The staffing model had been improved. All the wards were using safer staffing monies to recruit additional staff to boost the minimum numbers of staff on duty each shift. They had also introduced new roles, such as a privacy and dignity nurse and an intermediate life support response nurse. Falls risk assessments and moving and handling plans highlighted improvements in patients' mobility, which reduced the risk of falls.

Staff were debriefed and received support after a serious incident.

Is the service effective?

Assessment of needs and planning of care

During the inspection we examined 43 sets of patient notes or care plans.

Care plans were personalised, holistic and recovery-oriented and were developed to meet the patients' needs identified during assessment.

Staff assessed patients' physical health needs in a timely manner after admission and we saw evidence of ongoing physical assessments.

Staff completed a comprehensive mental health assessment of the patient in a timely manner after admission.

Staff updated care plans when necessary.

Staff monitored patients' nutritional needs, by having patients weighed and monitoring patients' fluid and dietary intake.

Best practice in treatment and care

This core service participated in three clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Hand hygiene observation audit	All teams delivering clinical care	Provider wide	Infection prevention & control	01/05/2018	•Audit reports are shared with the relevant IP&C lead and discussed at the IP&C committee •IP&C leads disseminate individual summary results to relevant teams so concerns can be addressed
Trust wide record keeping audit - paper health records	All relevant clinical teams	Provider wide	Clinical	01/05/2018	•A copy of the report has been shared with the Associate Director of Nursing and Healthcare Professionals, the Trust Records Manager and relevant leads. •Services have been provided with a copy of their local results, and are required to develop

					action/improvement plans to address any concerns. •The Associate Director of Nursing and Healthcare, and the Trust Records Manager will oversee strategic actions to ensure they are delivered. •The audit is included on the Trust annual clinical audit programme.
Trust wide record keeping audit - electronic health records	All relevant clinical teams	Provider wide	Clinical	01/05/2018	•A copy of the report has been shared with the Associate Director of Nursing and Healthcare Professionals, the Trust Records Manager, and relevant leads. •Services have been provided with a copy of their local results, and are required to develop action/improvement plans to address any concerns. •The audit is included on the Trust annual clinical audit programme.

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. This included a range of psychological interventions, such as cognitive behavioural therapy.

Hague and Summers wards undertook smoking and drinking assessments at admission. They offered brief interventions to support patients who wanted to reduce either of these behaviours, which is the goal of national CQUIN indicator 9 – preventing ill health by risky behaviours – alcohol and tobacco.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. This included patient referrals to other services when this was required including diabetes and tissue viability services.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration.

Staff used recognised rating scales to assess and record severity and outcomes. Wards were using the national early warning scores 2 (NEWS2), a standardised assessment of acute-illness severity. Recording a patient's NEWS regularly means trends in their clinical responses can be monitored to provide early warning of potential clinical deterioration and prompt escalation of clinical care. Recording of the NEWS trends provides guidance about the patient's recovery and

return to stability, enabling a lessening in the frequency and intensity of clinical monitoring towards patient discharge.

Staff participated in clinical audit, benchmarking and quality improvement initiatives, such as an evaluation of the effectiveness of 7-minute briefings, hand hygiene, record keeping, scrutiny of care plans and physical health interventions.

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

Skilled staff to deliver care

The trust's target rate for appraisal compliance was 85%. As at 31 May 2018, the overall appraisal rates for non-medical staff within this core service was 78%.

The wards failing to achieve the trust's appraisal target were Rosewood ward with an appraisal rate of 82% and Summers ward at 77%, Beech Ward & ECT Costs (58%), Ramsbottom ward and ECT (50%) and Cedar ward (39%).

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Oldham - Rowan Ward & ECT	16	16	100%
Saffron Ward	33	32	97%
Stockport - Davenport Ward	28	27	96%
Tameside - Hague Ward	18	16	89%
Stockport - Rosewood Ward	22	18	82%
Tameside - Summers Ward	22	17	77%
HMR - Beech Ward & ECT Costs	24	14	58%
Bury - Ramsbottom Ward and ECT	24	12	50%
Oldham - Cedar	18	7	39%
Core service total	**205**	**159**	**78%**
Trust wide	**4839**	**3808**	**79%**

Information provided by the trust, as shown in the table above, indicates appraisal rates varied across the service. The percentage of staff that had had an appraisal in the last 12 months up to 31 May 2018 varied from ward to ward with Cedar ward noted in the data to have only a 39% appraisal rate. However, during the inspection we found most non-medical staff had had an annual appraisal.

No information was provided relating to appraisals for medical staff within this core service, although there are no substantive medical staff recorded for this core service.

The trust was unable to provide information on the frequency of clinical supervision as there were varying positions across different services within the trust. Some services provided combined clinical and managerial supervision, others did separate sessions. The majority of services offered 4-6 weekly clinical supervision, with some offering sessions on a monthly basis. As well as clinical supervision, some services also offered peer, informal and/or group supervision.

The percentage of staff that received regular supervision varied across the core service, with records we reviewed showing staff received individual supervision between every 4 to 12 weeks depending on their role.

Managers ensured that staff had access to regular team meetings. They provided staff with supervision, meetings to discuss case management to reflect on and learn from practice and for personal support and professional development and appraisals of their work performance. Cedars ward had introduced 'team talk Thursday'. All staff on the ward met to discuss matters such as patient related issues and feedback from incidents.

The team included or had access to the full range of specialists required to meet the needs of patients on the ward. These included doctors, nurses, occupational therapists, clinical psychologists, social workers, pharmacists, speech and language therapists and dieticians.

Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group.

Managers provided new staff with appropriate induction with support staff which included using the care certificate standards as the benchmark for healthcare assistants.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge.

Managers ensured that staff received the necessary specialist dementia training for their roles where this was required.

Multi-disciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings.

Staff shared information about patients at effective handover meetings within the team.

The ward teams had effective working relationships, including good handovers with other relevant teams within the organisation for example, care co-ordinators and community mental health teams.

There were external relationships with, for example, the local safeguarding authority, local support groups for people living with dementia and their carers, independent advocacy services, palliative care teams, charities for older people amongst others.

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

Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. Information provided by the trust showed compliance with training was below the trust wide target of 95% at 58% as of 30 April 2018. This was higher than the 53% reported at the previous year.

However, during our visit the records we reviewed showed that all staff had either completed training or were booked on to a training course.

Staff had easy access to administrative support and legal advice on the implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were.

The provider had relevant policies and procedures that reflected the most recent guidance.

Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Staff ensured that patients were able to take section 17 leave, permission for detained patients to leave hospital, when this has been granted.

The service displayed a notice to tell informal patients that they could leave the ward freely.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training was included in mental health law training. The training was mandatory and renewed every 3 years.

All staff had either received training in the Mental Capacity Act or were booked onto a training course. Training included an assessment, which meant that managers were assured staff had a good understanding of the Mental Capacity Act.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it.

Staff knew where to get advice from within the trust regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it.

For patients who might have impaired mental capacity, the service assessed and recorded assessments of patients' mental capacity to consent appropriately. They did this on a decision-specific basis with regards to significant decisions. However, the usage of a capacity assessment was not consistent on all the wards visited.

There were no formal arrangements to monitor adherence to the Mental Capacity Act. Managers we spoke with told us that they recognised that the records regarding capacity and best interests were fragmented in several different patients' files and they were reviewing ways to improve this.

The service did not have audit arrangements in place to ascertain the appropriate application of the Mental Capacity Act. Where issues were identified, audits on specific cases were undertaken and action taken on any learning that resulted from it.

We reviewed three ‘do not attempt cardiopulmonary resuscitation’ records. Evidence of best interests’ discussions and justification for the decision was required to be recorded in the doctors’ notes. However, the rationale was not clear as there was no evidence to show that a best interest discussion had taken place. There was no record of the information given to relatives to enable them to fully participate in the discussion. This was not in line with trust policy or best practice guidance.

The trust told us that 87 Deprivation of Liberty Safeguard applications were made to the Local Authority for this core service between 1 May 2017 and 30 April 2018, of which three were approved. The greatest number of Deprivation of Liberty Safeguard applications were made in April 2018 with 10.

CQC received no direct notifications from Trust between 1 May 2017 and 30 April 2018.

Number of DoLS applications made by month

	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 17	Feb 17	Mar 17	Apr 17	Total
Applications made	9	9	4	4	4	5	11	11	5	9	6	10	**87**
Applications approved	2	0	0	0	0	0	0	0	0	0	0	1	**3**

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff were discreet, respectful, and responsive when caring for patients. Patients and carers across the service told us that the staff were friendly and caring. At meal times we saw staff supporting patients to make their own choices, respecting their cultural and personal preferences.

Staff gave patients help, emotional support and advice when they needed it. Group activities were available on all wards; however, staff and patients said they would like a wider variety. On some wards staff arranged one to one activities based on patient’s personal interests and needs. Efforts had been made to make the ward environment dementia friendly.

Staff directed patients to other services and supported them to access those services if they needed help. Staff across all wards knew how to access other services for patients’ physical health needs, such as eye care and dental care.

Staff understood and respected the individual needs of each patient. On some wards staff used ‘life story’ work to learn more about patients with dementia and their personal interests, involving carers in this where possible. Staff held ‘dental days’ and other group sessions to help patients to live healthier lives and promote self-care and independence.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff told us the culture of the wards was open and they could seek support from other members of staff when needed.

Staff followed policy to keep patient information confidential.

The 2018 patient-led assessments of the care environment score for privacy, dignity and wellbeing at two core service locations (Fairfield General Hospital and Royal Oldham Hospital) scored higher than similar organisations.

The other three locations scored lower when compared to other similar trusts for privacy, dignity and wellbeing.

Site name	Privacy, dignity and wellbeing
Birch Hill Hospital	85.7%
Fairfield General Hospital	93.6%
The Meadows (Old Age Psychiatry Unit)	83.8%
Royal Oldham Hospital	94.5%
Tameside General Hospital	88.5%
Trust overall	**88.7%**
England average (mental health and learning disabilities)	**91.0%**

Involvement in care

Involvement of patients

Staff introduced patients to the wards and the services as part of their admission. Staff orientated patients to the ward, gave them welcome packs and they had access to advocacy.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Patients were involved in care planning as much as possible. This was sometimes difficult due to their conditions but staff made efforts to include them. Care plans were mainly person centred and written in ways that the patient could understand. Care plans showed that there was good family member or carer involvement.

Patients could give feedback on the service and their treatment and staff supported them to do this. This was done through discussions with their named nurse, through family and friends or advocacy. Community meetings were held every month and recorded to ensure that actions from previous meetings were completed. Information on how to feedback was displayed on the corridors. The friends and family test summary report (August 2018) showed that 93% of people would recommend the trusts mental health services.

Involvement of families and carers

Staff supported, informed and involved families and carers. The service had been implementing the triangle of care scheme that recognises the essential role carers play in the welfare and support of people with mental health conditions. Families and carers were invited to ward rounds and received regular updates from staff. Families and carers also received information packs.

Staff helped families to give feedback on the service. Families and carers were invited to the community meetings and a patient advice and liaison service was available. Carers' events were also held across the service. Compliment cards and letters were displayed on the wards.

Staff gave carers information on how to find the carer's assessment. Resources were available and staff knew how to signpost carers to social services.

Is the service responsive?

Access and discharge

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient.

Most patients were admitted from home. On Saffron wards, some were admitted from home and some from the acute trust. When patients were moved or discharged, this happened at an appropriate time of day.

Staff planned for patients' discharge early in the admission. They formulated a leaving hospital care plan that included the family's wishes for the patient's future care. They liaised with care co-ordinators and other care providers to facilitate discharge.
Between 1 May 2017 and 30 April 2018 there were 499 discharges within this core service. This amounted to 4% of the total discharges from the trust overall (11960).
Of these, 109 (1%) discharges were delayed. The number of delayed discharges varied between 26 (June 2017) and 75 (March 2018).
The trust did not provide any details relating to referral to assessment and treatment times for this core service.

Facilities that promote comfort, dignity and privacy

The trust provided information regarding average bed occupancies for the nine wards in this core service between 1 May 2017 and 30 April 2018.
All the wards within this core service reported average bed occupancies ranging above the provider benchmark of 85% over this period.
We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time-period that was covered.

Ward name	Average bed occupancy range (**1 May 2017 – 30 April 2018**) (current inspection)
Bury - Ramsbottom Ward	107%
Oldham - Cedar Ward	100%
Oldham - Rowan Ward	104%
Rochdale - Beech Ward	104%
Stockport - Davenport Ward	100%

Stockport - Rosewood Ward	96%
Stockport - Saffron Ward	89%
Tameside - Hague Ward	94%
Tameside - Summers Ward	92%

The trust provided information for average length of stay for the period 1 May 2017 to 30 April 2018. We were unable to compare the average length of stay data to the previous inspection due to differences in the way we asked for the data and the time-period that was covered.

Ward name	Average length of stay range (**1 May 2017 – 30 April 2018**) (current inspection)
Tameside - Summers Ward	108
Stockport - Rosewood Ward	100
Rochdale - Beech Ward	96
Oldham - Rowan Ward	83
Stockport - Davenport Ward	83
Bury - Ramsbottom Ward	77
Oldham - Cedar Ward	63
Tameside - Hague Ward	59
Stockport - Saffron Ward	58

This core service reported one out of area placement between 1 May 2017 and 30 April 2018.
As of 14 June 2018, this core service had no ongoing out of area placements.
The placement lasted 20 days and was due to capacity issues.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements
1	0	1	20	0

This core service reported 40 readmissions within 28 days between 1 May 2017 and 30 April 2018. Twenty-nine readmissions (73%) were readmissions to the same ward as the patient was discharged from. Sixteen of these related to Davenport Ward.
The average number of days between discharge and readmission was six days. There were eight instances whereby patients were readmitted on the same day as being discharged and there were six instances where patients were readmitted the day after being discharged. The reason for these re-admissions was due to patients being moved between the wards and this being logged as “discharged” and then “re-admitted”. This was usually based on the patient’s presentation.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Davenport	18	16	89%	0-17	6
Saffron	12	6	50%	0-7	2

Rosewood	2	0	0%	0-0	0.0
Rowan	2	2	100%	2-27	15
Hague	2	1	100%	9-19	14
Ramsbottom	2	2	100%	16-22	19
Summers	1	1	100%	5-5	5
Cedars	1	1	100%	16-16	16

Patients' engagement with the wider community

Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain. Across the service, there were relationships with, for example, local support groups for people living with dementia and their carers, independent advocacy services and charities for older people. Some of these groups visited the wards to engage with patients.

Meeting the needs of all people who use the service

The wards had made efforts to provide dementia friendly surroundings although they were restricted by the physical environment. Signage was clear and there were contrasting colours, for example, toilet seats and hand rails, there were quiet spaces and areas where patients could meet visitors, and views outside. Flooring was non-reflective and non-slip and seating was traditional.

On most of the wards, patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Patients could personalise their bedrooms.

On most wards patients had somewhere secure to store their possessions. However, on Davenport ward patients were encouraged to have valuables sent to the main office if they were worth more than twenty pounds.

Staff and patients had access to the full range of rooms and equipment to support treatment and care, which included clinic room to examine patients, activity and therapy rooms.

The accommodation was accessible for those with reduced mobility, with accessible toilets and bathrooms available for patients, and all wards except Ramsbottom were on the ground floor.

Patients could make a phone call in private.

Patients had access to outside space.

Staff ensured that patients had access to appropriate spiritual support.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. The food was of a good quality with a trust average food quality score of 92.2% from patient-led assessments of the care environment. Patients could make hot drinks and snacks whenever they liked. The wards had a designated nutrition champion. There were pictorial menus to help patients choose their meals.

The 2018 patient-led assessments of the care environment score for ward food at Birch Hill Hospital scored higher than similar trusts. Fairfield Hospital, Royal Oldham Hospital and Tameside General Hospital scored slightly lower than the England average and the Meadows scored much lower (71.8%).

Site name	Ward food
Birch Hill Hospital	99.4%
Fairfield General Hospital	90.8%
The Meadows (Old Age Psychiatry Unit)	71.8%
Royal Oldham Hospital	91.9%
Tameside General Hospital	86.9%
Trust overall	**90.6%**
England average (mental health and learning disabilities)	**92.2%**

Managers ensured that staff and patients had easy access to interpreters and/or signers.

Beech ward was working with the trust mental health law manager to develop dementia friendly leaflets about patients' rights under the Mental Health Act 1983.

However, the information displayed on the wards was not in a form accessible to the patient group; for example, it was not in large print or pictorial. Information leaflets were not displayed in different languages spoken by patients or in different formats. The service told us that large print leaflets or leaflets in languages other than English and in various formats were available. However, on all the wards we visited, none of the leaflets displayed were in other formats. Staff told us that if these were needed they would make them available.

We also noted large numbers of pieces of information posted around the wards.

On Hague there were 26 posters on walls and cupboards additional to those on the notice boards. On Saffron, in the female patients' lounge, there were over 40 different pieces of posted information. Patients we spoke with said they did not read them as they were "too small" and "too many to read".

Listening to and learning from concerns and complaints

This core service received eight complaints between 1 May 2017 and 30 April 2018. None of these were fully upheld, five were partially upheld and one was not upheld. None were referred to the Ombudsman. Two were still under investigation at the time of reporting.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Under investigation	Referred to Ombudsman	Upheld by Ombudsman
Saffron Ward	3	0	2	1		0	-
Ramsbottom Ward	3	0	1	1	1	0	-
Cedars Ward	2	0	1	0	1	0	-
Davenport Ward	1	0	1	0		0	-

All wards within this service had information displayed about how patients or carers could make a complaint. Patients and carers we spoke with knew how to complain or raise concerns.

Staff knew how to handle complaints appropriately

This core service received 16 compliments during the last 12 months from 1 May 2017 to 30 April 2018, which accounted for 3% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.
Leaders were visible in the service and approachable for patients and staff. The managers we spoke with told us they had an open-door policy. Staff confirmed this and said they could always speak to the managers. The new chief executive and board members had visited the wards. Some had worked alongside staff, for first-hand experience of life on the wards and the challenges frontline staff faced. Staff were very positive about the new management. They reported that they were already seeing changes. There was increased engagement with staff and a better understanding from senior leaders in the trust to the pressures middle management and frontline staff faced, and greater investment in the fabric of buildings with refurbishment in several areas. Leadership development opportunities were available, including opportunities for staff below team manager level. Staff told us there were various management and leadership courses available, plus access to coaches for 1-1 support.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Posters were displayed on the wards. Staff understood the trust ethos and explained how they applied the vision and values in their work. We saw some discussion in supervision records.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff could discuss developments in the service in supervision. Managers could feed issues into the senior managers' meetings. There was an annual staff survey. Some staff had been involved in task and finish groups. However, some staff said they did not have opportunity to be involved.

Staff could explain how they were working to deliver high quality care within the budgets available. Managers had a good understanding of financial constraints. There was recent investment in the service and new staff were being recruited.

Culture

Staff felt respected, supported and valued. They told us they were supported by their colleagues and managers, including senior managers.

Staff felt positive and proud about working for the provider and their team. Managers told us the new chief executive had a real passion to understand the challenges staff faced and

acknowledged that staff were under pressure. Staff were optimistic about the new management structure and happy about the changes already being made. One staff member told us they had considered delaying their retirement so they could see the changes taking place.

Staff felt able to raise concerns without fear. They knew how to use the whistle-blowing process and about the role of the Speak Up Guardian, who reported staff concerns to the board. Managers dealt with poor staff performance when needed. During the reporting period there were two cases where staff were suspended.

Of the two cases, both involved Band 2 staff group. Investigations were ongoing.

Teams worked well together. There were good relationships between teams, and with external organisations.

Staff appraisals included conversations about career development and how it could be supported.

Staff reported that the trust promoted equality and diversity in its day to day work and in providing opportunities for career progression. There were forums and network groups for staff.

There was an equality and diversity team that staff could access for support.

The service's staff sickness and absence rates were worse than the average for the trust.

Staff had access to support for their own physical and emotional health needs through a staff wellbeing service that provided confidential help and support.

The provider recognised staff success within the service through annual staff awards. There was also a 'star of the month' scheme in some boroughs, where staff were recognised and given a voucher for going above and beyond.

Governance

The trust provided a document detailing their highest profile risks. Those identified as high risk which relate to this core service are summarised below.

Key:

Opened	ID	Description	Trend of Risk Rating	Last review date
17/07/2017	1158/07-17	There is a risk of failure of the estate of PCs/laptops/tablets (end user device)	Static	05/07/2018
03/07/2017	1147/07-17	Manual locking systems on bedroom doors on inpatient wards	Static	20/06/2018
30/08/2016	1062/12-16	Not achieving / delivering CQC recommendations / targets	Static	30/06/2018

Following this inspection, we requested up to date data from the risk register. The trust reported that there was only one risk for this core service; that was manual locking systems on bedroom doors.

Overall, governance systems for this core service were effective. There were systems and procedures to ensure that wards were safe and clean, there were enough staff on each shift, staff

were trained and supervised, although supervision was not carried out as frequently as the trust policy provided for, patients were assessed and treated well, physical health was monitored, the wards adhered to the Mental Health Act 1983 and Mental Capacity Act 2005, beds were managed well, discharges were planned, information was provided in accessible ways, and incidents were reported, investigated and learnt from.

There was a clear framework for discussions at ward, team or directorate level to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. All the wards had made improvements in safety.

The safer staffing database initiated an audit if levels fell below what was perceived to be safe. This audit ensured that quality of care was not compromised.

The audits were sufficient to provide assurance and staff acted on the results when needed.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when they needed to.
Staff concerns matched those on the risk register.
The service had plans for emergencies and there was guidance available for staff.

Where cost improvements were taking place, they did not compromise patient care.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. The electronic patient record system collected data but it was not fully embedded across this core service. There were also databases that collected information about average lengths of stay and re-admission rates.

Staff had some access to the information technology equipment needed to do their work. The electronic case recording system was still not embedded across this core service and staff said that using different methods of recording meant sharing information was difficult.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

With the exception of authorised applications made under the Deprivation of Liberty Safeguards, staff made notifications to external bodies as needed.

Engagement

Staff, patients and carers had access to up-to-date information about the services they used and about the trust, for example, through the intranet, bulletins, newsletters.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.
Managers and staff had access to feedback from patients, carers and staff and used it to make improvements. For example, managers received minutes of ward community meetings.

Patients and carers were involved in decision-making about changes to the service.

Patients and staff could meet with members of the provider's senior leadership team to give feedback.
Directorate leaders engaged with external stakeholders.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes.

Staff had opportunities to participate in research.
Innovations were taking place in the service.

Cedars ward had introduced 'team talk Thursday', a weekly meeting of all disciplines of staff on the ward to discuss any patient related issues on the ward, including feedback from incidents. This had already resulted in the formulation of comprehensive care plans for patients due to a true multi-disciplinary approach.

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

Staff used quality improvement methods and knew how to apply them. For example, action plans from incidents, feedback or complaints were reviewed and changes were made to improve patient outcomes. Staff used the friends and family test, which measures patient experience, to make service improvements based on direct patient feedback.

There was good information sharing and discussion on the wards; however, there was no forum for discussion or sharing good practice across the service.

Accreditation of services

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

No information on accreditations relating to this core service was supplied by the trust. Managers we spoke with said the service had not participated in any accreditation schemes.

Mental health crisis services and health-based places of safety

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Bury Mental Health Services	A&E RAID		Mixed
Bury Mental Health Services	Access and Crisis Service		Mixed
Bury Mental Health Services	Home Treatment Team		Mixed
Oldham Mental Health Services	RAID Team		Mixed
Rochdale Mental Health Services	Access and Crisis Team		Mixed
Rochdale Mental Health Services	Home Treatment Team		Mixed
Tameside Mental Health Services	Tameside RAID A&E		Mixed
Tameside Mental Health Services	Home Treatment Team/Review and Housing	N/A	Mixed
Stockport Mental Health Services	Stockport Adult RAID		Mixed
Stockport Mental Health Services	Home Treatment Team		Mixed
Stockport Mental Health Services	Stockport Team for Early Management (STEM)	9pm - 9am	N/A

At this inspection we inspected the following teams:

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

- Oldham
- Rochdale

- Bury
- Tameside
- Stockport.

The access team in Stockport.

The access and crisis teams in the following boroughs:

- Bury
- Rochdale

Is the service safe?

Safe and clean environment

We toured all community teams where patients were seen and found either interview rooms were fitted with alarms or staff used personal alarms which if activated were linked to the system so neighbouring teams could respond.

Teams did not have clinic rooms. Where medicines were held they were stored in a locked medicine cupboard. The necessary equipment to carry out physical examinations was available either within teams or shared with the neighbouring wards.

The health based places of safety had all been refurbished since the last inspection. They were clean and well maintained.

Cleaning records were up to date and demonstrated that the environment was regularly cleaned. Records confirmed Legionella checks took place.

Safe staffing

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	30 April 2018	131.5	N/A
Total number of substantive staff leavers	1 May 2017 – 30 April 2018	25.1	N/A
Average WTE* leavers over 12 months (%)	1 May 2017 – 30 April 2018	19%	N/A
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	31 March 2018	44.4	N/A
Total vacancies overall (%)	31 March 2018	24%	7.5%
Total permanent staff sickness overall (%)	30 April 2018	3.0%	5%
	1 May 2017 – 30 April 2018	5.9%	5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31 March 2018	139.0	N/A

Establishment levels nursing assistants (WTE*)	At 31 March 2018	2.0	N/A
Number of vacancies, qualified nurses (WTE*)	At 31 March 2018	34.4	N/A
Number of vacancies nursing assistants (WTE*)	At 31 March 2018	15.2	N/A
Qualified nurse vacancy rate	At 31 March 2018	25%	7.5%
Nursing assistant vacancy rate	At 31 March 2018	13%	7.5%
Bank and agency Use			
Hours filled by bank staff to cover sickness, absence or vacancies (qualified nurses)	1 May 2017 – 30 April 2018	32566	N/A
Hours filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 May 2017 – 30 April 2018	2218	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 May 2017 – 30 April 2018	10009	N/A
Hours filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	29004	N/A
Hours filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	138	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 May 2017 – 30 April 2018	-25278	N/A

*Whole Time Equivalent

This core service reported an overall vacancy rate of 25% for registered nurses at 31 March 2018.

This core service reported an overall vacancy rate of 13% for nursing assistants.

This core service has reported a vacancy rate for all staff of 24% as of 31 March 2018.

	Registered nurses			Health care assistants			Overall staff figures		
Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Bury and Rochdale Street Triage	2.4	2.4	100%	-	-	-	2.4	2.4	100%
Stem Stockport	0.9	1.9	47%	1.8	1.8	100%	2.7	3.7	73%
Bury Home Treatment Team	2.7	7.7	35%	1.4	2.4	59%	7.2	15.0	48%
Raid A&E Liaison	3.6	12.9	28%	-	-	-	6.1	15.9	38%

	Registered nurses			Health care assistants			Overall staff figures		
Tameside Review and Housing Team	0.9	1.4	62%	0.0	1.1	0%	0.9	2.4	35%
Bury Access and Crisis	3.0	8.0	38%	0.0	0.0	-	3.0	9.0	33%
Home Treatment Team Tameside	3.2	10.8	30%	0.0	1.0	0%	3.2	11.8	27%
Bury and Rochdale Adult A & E Raid	3.0	9.0	33%	-1.0	0.0	-	2.5	9.5	26%
Home Treatment Oldham	3.8	10.8	35%	-0.3	4.9	-6%	5.3	21.5	25%
Rochdale Infirmary Raid	1.2	4.8	25%	-	-	-	1.2	5.0	24%
Home Treatment Team Stockport	1.8	10.4	17%	-	-	-	3.3	14.2	23%
Tameside Adult Raid	3.3	14.0	24%	-	-	-	3.3	15.2	22%
Access and Crisis Team Tameside	0.4	5.5	8%	-	-	-	1.4	7.2	20%
Rochdale Home Treatm	3.0	10.0	30%	0.0	4.0	0%	2.2	14.8	15%

	Registered nurses			Health care assistants			Overall staff figures		
ent Team									
Rochdale Access and Crisis	1.0	7.0	14%	-	-	-	1.0	9.0	11%
Working Age Raid Team Stockport	0.5	11.1	5%	-	-	-	1.3	12.9	10%
Access and Crisis Team Stockport	1.2	7.2	16%	-	-	-	0.2	9.2	2%
Oldham Access Crisis	-1.4	4.0	-35%	-	-	-	-2.7	4.7	-58%
Bury and Rochdale Street Triage	2.4	2.4	100%	-	-	-	2.4	2.4	100%
Core service total	**34.4**	**139.0**	**25%**	**2.0**	**15.2**	**13%**	**44.4**	**183.4**	**24%**
Trust total	**230**	**1703**	**14%**	**105**	**932**	**11%**	**464**	**4081**	**11%**

NB: All figures displayed are whole-time equivalents

Between 1 May 2017 and 30 April 2018, bank staff filled 32566 available hours to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 2218 available hours for qualified nurses. 10009 available hours were unable to be filled by either bank or agency staff.

Team	Total hours available / establishment	Bank use (hours)	Agency use (hours)	Total hours NOT filled by bank or agency staff
Bury - Home Treatment Team	11965	1438	0	-750

Oldham - Home Treatment Team	16561	1135	0	2901
HMR - Home Treatment Team	15004	3713	0	-525
Stockport - Home Treatment Team	16781	1043	0	-569
Tameside - Home Treatment Team	18777	2246	0	1812
North Manchester - RAID	2575	13	0	1258
Bury and Oldham - RAID Inpatients	14470	1568	73	-18
Oldham - A&E RAID and Street Triage	28868	3226	0	6492
Oldham - Access and Crisis	7659	633	0	-3388
Bury and HMR - A&E RAID & Street Triage	17827	9274	0	-5596
HMR - Access and Crisis	13362	1618	0	947
Tameside - A&E RAID and Street Triage	24808	3833	236	-883
Stockport - Adult RAID and Street Triage	26589	1453	1860	3917
Bury - Access and Crisis	15317	518	0	4354
Stockport STEM	3647	855	49	57
Core service total	**234210**	**32566**	**2218**	**10009**
Trust Total	**3580727**	**173361**	**70461**	**286744**

Between 1 May 2017 and 30 April 2018, 29004 available hours were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered 138 available hours. The trust reported that -25278 available hours were unable to be filled by either bank or agency staff. This indicates that shifts were filled above the planned number.

After querying the data with the trust, they have stated that, “the reason some of the data is in negative figures is because the team/service have overspent on their budgets. This could be due to vacancies, short or long- term sickness, maternity leave or (for wards) high levels of observations.” This has meant we cannot calculate the percentage of hours worked by bank or agency staff because the number of available hours is not a true reflection of the hours worked by staff.

Team	Total hours available / establishment	Bank use (hours)	Agency use (hours)	Total hours NOT filled by bank or agency staff
Bury - Home Treatment Team	4616	236	0	632
Oldham - Home Treatment Team	9039	1270	23)	-2710
HMR - Home Treatment Team	7985	1004	13	-1709
Stockport - Home Treatment Team	0	69	0	-68
Tameside - Home Treatment Team	1955	142	0	-142
North Manchester - RAID	326	0	0	407
Bury and Oldham - RAID Inpatients	3911	310	0	81
Oldham - A&E RAID and Street Triage	0	7775	0	-7773
Oldham - Access and Crisis	0	143	0	-143
Bury and HMR - A&E RAID & Street Triage	652	12780	16	-12145
HMR - Access and Crisis	0	297	0	-297

Tameside - A&E RAID and Street Triage	0	574	0	-574
Stockport - Adult RAID and Street Triage	0	2699	75	-2773
Bury - Access and Crisis	0	65	0	-10
Stockport STEM	3598	1640	11	1946
Core service total	**32082**	**29004**	**138**	**-25278**
Trust Total	**1507115**	**459367**	**84134**	**-332234**

This core service had 25.1 (19%) staff leavers between 1 May 2017 and 30 April 2018.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
North Manchester - RAID	0.4	3.5	231%
Stockport STEM	1	1	80%
HMR - Home Treatment Team	10.8	7	57%
Bury - Home Treatment Team	7.8	2.6	27%
Oldham - A&E RAID and Street Triage	9.4	2	18%
Tameside - A&E RAID and Street Triage	12	2	16%
Oldham - Access and Crisis	7.4	1	13%
HMR - Access and Crisis	8	1	13%
Tameside - Home Treatment Team	9.3	1	12%
Stockport - Home Treatment Team	12	1	11%
Bury and HMR - A&E RAID & Street Triage	9.6	1	11%
Stockport - Adult RAID and Street Triage	12.5	1	9%
Oldham - Home Treatment Team	16.1	1	6%
Bury and Oldham - RAID Inpatients	8.2	0	0%

Bury - Access and Crisis	7	0	0%
Core service total	**131.5**	**25.1**	**19%**
Trust Total	**4244**	**662**	**16%**

The sickness rate for this core service was 5.9% between 1 May 2017 and 30 April 2018. The most recent month's data (April 2018) showed a sickness rate of 3.0%.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Oldham - A&E RAID and Street Triage	8.0%	9.2%
Bury and Oldham - RAID Inpatients	1.6%	9.0%
Bury - Access and Crisis	4.3%	8.4%
Oldham - Home Treatment Team	6.4%	8.3%
Bury - Home Treatment Team	0.0%	8.1%
Tameside - Home Treatment Team	0.0%	8.1%
Stockport STEM	0.0%	8.1%
HMR - Access and Crisis	12.5%	6.1%
Tameside - A&E RAID and Street Triage	1.5%	5.3%
HMR - Home Treatment Team	0.0%	5.3%
North Manchester - RAID	-	4.3%
Stockport - Adult RAID and Street Triage	0.0%	3.5%
Bury and HMR - A&E RAID & Street Triage	0.3%	1.8%
Stockport - Home Treatment Team	0.3%	1.1%
Oldham - Access and Crisis	3.2%	0.9%
Core service total	**3.0%**	**5.9%**
Trust Total	**4.5%**	**5.4%**

The provider had estimated the number and grade of nurses required for the team using a recognised tool however; staffing was a challenge. All teams except the Stockport home based treatment team had vacancies at the time of the inspection. Managers reported difficulties with recruitment. There were vacancies for team managers at Tameside home based treatment team,

Rochdale Access and Crisis team. Acting managers were in post at Bury RAID and Rochdale home based treatment team. Bank staff were used however we observed managers being included in the numbers and providing clinical interventions due to staffing challenges and the pressures of the service.

We had concerns regarding the staffing for the health based places of safety. The RAID teams coordinated the section 136 arrangements however; the size of their teams, and other elements of their role meant they were not always able to provide staff for the health-based places of safety. Staff told us and we observed that staff from neighbouring wards provided staff to the places of safety which meant ward numbers being reduced. Bury RAID were responsible for the health based places of safety at Rochdale and Bury. Records showed that on one occasion in Tameside due to staffing levels, the approved mental health practitioner was left alone in the health based place of safety with no keys, alarm or access to the patient if an emergency occurred. Phones calls to the wards were left unanswered for a significant amount of time.

Medical staff

There was rapid access to a psychiatrist when required. This was either via the psychiatrists allocated to the teams or for teams that did not have their own psychiatrists, via the sector consultants.

Data on the use of medical locums was not provided at a core service level. The trust reported that they used medical locums to cover emergency services for general adult and older people, community services and trust inpatient services.

The trust told us that:

“We are currently advertising all vacant posts on a rolling basis on NHS Jobs. We have now created the facility of a trust bank to allow a flexible for available workers. We are utilising the offer of relocation packages to support those out of the area. We are also the creation of non-medical roles to support the gaps including AP's and nurse consultants. We have used the raising the research and development profile of the trust as a method of attraction to the trust. We are currently in the planning and scoping stages for international recruitment. Medical Workforce Strategy to be presented to Workforce Committee in October 2018.”

Mandatory training

The compliance for mandatory and statutory training courses at 31 December 2017 was 80%. Of the training courses listed all but one failed to achieve the trust target and of those, four failed to score above 75%.

The training compliance reported for this core service during this inspection was the same as the 80% reported last year. Mental Health Law, Conflict Resolution Level 2 and Infection Level 2 had below 75% compliance in both years.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	This core service	Trust target %	Trust wide mandatory/ statutory training total %
Infection Control Level 1	**95%**	95%	96%
Child Safeguarding Level 1	92%	95%	93%
Child Safeguarding Level 2	90%	95%	91%

Training course	This core service	Trust target %	Trust wide mandatory/ statutory training total %
Health and Safety Level 1	86%	95%	92%
Conflict Resolution Level 1	85%	95%	92%
Preventing Radicalisation	82%	95%	92%
Adult Safeguarding Level 1	82%	95%	88%
Moving and Handling Level 1	79%	95%	93%
Information Governance Level 1	79%	95%	86%
Equality and Diversity	79%	95%	88%
Fire Safety Level 1	78%	95%	92%
Medicines Management	77%	95%	83%
Child Safeguarding Level 3	75%	95%	91%
Moving and Handling Level 2	75%	95%	81%
Infection Control Level 2	72%	95%	77%
Basic Life Support	65%	95%	83%
Conflict Resolution Level 2	62%	95%	86%
Mental Health Law	56%	95%	65%
Core Service Total %	**80%**		**89%**

During inspection we reviewed the electronic staff record system which showed that staff had received and were up to date with appropriate mandatory training.

Assessing and managing risk to patients and staff

Staff undertook a risk assessment of every patient at initial triage/ assessment and updated this regularly. Risk assessments were detailed and comprehensive.

The teams created and made good use of crisis plans which included strategies for keeping people safe and contact details of organisations for support.

Teams worked flexibly and planned visits at a daily handover. They responded promptly to the sudden deterioration in people's mental health.

Teams had good personal safety protocols including lone working practice. We reviewed systems for monitoring staff whereabouts.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Staff were trained in safeguarding and knew how to make a safeguarding alert and did this when appropriate.

Pennine Care NHS Foundation Trust submitted details of one serious case review commenced or published in the last 12 months that related to this core service. It was a trust wide external case review which was completed in 30 April 2018.

This case review related to the Stockport RAID team and a patient that was not on the trusts caseload at the time of an incident and as of 18 June 2018 the review was currently ongoing. The trust has taken the following actions based on the early findings:

- Multi-agency learning event
- Seven-minute briefing session to share across the trust.

Medicines management

Medicines were not managed safely. At Oldham home based treatment team, staff were administering medicines to patients without completing a medicine administration record. There was no system of recording the quantity administered and balance of medicines. At Tameside home based treatment team, staff held medicines for patients, records showed medicines were signed in however; they had not been signed out and were not present in the medicine cupboard. In Stockport home based treatment team, the form did not allow for the recording of the quantity of medicines received from pharmacy or the quantity remaining once administered. There had been improvements in recording allergies in records since the last inspection however; there were still gaps at Stockport. There were challenges with accessing doctors to write prescriptions in Bury home based treatment team. There were large quantities of medicines awaiting disposal within Oldham home based treatment team. Daily checks of recorded drugs were not taking place consistently. Where medicines were stored and temperatures recorded, records reviewed at Rochdale and Tameside home based treatment teams had gaps in the monitoring. In Tameside when the readings for the fridge exceeded the recommended range there was no action taken. Staff were not following the trust's medicines policy dated December 2016.

Track record on safety

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified.

Between 1 May 2017 and 30 April 2018 there were 15 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was *Apparent/actual/suspected self-inflicted harm* with 14. There were no 'unexpected inpatient deaths' related to this core service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

It should be noted that one additional incident that related to 'Apparent/actual/suspected self-inflicted harm' was included in the trust's serious incident data but was not within the STEIS data. However, after contacting the trust they stated this incident (STEIS reference 2018/5141) was also reported to STEIS by another NHS Trust on STEIS number 2018/5817. Rather than have this reported under two STEIS numbers, STEIS had removed the Pennine Care NHS Foundation Trust STEIS number".

	Number of incidents reported

Type of incident reported on STEIS	Apparent/actual/suspected self-inflicted harm	Apparent/actual/suspected homicide	Total
Home Treatment Team - Oldham	3		3
Access & Crisis Team - Stockport	2		2
RAID Adult – Oldham	2		2
RAID Adult – Stockport	2		2
Access & Crisis Team – HMR	1		1
Access & Crisis Team – Oldham		1	1
Home Treatment Team - Stockport	1		1
Home Treatment Team - T&G	1		1
RAID Adult - Bury	1		1
RAID Adult - T&G	1		1
Total	14	1	15

Staff we spoke with gave examples of serious incidents relating to their service and the leaning from the incidents.

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing future deaths.

In the last two years, there have been 12 'prevention of future death' reports sent to Pennine Care NHS Foundation Trust. Six of these related to this core service

Staff we spoke with knew how to report incident and what to report. Staff used the electronic incident reporting system.

Staff were open and transparent and explained to patients when something went wrong. Records reviewed confirmed patients and families were invited to contribute to serious incident investigations. Managers apologised to patients both verbally and in writing, offering the opportunity for ongoing support and engagement in the investigation process if an incident met the threshold for the duty of candour requirement.

Staff told us and records confirmed they received feedback from investigation of incidents both internal and external to the service. Team meeting minutes confirmed staff met to discuss this feedback.

There was evidence of changes having been made as a result of feedback following incidents and in response to Regulation 28 coroner's reports. Examples included the home- based treatment teams trying to see patients on days two and three following their discharge from hospital as research showed this was when they were at their most vulnerable and they had a heightened risk to self.

Staff were de-briefed and supported after a serious incident.

Is the service effective?

Assessment of needs and planning of care

We reviewed 62 care records. There had been progress made in record keeping and documentation since the last inspection. Records reviewed included a comprehensive assessment completed in a timely manner.

Dependant on the teams, care records contained up to date, personalised, holistic, recovery-oriented care plans. For the access and crisis teams, where patients may only have one contact with a practitioner, patients jointly created a safety plan with the practitioner, including strategies to keep themselves safe and contact details of organisations that could offer support.

Records were a combination of paper and electronic. Paper records were stored in locked cupboards and offices. All information needed to deliver care was stored securely and was available to staff when they needed it in an accessible form.

Managers reported although ideally patients would have a named practitioner, due to the nature of the teams and patients often requiring daily or twice daily visits this was not practical. Detailed handovers were in use to pass on information to colleagues including a risk rating and the structured communication of SBAR: situation, background, assessment and recommendation. Physical health and safeguarding concerns were also shared with colleagues.

Best practice in treatment and care

Consultants prescribed and reviewed medicines for patients. This was in line with National Institute of Health and Care Excellence guidance.

The teams did not have access to psychological therapies however, teams could refer patient to the trust's improving access to psychological therapies service once their risks had reduced.

Home based treatment teams were multidisciplinary and could provide support in relation to employment, housing and benefits. Records reviewed confirmed teams also referred patients onto other agencies for specialist support.

Staff considered patients physical healthcare needs, including undertaking a baseline assessment prior to prescribing new medicines. Teams had improved on the recording of allergies following our last inspection. Patients were only with the teams for short periods of time, therefore they were not responsible for completing an annual health check. Teams liaised with the community mental health teams if patients were open to a care coordinator to access their information in relation to physical health.

Teams used the CORE-10: A short measure of psychological distress assessment with patients at the first contact with the team and at discharge to monitor outcomes and rate severity of symptoms.

Team members had lead roles in relation to carers and safeguarding. Managers had access to the electronic dashboards to monitor performance and clinical audit.

This core service participated in four clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Hand hygiene observation audit	All teams delivering clinical care	Provider wide	Infection prevention & control	01/05/2018	•Audit reports are shared with the relevant IP&C lead and discussed at the IP&C committee •IP&C leads disseminate individual summary results to relevant teams so concerns can be addressed
Trust wide record keeping audit - paper health records	All relevant clinical teams	Provider wide	Clinical	01/05/2018	•A copy of the report has been shared with the Associate Director of Nursing and Healthcare Professionals, the Trust Records Manager and relevant leads. •Services have been provided with a copy of their local results, and are required to develop action/improvement plans to address any concerns. •The Associate Director of Nursing and Healthcare, and the Trust Records Manager will oversee strategic actions to ensure they are delivered. •The audit is included on the Trust annual clinical audit programme.
Trust wide record keeping audit - electronic health records	All relevant clinical teams	Provider wide	Clinical	01/05/2018	•A copy of the report has been shared with the Associate Director of Nursing and Healthcare Professionals, the Trust Records Manager, and relevant leads. •Services have been provided with a copy of their local results, and are required to develop action/improvement plans to address any concerns. •The audit is included on the Trust annual clinical audit programme.

IP&C Community environmental inspection of community buildings	All community clinic rooms from which PCFT delivers clinical care	Provider wide	Infection prevention & control	01/02/2018	•A copy of the audit report has been shared with the IP&C leads for discussion at the IP&C Committee. •IP&C leads disseminate individual reports to relevant services areas highlighting areas that need to be addressed, and will monitor progress of improvement.

Skilled staff to deliver care

Teams included the full range of mental health disciplines required to care for the patient group including doctors, nurses, occupational therapists, social workers and support time and recovery workers. Staff were experienced and qualified to undertake their roles.

Prior to the inspection the trust was unable to provide information on the frequency of clinical supervision as there were varying positions across different services within the trust. They advised some services provided combined clinical and managerial supervision, others did separate sessions. Most services offered 4-6 weekly clinical supervision, with some offering sessions monthly. As well as clinical supervision, some services also offered peer, informal and/or group supervision.

During the inspection we found staff were not receiving regular management supervision. We reviewed 37 staff supervision records. Twenty-seven of those records showed staff had not received supervision in line with the trust policy, the intervals of supervision were more than two monthly. The trust's Individual Performance and Development Review and Progression of Pay Policy, dated October 2016 stated that management supervision should take place every four to six weeks with a six monthly and annual review. Records of these meetings should be recorded.: This was not happening. Several records showed staff had not had supervision for more than a year.

Team meetings took place, however these varied in the frequency and numbers of staff that attended. Agenda items included changes within the teams, performance and learning from incidents.

In addition to the mandatory training, staff had attended the STORM (suicide prevention) training.

Managers told us and records confirmed that poor staff performance was addressed promptly and effectively.

The trust's target rate for appraisal compliance was 85%. As at 31 May 2018, the overall appraisal rates for non-medical staff within this core service was 60%.
Nine of the teams failed to achieve the trust's appraisal target.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Stockport - Adult RAID and Street Triage	13	13	100%

Stockport STEM	1	1	100%
Bury - Access and Crisis	7	7	100%
Stockport - Home Treatment Team	12	11	92%
Bury - Home Treatment Team	8	7	88%
Oldham - Access and Crisis	7	5	71%
Tameside - Home Treatment Team	10	6	60%
Bury and Oldham - RAID Inpatients	9	5	56%
Tameside - A&E RAID and Street Triage	13	7	54%
Oldham - A&E RAID and Street Triage	10	4	40%
Bury and HMR - A&E RAID & Street Triage	10	4	40%
Oldham - Home Treatment Team	18	7	39%
HMR - Home Treatment Team	11	3	27%
HMR - Access and Crisis	8	2	25%
North Manchester - RAID	0	0	-
Core service total	**137**	**82**	**60%**
Trust wide	**4839**	**3808**	**79%**

When we reviewed the electronic staff records on site, they confirmed all staff had been appraised. The level at inspection was higher than 79% which was provided by the trust prior to inspection.

No information was provided regarding appraisals for medical staff within the core service.

Multidisciplinary and interagency team work

We attended a zoning meeting and a handover meeting. These were through, comprehensive and staff knew the patients well. Minutes confirmed regular multi-disciplinary meetings took place. Team members attended meetings of other teams to ensure effective handovers and information sharing took place.

We observed positive interactions and supportive practices between teams. There was good working links, including effective handovers, with other teams and professionals external to the organisation.

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

As of 31 December 2017, 56% of the workforce had received training in the Mental Health Act (called Mental Health Law training). The trust stated that this training was mandatory for all core services for inpatient and all community staff and was renewed every three years.

The training compliance reported during this inspection was higher than the 46% reported at the previous year and the 27% reported in the year before.

We reviewed 36 Mental Health Act records in relation to patients detained under section 136 of the Mental Health Act. There were gaps in 28 of the records, including blanks in relation to the name

of the person who had received the patient, risks and intoxication levels. In 31 of the records, patients had not seen an approved mental health professional. Fifteen of the records showed no evidence of patients having their rights explained to them. There was a long delay for six patients in having their rights explained to them. There was an example where the police had brought a patient from their home which requires the police to obtain a warrant under section 135 of the Mental Health Act. However; the police had used section 136 of the Mental Health Act which can only be used if the patient is removed from a public place not their home. This meant that the detention of the patient under section 136 was not lawfully applied.

Mental Health Act administrators we spoke with advised they had highlighted some of the errors within the paperwork however errors were still being made. Mental Health Act administrators were available for support in each of the boroughs with central oversight. Staff knew who these were and how to contact them.

Staff we spoke with had a good understanding of the Mental Health Act however they acknowledged they had not received specific training in relation to receiving papers and their role in relation to this.

Consent to treatment and capacity requirements were adhered to.

Patients had access to the independent mental health advocacy services and staff were clear on how to access and support engagement with the independent mental health advocates to capture the wider issues of referrals, capacity issues, etc. Information regarding the role of the independent mental health advocate was displayed within teams and waiting rooms.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training for this service was below the trust average. The training was incorporated into the Mental Health Law training. Therefore, the service attendance rates were 56% of the workforce completing the training as of 31 December 2017, compared with 65% for the trust.

Staff we spoke with understood the Mental Capacity Act and how this was relevant to their role. Examples were given where patients had the capacity to decide who they consented to share information about their treatment with. Staff were aware of the policy on the Mental Capacity Act which they could refer to.

The criteria for the home- based treatment team was that patients consented to engage with the team as an alternative to a hospital admission.

Staff knew where to get advice regarding the Mental Capacity Act within the trust and they knew of the resources available on the intranet.

One of the team managers was a best interest's assessor and they shared their knowledge via their additional training with their team and neighbouring teams.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We spoke with 22 patients and one carer.

During the home visits we observed, staff were responsive, caring and respectful to patients.

When staff spoke about patients, this was with compassion.

Patients told us that staff were supportive, encouraging and assisted their recovery. Patients felt that the teams involved them in their care and considered their feelings and wishes. However, two patients felt staff were rushed on their visits, it was a tick box exercise and they did not feel supported by the staff.

Feedback from patients who accessed the health based places of safety was positive. They felt that staff treated them well and explained why they were there. The patients felt that the suites were clean and comfortable.

Staff understood the individual needs of patients.

Involvement in care

Patients told us they were involved in care planning, were provided with a variety of information and the strategies suggested by staff were appropriate to their needs. The interventions from the teams were focused on encouragement to maintain independence.

Details regarding access to advocacy was displayed on notice boards within the waiting areas of teams.

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

There was mixed feedback from patients we spoke with regarding care plans. Of the 14 patients we asked if they were involved in their care and had a copy of the care plan, all said they felt involved in their care. Nine patients confirmed they had care plans and had received a copy. Two patients stated they had a care plan in place but did not have a copy.

Involvement of patients

Patients gave examples of staff from the home treatment teams linking them in to groups and services in the local area that would suit their needs.

Staff gave patients a survey at the point of discharge with a self -addressed envelope to provide feedback.

Involvement of families and carers

Patients explained that the teams involved family, friends and carers as per their wishes. Family members were reassured and supported by the teams. However, one patient felt it would have been beneficial to have family support available for their family members supporting them through a period of crisis.

Teams identified a carers champion who attended the triangle of care meetings and shared carer issues and updates with the wider team.

Is the service responsive?

Access and waiting times

No information was provided by the trust regarding the referral times to assessment and treatment for this core service.

The access teams had set a target for time from referral to triage/assessment and from assessment to treatment. The target was to contact patients by phone within four hours. They screened referrals by phone to determine if they required a face to face assessment. RAID teams had a target of seeing patients within an hour. Teams could see urgent referrals quickly and non-urgent referrals within two months at the Stockport Access team.

Patients were triaged by the access and crisis teams via a phone triage initially and then a face to face assessment if deemed clinically appropriate. Home based treatment teams could see new patients within a couple of days and allocations were made at daily handover meetings.

Home based treatment teams operated between the core hours of 9am to 9pm, seven days a week. The RAID teams operated 24 hours seven days a week. Access teams operated Monday to Friday. The access teams had appointments daily to access patients who were in crisis.

We observed the teams responding promptly and appropriately when patients phoned in.

Teams had information leaflets providing information to both patients and carers which included what to do in a crisis and local contact details for organisation that could offer support.

The teams took active steps to engage with patients who found it difficult or were reluctant to engage with mental health services. The home- based treatment teams supported patients at home, RAID teams saw patients in accident and emergency departments and on medical wards and access teams could provide home visits where needed.

Concerns regarding patient's engagement with the teams, and their treatment were discussed at daily handover meetings and within zoning meetings. Support could be increased and times of appointment changed to meet the needs of patients.

The facilities promote comfort, dignity and privacy

Within the hospitals and community teams we visited, there was a full range of rooms and equipment to support treatment and care. Interview rooms had adequate sound proofing.

Meeting the needs of all people who use the service

Buildings where patients were seen were accessible for patients requiring disabled access.

Information leaflets regarding the services, patient rights and self- help resources were only available in English. The boroughs that the trust served were culturally diverse with Bangladeshi, Pakistani and Polish speaking communities. The trust was not providing information that was accessible to all patients.

The trust had a contract with a translation service. Staff could book an interpreters or signer.

Staff had a good understanding of the cultural difference in relation to how mental health needs were viewed within certain cultures. Staff told us of examples where patient's families were not willing for them to go to a mental health unit or have a home visit, therefore staff arranged to meet patients in a community setting to ensure they could support individuals.

Staff supported an individual in Oldham who had a learning disability, difficulties with literacy and understating written information. Staff supported them to learn the public transport route to the location to ensure they could participate in community activities to reduce their isolation. This increased the patient's community participation.

Listening to and learning from concerns and complaints

This core service received 22 complaints between 1 May 2017 and 30 April 2018. None of these were fully upheld, five were partially upheld and 13 were not upheld. None were referred to the Ombudsman. Five were still under investigation.

Team name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Under investigation
RAID Adult - Stockport	3		1	2	
RAID Adult - T&G	3			3	
Access & Crisis Team - HMR	2				2
Access & Crisis Team - Stockport and Dept. Of Psychiatry SHH	2			2	
RAID Adult - Oldham	2			1	1
Access Team - Tameside	1		1		
RAID Adult - Stockport and Arden Ward	1				1
Sec 136 Suite - Bury	1		1		
RAID Adult - HMR and Thinking Ahead - HMR and Home Intensive Treatment - HMR	1			1	
RAID Adult - Stockport and Dept. Of Psychiatry SHH	1			1	
Access & Crisis Team - Stockport	1			1	
RAID Adult - T&G and Home Treatment Team - T&G and Outpatients Dept. - TGH	1				1
RAID Adult - Oldham and South Ward and Home	1		1		

Team name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Under investigation
Treatment Team - Oldham and Aspen Ward					
RAID Adult - HMR	1			1	
Access & Crisis Team - Oldham and Healthy Minds - Oldham	1			1	
Total	**22**	**0**	**5**	**13**	**5**

This core service received four compliments during the last 12 months from 1 May 2017 to 30 April 2018 which accounted for less than 1% of all compliments received by the trust as a whole.

Of the 22 patients that we spoke with, eight did not know how to complain about the service.

Staff understood how to handle complaints appropriately. Team meeting minutes confirmed staff received feedback on the outcome of investigations of complaints and teams acted on the findings.

Is the service well led?

Leadership

Staff told us team and service managers were supportive however; they were not always available.

Managers worked in the numbers providing clinical input. In Bury, one team manager managed two teams; the home- based treatment team and access and crisis team. The demands of these two teams were evident. Other boroughs had a manager for each team.

Managers reported the staffing pressures meant they spent time in the numbers which resulted in tasks such as staff supervision not being prioritised.

Sickness levels were 5.9%. The qualified nurses' vacancy level was 25% and the nursing assistant vacancy level was 13% as of end of March 2018. All teams except the Stockport home based treatment team had vacancies at the time of the inspection. Managers reported difficulties with recruitment. Bank staff were used however; we observed managers being included in the numbers and providing clinical interventions due to staffing challenges and the pressures of the service.

There were no bullying and harassment cases reported. Staff knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation.

Staff reported enjoying their roles and a number had worked for the trust for many years. However, staff morale was quite low due to the demands of the service, an increase in referrals,

the nature of the work, staff supporting patients in crisis and heightened distress and the vacancies within the teams.

There were two staff acting up to management positions. There were vacancies for team managers at Tameside home based treatment team and Rochdale access and crisis team. Acting managers were in post at Bury RAID and Rochdale home based treatment team. Acting managers reported the trust were supportive in their leadership development.

We observed and staff told us there was positive team working and mutual support within teams and between neighbouring teams.

Staff understood the duty of candour regulation. Staff were open and transparent and explained to patients when something went wrong. Records confirmed staff had phone calls and meetings with patients and family members regarding incidents and involved them in the investigation process.

Staff were involved in table top reviews regarding serious incidents. Staff gave feedback on services via regional events and directly to their managers.

Vision and strategy

Staff knew and agreed with the organisation's values.

Teams did not have individual objectives. The focus at the time of the inspection was the development of the core 24 service, a non- inpatient provision of care that is available to patients in distress 24 hours a day. The development of the additional service was allocated primarily to the home based treatment team managers. Staff roles were changing in relation to hours to support the new service, this caused staff to feel unsettled as their working hours and conditions would be changing.

Staff reported senior managers were not visible in the team.

Culture

Staff within the teams were experienced and motivated in their role, passionate about improving the mental wellbeing and coping strategies of patients to deal with distress and crisis. Staff felt supported by their managers.

During the reporting period there were no cases where staff were either suspended, placed under supervision or were moved to a different team.

Records confirmed managers were responding to poor performance appropriately.

Governance

The trust provided a document detailing their highest profile risks. Each of these had a current risk score of 15 or higher. The following related to this core service.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Trend of Risk Rating	Last review date

13/07/2017	1150/07-17	Lack of capacity within Trust wide Adult Community Mental Health Services	Static	31/08/2018
17/07/2017	1158/07-17	There is a risk of failure of the estate of PCs/laptops/tablets (end user device)	Static	05/07/2018
30/08/2016	1062/12-16	Not achieving / delivering CQC recommendations / targets	Static	30/06/2018

Systems were not effective in ensuring that staff were supervised and Mental Health Act requirements were followed in relation to the documentation, explaining rights to patients and ensuring they were assessed by an approved mental health professional. Learning from Regulation 28 reports and previous incidents noted by the Mental Health Act administrators was not acted upon or monitored. Not all incidents were reported, we saw an example of an approved mental health professional not having access to staff or the health based place of safety to assess a patient or access the suite and this was not recorded as an incident. Managers told us staff assisted with staffing the health based place of safety which left their teams short, these were not reported as incidents.

Team meetings took place, however the frequency varied. Agenda items included learning from incidents and complaints feedback.

There was no opportunity for managers to meet with their counterparts in other boroughs. Meetings had occurred in the past however; these were not being held at the time of inspection. Therefore, managers could not share challenges, learning and what worked well to improve consistency across the boroughs.

Managers had access to a computer database which measured the key performance indicators and other indicators to gauge the performance of the team. This included training levels, appraisals levels and sickness levels and provided a current view of the team's performance.

Staff mandatory training was 80% for this core service.

Management of risk, issues and performance

Managers had sufficient authority and administration support. They had the ability to submit items to the trust risk register.

Clinical meetings and effective governance and communication structures were in place within the team and borough service.

Information management

Electronic care records were being introduced to the service. The aim was to fully role this out by early 2019. The electronic incident reporting system was embedded and staff were confident using it. Paper records were locked away in offices and cupboards.

Mental Health Act administrators scanned the Mental Health Act documentation onto the electronic care record system.

Staff attended mandatory information governance training with 79% compliance.

Engagement

Patients completed the friends and family test questionnaires.

Staff gave patients a survey at the point of discharge with a self -addressed envelope to provide feedback.

Teams identified a carers champion who attended the triangle of care meetings and shared carer issues and updates with the wider team.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

This service was not involved in national quality improvement programmes.

Staff represented teams at suicide awareness conferences. The Stockport access team manager was a best interest assessor and attended events relevant to this aspect of their role. Learning was shared with the wider teams.

Teams had students on placement.

Trust-wide leadership

Facts and data about this trust

The service supports a population of 1.3 million people across Oldham, Bury, Heywood, Middleton, Rochdale, Tameside and Glossop, Stockport and Trafford. The trust provides both community and inpatients services. Services are provided across 234 locations within six boroughs in the Greater Manchester area. Overall, the trust provides 337 different services, 132 for mental health and 205 for community. There are 5525 staff employed to deliver the services commissioned from 13 different key commissioners.

The trust had 21 locations registered with the CQC (on 28 August 2018).

Registered location	Code	Local authority
Bealey Community Hospital	RT2C3	Bury
Bury Mental Health Services	RT201	Bury
Butler Green House	RT2C1	Oldham
Cambeck Close	RT2C4	Bury
HMP Buckley Hall	RT2W1	Rochdale
Heathfield House - Specialist Services Division	RT210	Stockport
Integrated Care Centre	RT2F3	Oldham
Moorgate Primary Care Centre	RT2D6	Bury
Nye Bevan House	RT2H7	Rochdale
Oldham Mental Health Services	RT203	Oldham
Phoenix Centre	RT2H8	Rochdale
Prestwich Walk In Centre	RT2V2	Bury
Radcliffe Primary Care Centre	RT2D8	Bury
Rhodes Place	RT242	Oldham
Rochdale Mental Health Services	RT204	Rochdale
Stansfield Place	RT243	Rochdale
Stockport Mental Health Services	RT205	Stockport
Tameside Mental Health Services	RT202	Tameside
The Meadows	RT2Y6	Stockport
Trust Headquarters	RT2HQ	Tameside
Whitehall Street Clinic	RT2X8	Rochdale

The trust had 512 inpatient beds across 32 wards, 22 of which were children's mental health beds. The trust also had 148 outpatient clinics a week, 94 community mental health clinics a week and 148 community physical health clinics a week.

Total number of inpatient beds	**512**
Total number of inpatient wards	32
Total number of day case beds	5
Total number of children's beds (MH setting)	22
Total number of children's beds (CHS setting)	0
Total number of outpatient clinics a week	148
Total number of community mental health clinics a week	94
Total number of community physical health clinics a week	148

Is this organisation well-led?

Leadership

The executive board had 0% black and minority ethnic (BME) members and 50% women.

The non-executive board had 12.5% BME members and 50% women.

	BME %	BME (Number)	Female %	Female (Number)
Executive	0%	0	50%	3
Non-executive	12.5%	1	50%	4
Total	**7%**	**1**	**50%**	**7**

The trust board had undergone and continued to undergo changes in its representation of directors. The leadership changes were recognised by the board and staff to be bringing about both the plans and means to improve the quality of services. However, at the time of inspection they were not fully embedded to allow a judgement to be made on their effectiveness.

The board of directors is a unitary board. The non-executive directors and executive directors make decisions as a single group and share the responsibility and liability. All directors, executive and non-executive, have clear responsibilities and are supported to provide constructive challenge during board discussions.

The board of directors has a framework of local accountability to members with a council of governors responsible for holding the non-executive directors, individually and collectively, responsible for the performance of this unitary board. In turn the governors are accountable to the members who elect or appoint them and must represent their interests and those of the public. Records we reviewed confirmed that the board met on nine occasions in 2017 and schedule 11 board meetings for 2018 with eight of those meetings held prior to the inspection. All board meetings took place at trust headquarters.

The trust board had the appropriate range of skills, knowledge and experience to perform its role. Executive directors hold responsibility for the day to day running of the trust whilst the non-executive directors brought external expertise to the organisation and provide advice and guidance to the senior management team. In interviews with members of the board they confirmed that they were engaged and worked together appropriately. There were designated responsibilities to the non-executives to take forward trust plans.

The chair of the trust was being provided with support in the role following a period of absence.

The trust had a lead for child and adolescent mental health, learning disability and autism.

The trust board and senior leadership team displayed integrity on an ongoing basis. The trust board was accountable for setting the strategic direction of the trust, monitoring performance against local and nationally set objectives, ensuring high standards of performance and promoting links between the service and the local community. Discussions with the leadership team demonstrated a level of awareness of the priorities and challenges facing the trust. The challenges to quality and sustainability were clearly understood by the leaders and articulated through the refreshed operational plan.

Fit and Proper Person checks were in place. The trust policy on pre-employment checks covered criminal record, financial background, identity, right to work, employment history, professional registration and qualification checks. We reviewed the personnel files of all directors on the board. In all the files we reviewed evidence was provided which showed that all relevant checks had been done. However, there was limited information on medical fitness in all but two personnel files.

When senior leadership vacancies arose the chair and chief executive reviewed capacity and capability needs.

The trust reviewed leadership capacity and capability on an ongoing basis. The board had 11 directors which included six non-executive and five executive directors in addition to the chief executive and chair. The executive directors included: Medical director, Executive Director of Finance and Deputy Chief Executive, Executive Director of Operations, Executive Director of Service Development and Delivery and Executive Director of Nursing, Healthcare Professionals and Quality Governance. The Board also has an Interim Director of Workforce this post has been recruited to and the additional director was to become an additional member of the board. A new executive director of finance had been appointed to replace the existing director who was leaving the role at the time of the inspection.

The trust leadership team had a comprehensive knowledge of current priorities and challenges and acted to address them. All board members spoken with described significant improvements in the collaborative working of the board and the support to undertake their individual roles in a constructive manner.

There was consistent involvement of both the non-executive directors and executive directors, they were aware of the key issues and challenges. Non-executive directors were comfortable to challenge the board and told us they felt they were listened to.

There was a programme of board visits to services and staff felt that leaders were visible and approachable. Findings from service visits were discussed at board meetings and issues identified were fed back to the board. Leaders across the trust had limited development opportunities available, including opportunities for staff below team manager level to effectively progress. There was a lack of training and ongoing support to ensure that managers maintained the correct skills to

undertake their job roles effectively. This had been recognised by the trust and plans were developed to address this.

Succession planning was in place throughout the trust.

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities. However, following a review from an external organisation it was recognised that the values and visions needed to be amended. Overall, the refreshed vision and values outlined “a happier and more hopeful life for each and every person within our communities”. With an objective, “To maximise people’s potential to live healthier and more rewarding lives and to create a fulfilling work environment for our employees”. The refreshed high-level values were; Kindness, Fairness, Integrity and Determination.

The strategy for achieving trust priorities and developing good quality, sustainable care in a place no longer matched the values and visons that the trust was intending to implement. The board had a five-year strategic plan covering the period 2016 -2021 in launched in March 2016. The strategic plan set out the vision, mission and strategic goals for the organisation together with the trusts strategy for its mental health and community services, and its strategy in each town. Following a well led review from an independent organisation the trust recognised there had been significant changes to the context that the organisation wished to operate under as a result they have refreshed their strategy.

This was a recent development and the board had worked to produce a published document entitled “Position Paper – Trust Strategy 2019-22: Maximising Potential”. This outlined the refreshed strategy. The paper set out the rationale for the refresh of the strategy, the process undertaken and the progress. The paper set out what was being proposed and work to be undertaken to finalise the strategy. As yet, this had not been implemented within the organisation.

There were arrangements for staff, patients, carers and external partners to have an opportunity to contribute to discussions about the strategy, especially as there were plans to change services going forward. The trust outlined how it intended to seek contribution and what actions it had taken so far. The trust had an annual operational plan which was signed off by the board. This plan was underpinned by suite of delivery indicators which were reviewed. Remedial actions to address any performance issues were presented to the board.

Staff were not yet fully aware of and understood the trust’s refreshed vision, values and strategy and how achievement of these applied to the work of their team. This was a recent development, consultation had taken place with staff but the strategy to ensure that the arrangements were fully reflected at divisional level had not been yet been implemented.

The trust had not yet embedded its refreshed vision, values and strategy in corporate information received by staff. The previous values remained the values in operation throughout the trust and on their website.

The Trust had endeavoured to align its strategy to local plans in the health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. The Trust has engaged with their commissioners regarding the strategy. The Trust has given notice that it will cease to provide Trafford Community Services, the contract for which expired in March 2018, but continues provision of services pending the identification of a new provider. All other significant block contracts were due to expire on 31 March 2019.

The trust was reviewing its planned services to take into account the needs of the local population.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans. This monitoring led to the strategy being refreshed in order that the trust could sustain the quality of care provided by its services.

The trust's refreshed strategy also included meeting the needs of patients with a mental health, learning disability, autism or dementia diagnosis. Which incorporated its current commitments for physical healthcare needs of patients within the community.

There was a strategy for achieving the priorities and developing good quality care. However, this was not yet embedded within the organisational practice and the impact on the sustainability of the trust was not yet clear.

The board assurance framework outlined the key risks to the trust and was reviewed at each board meeting. Senior staff were familiar with the risks and controls to mitigate these.

Culture

In the 2017 NHS Staff Survey the trust had better results than other similar trusts in nine key areas:

Key finding	Trust score	Similar trusts average
KF7. % able to contribute towards improvements at work	75%	73%
KF10. Support from immediate managers	3.93	3.89
KF15. % satisfied with the opportunities for flexible working patterns	64%	58%
KF16. % working extra hours	68%	71%
KF19. Org and mgmt. interest in and action on health and wellbeing	3.78	3.70
KF20. % experiencing discrimination at work in last 12 months	9%	11%

Key finding	Trust score	Similar trusts average
KF22. % experiencing physical violence from patients, relatives or the public in last 12 months	12%	14%
KF23. % experiencing physical violence from staff in last 12 months	1%	2%
KF28. % witnessing potentially harmful errors, near misses or incidents in last month	19%	23%

In the 2017 NHS Staff Survey: the trust had worse results than other similar trusts in five key areas

Key finding	Trust score	Similar trusts average
KF12. Quality of appraisals	3.02	3.10
KF17. % feeling unwell due to work related stress in last 12 months	42%	40%
KF18. % attending work in last 3 months despite feeling unwell because they felt pressure	54%	53%
KF24. % reporting most recent experience of violence	85%	88%
KF29. % reporting errors, near misses incidents witnessed in last month	91%	92%

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 89.2% and 93.7%, better than the England average for patients recommending it as a place to receive care for six of the six months in the period (December 2017 to May 2018). April 2018 saw the highest percentage of patients who would recommend the trust as a place to receive care with 93.7%.

	Trust wide responses				England averages	
	Total eligible	Total responses	% that would recommend	% that would not recommend	England average recommend	England average not recommend
May 2018	11415	480	91.5%	3.5%	88.9%	3.7%
April 2018	10709	252	93.7%	3.2%	88.7%	4.2%
March 2018	10792	386	93.3%	2.3%	89.0%	4.0%

	Trust wide responses				England averages	
	Total eligible	Total responses	% that would recommend	% that would not recommend	England average recommend	England average not recommend
February 2018	10513	299	93.0%	2.7%	88.7%	4.3%
January 2018	8173	250	89.2%	4.0%	88.5%	4.2%
December 2017	9821	204	91.0%	2.0%	88.0%	4.0%

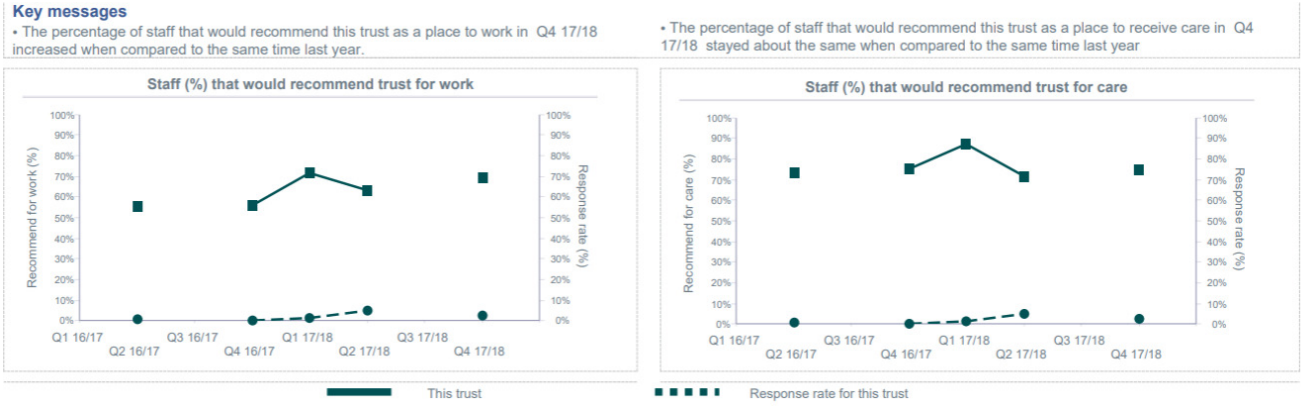
The Staff Friends and Family Test asks staff members whether they would recommend the trust as a place to receive care and as a place to work.

The trust showed a fluctuating trend over the last six quarters. Quarter one had the highest scores for staff recommending the trust as a place to receive care and work for 2017/2018. Response rates was among the lowest in this quarters and are therefore less likely represent the staff views overall.

There is no reliable data to enable comparison with other individual trusts or all trusts in England.

Definition

Substantive – All filled allocated and funded posts.



Establishment – All posts allocated and funded (e.g. substantive + vacancies). **Substantive staff figures**			**Trust target**
Total number of substantive staff	At 31 March 2018	4243.8	N/A
Total number of substantive staff leavers	1 April 2017 to 31 March 2018	662.3	N/A
Average WTE* leavers over 12 months (%)	1 April 2017 to 31 March 2018	16%	n/a
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31 March 2018	464.3	N/A
Total vacancies overall (%)	At 31 March 2018	11%	7.5%
Total permanent staff sickness overall (%)	Most recent month (At 30 April 2018)	4.5%	5%
	1 May 2017 to 30 April 2018	5.4%	5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31 March 2018	1703	N/A
Establishment levels nursing assistants (WTE*)	At 31 March 2018	932	N/A
Number of vacancies, qualified nurses (WTE*)	At 31 March 2018	230	N/A
Number of vacancies nursing assistants (WTE*)	At 31 March 2018	105	N/A
Qualified nurse vacancy rate	At 31 March 2018	14%	N/A
Nursing assistant vacancy rate	At 31 March 2018	11%	N/A
Bank and agency Use			
Hours bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 May 2017 to 30 April 2018	173,361	N/A
Hours filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 May 2017 to 30 April 2018	70,461	N/A
Hours NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 May 2017 to 30 April 2018	286,744	N/A
Hours filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017 to 30 April 2018	459,367	N/A
Hours filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 May 2017 to 30 April 2018	84,134	N/A
Hours NOT filled by bank staff where there is sickness, absence or vacancies (Nursing Assistants)	1 May 2017 to 30 April 2018	-332,234	N/A

*Whole-time Equivalent

As at 30 April 2018, the training compliance for trust wide services was 89% against the trust target of 95%. Of the training courses listed 20 failed to achieve the trust target and of those, one failed to score above 75%.

The trust achieved the highest completion rate for Infection Control Level 1 (96%) and the lowest completion rate for Mental Health Law (65%). Training data is reported internally on a rolling basis.

The training compliance reported for the trust during this inspection was the same as the 84% reported at the last inspection.

The trust's target rate for appraisal compliance is 85%. As at 31 May 2018, the overall appraisal rates for non-medical staff was 79%.

Five of the 20 teams (25%) achieved the trust's appraisal rate. The core services failing to achieve the trust's appraisal target include 'MH – Substance misuse with 34%, 'CHS-Urgent Care' with 50% and 'MH - Mental health crisis services and health-based places of safety with 60%. The rate of appraisal compliance for non-medical staff reported during this inspection is higher than the 80% reported at the last inspection.

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% of non-medical staff who have had an appraisal
CHS - Community Inpatients	99	94	95%
MH - Secure wards/Forensic inpatient	87	82	94%
CHS - End of life Care	28	26	93%
CHS - Children, Young People and Families	792	701	89%
MH - Child and adolescent mental health wards	73	64	88%
Other	408	349	86%
CHS - Adults Community	959	793	83%
MH - Wards for older people with mental health problems	205	159	78%
MH - Long stay/rehabilitation mental health wards for working age adults	167	127	76%
Other - ASC service	20	15	75%
CHS - Community Dental	114	85	75%
MH - Community-based mental health services for older people	266	198	74%
MH - Acute wards for adults of working age and psychiatric intensive care units	353	259	73%

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% of non-medical staff who have had an appraisal
MH - Community-based mental health services for adults of working age	707	501	71%
MH - Community mental health services for people with a learning disability or autism	98	68	69%
MH - Specialist community mental health services for children and young people	256	171	67%
MH - Other specialist services	28	18	64%
MH - Mental health crisis services and health-based places of safety	137	82	60%
CHS - Urgent Care	10	5	50%
MH - substance misuse	32	11	34%
Grand Total	**4,839**	**3,808**	**79%**

The trust's target rate for appraisal compliance is 85%. As at 31 May 2018, the overall appraisal rates for medical staff was 76%.

Four of the seven teams (57%) achieved the trust's appraisal rate. The core services failing to achieve the trust's appraisal target include 'CHS – Children, Young People and Families' with 70%, 'MH – Child and adolescent mental health wards' with 75%, and 'MH – Community-based mental health services for adults of working age' with 78%.

Core Service	Total number of permanent medical staff who have had an appraisal within the last 12 months	Total number of permanent medical staff who have not had an appraisal in the last 12 months	% appraisals
MH - Other specialist services	1	1	100%
MH - Specialist community mental health services for children and young people	15	15	100%
MH - Long stay/rehabilitation mental health wards for working age adults	12	11	92%
MH - Community-based mental health services for older people	22	19	86%

Core Service	Total number of permanent medical staff who have had an appraisal within the last 12 months	Total number of permanent medical staff who have not had an appraisal in the last 12 months	% appraisals
Other	10	8	80%
MH - Community-based mental health services for adults of working age	50	39	78%
MH - Child and adolescent mental health wards	4	3	75%
CHS - Children, Young People and Families	10	7	70%
Grand Total	**124**	**103**	**83%**

The trust was unable to provide information on the frequency of clinical supervision as there are varying positions across different services within the trust. Some services provide combined clinical and managerial supervision, others do separate sessions. Most of services offer 4-6 weekly clinical supervision, with some offering sessions monthly. As well as clinical supervision, some services also offer peer, informal and/or group supervision.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

	In Days	Current Performance
What is your internal target for responding to* complaints?	3	99% ((target is for 95% responded to within 3 working days after day of receipt)
What is your target for completing** a complaint?	n/a	This will be reported on in future reports once the complaints process has been amended to provide fixed timescales in accordance with well-led review (Currently no set targets. This was highlighted through the recent well-led review at the Trust and an action agreed that the testing of KPIs will be run in Quarter 2 2018/19)
If you have a different target for complex complaints please indicate what that is here	n/a	This will be reported on in future reports once the complaints process has been amended to provide fixed timescales in accordance with well-led review (Currently no set targets.

	In Days	Current Performance
		This was highlighted through the recent well-led review at the Trust and an action agreed that the testing of KPIs will be run in Quarter 2 2018/19)

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

	Total	Date range
Number of complaints resolved without formal process*** in the last 12 months	702	1 May 2017 to 30 April 2018
Number of complaints referred to the Ombudsman (PHSO) in the last 12 months	2	1 May 2017 to 30 April 2018

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example, PALS resolved or via mediation/meetings/other actions

This trust received 569 compliments during the last 12 months from 1 May 2017 to 30 April 2018. This was lower than the 750 reported at the last inspection. 'CHS – Adults Community' had the highest number of compliments with 31%, followed by 'MH – Child and adolescent mental health wards' with 15% and 'CHS – Children, Young People and Families' with 11%.

Staff did not consistently feel respected, supported and valued. Throughout the trust there were staff that did feel valued and supported but there were areas were staff reported that this was not their view. However, all staff felt that there had been a significant improvement in in the culture which was now more open, transparent and responsive to challenge.

Most staff felt positive and proud about working for the trust and their team.

The trust recognised staff success by staff awards and through feedback.

The trust worked appropriately with trade unions.

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. The Speak Up Guardian attended board meetings every three months to keep the board informed of themes within the organisation.

The handling of concerns raised by staff was not consistently met with best practice.

There was not a consistent view from staff that they could raise concerns without fear of retribution. Most staff raising concerns wished to remain anonymous. This was reported by the Speak Up Guardian at a board meeting as a matter of concern.

Staff knew how to use the whistle-blowing process. Staff did not consistently have awareness about role of the Speak Up Guardian. There were plans to increase the profile of the Speak Up Guardian and there had been an increase over the last 12 months in staff approaching for support.

The trust applied Duty of Candour. Records reviewed showed that the trust was open and transparent. However, there were occasions when the trust had not fully followed the best practice

of Duty of Candour in relation to a written apology. This had been due to a misinterpretation of the regulations and was address immediately.

The trust took appropriate learning and action because of concerns raised. However, lessons learnt and feedback to staff was not consistently put onto place across all services.

Not all staff had the opportunity to discuss their learning and career development needs at appraisal.

Staff had access to support for their own physical and emotional health needs through occupational health.

Board members, governors and senior management recognised that they had work to do to improve equality and diversity across the trust. The trust acknowledged the importance of supporting the development of black, minority ethnic staff. Feedback from the Workforce Race Equality Standard report 2018 prompted the trust to develop an action plan to support the inclusive development and engagement of black and minority ethnic staff group.

Data provided by the trust and reported on for Workforce Race Equality Standard (WRES) 2017-1018 showed that overall the BME staff representation has increased from 10% to 11% in 2017 to 2018, there were still areas where there was underrepresentation of BME staff in relation to the community served.

There were ongoing improvements with white staff being appointed from shortlisting as 1.34 higher. Compared to 2017 of 1.73 higher and 2016 of 3.06 higher. However, the data showed that white staff were more likely to be shortlisted than BME staff.

The 2018 figure for Pennine Care Trust as at July 2018 showed BME staff entered the formal disciplinary process 4.52 times greater than white staff. This has increased since 2017 were the figures were 2.55 times greater and 2016 of 1.31 times greater. This is a deterioration over the last three reporting periods.

The relative likelihood of white staff accessing non-mandatory training was 0.97 times greater. This was a changed from change from 2017 of 0.58 times greater and 2016 of 1.01 times greater. The improvements noted in 2017 had not been sustained in 2018.

For white staff in relation to harassment bullying and abuse from patients, relatives or the public, there was an improvement in the number of staff experiencing this. Data collected showed an improvement from the 2015/16 figure down from 27% to 24% in 2017/18. For BME staff, the trend had reversed with an increase from 23% in 2015/16 to 27% for 2017 and 2018.

Over the reporting periods 2015/16, data captured across both White and BME staff indicated similar experiences of harassment, bullying or abuse from staff. Whilst the figures for white staff remained at 18% for 2016 / 17, the figure for BME in 2016/17 had dropped down to the same level as their White counterparts (18%).The data 2017/18 for both groups have increased although this is minimal for white staff of 1% up to 19%). BME staff showed a statistically significant increase from 18% up to 31%, BME staff rates of bullying and harassment form colleagues had significantly increased and were significantly higher than incidents experienced by white staff.

White and BME groups believing that the organisation provides equal opportunities for career progression or promotion in 2015/16 and 2016/17 were on equal par in stating the Trust provided equal opportunities for career progression. However, both groups show a decrease in career progression in 2018. For BME group this was a significant change from previous year at 89% in 2017 to 66% in 2018.

The proportion of BME staff saying they have personally experienced discrimination at work from their manager, team leader, or colleague reduced from 12% in 2015/16 to 6% in 2016/17. For White staff the figures reported from 2017/18 have remained at the same level. However, across the three reporting periods there was a greater fluctuation for BME staff. BME figures were up from 6% in 2016/17 to 16% in 2017/18. BME staff experienced a statistically significant level of discrimination in 2018 and a deterioration in their experiences since 2017.

The trust had developed and action plan to address the identified areas from the WRES report this included close working with the Equality Working Group and the BME network to monitor ongoing data and any concerns. There were also actions that increased the awareness and training of management throughout the organisation. Additionally, there was an emphasis on receiving organisational support such as HR and the Speak Up Guardian.

A board meeting, we observed demonstrated that there was an understanding at board level of the need to recognise and improve the equality arrangements throughout the trust.

The Trust's People Strategy set out an intention 'to recruit, retain, reward, recognise and develop the right people, with the right skills, at the right time who are committed, motivated and engaged and are supported to deliver the vision. The trusts overall strategy included a recognition as a priority for 2017 – 2018 that they would ensure that the workforce was able to deliver safe and effective services. There was a commitment to refresh people strategic plan to be clear on outcomes and implementation priorities. An Independent consultant review of the workforce strategy outlined that the strategy was applicable. However, the strategy design needed to be clearer on priorities and measures. The strategy was in the process of being refreshed and redrafted, with a full implementation plan, to be established in by December 2018. Additionally, there was a further commitment to undertake cultural audit for 2018 – 2019 and incorporate the findings into the refreshed strategic plan.

Staff networks were in place promoting the diversity of staff. Staff reported that these were not as active as they had been and were not as widely supported.

Local teams had positive relationships, worked well together and addressed any conflict appropriately.

Governance

The trust provided its Board assurance framework. This detailed any risk scoring 15 or higher and gaps in the risk controls that affect strategic ambitions. The trust outlined five strategic ambitions:

1 - Drive and sustain quality improvement and innovation.

2 - Deliver the Trust's Health Informatics Strategy.

3 - Ensure financial sustainability of the Trust: addressing immediate pressure in 2017/18 and 2018/19 and reviewing the sustainability of the business model in 2019/20.

4 - Ensure that the Trust has the workforce required to deliver safe and effective services; addressing current and predicted gaps in numbers and skills by focussing on development, attraction and retention of a flexible and skilled workforce.

5 - Cement role as trusted partner in the delivery of place based care, providing leadership into each locality.

The trust provided a document detailing its highest profile risks. Each of these had a current risk score of 15 or more

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Description	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
Failure to deliver a quality service offer	15	10	1	19 March 2018
Failure to deliver the Trust's Health Informatics Strategy	20	15	2	19 March 2018
Failure to ensure financial sustainability of the Trust and address immediate pressure in 2017/18 and 2018/19, would lead to failure to be able to deliver a sustainable business model by 2019/20	25	16	3	19 March 2018
Failure to ensure that the Trust has the workforce required to deliver safe and effective services, addressing current and predicted gaps in numbers and skills by focussing on development, attraction and retention of a flexible and skilled workforce	20	15	4	19 March 2018
Failure to Enhance and develop our role as a system leader and trusted partner in the delivery of place-based care, providing leadership into each locality will impact on our ability to sustain the Trust's current business model	15	10	5	19 March 2018

The trust has provided a document detailing their highest profile risk:

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Risk score (current)	Last review date
14/08/2017	1189/08-17	Consultant vacancies		20/06/2018
14/02/2018	1222/02-18	Ward staffing on adult acute inpatient services – qualified nurse practitioners		13/07/2018
13/07/2017	1150/07-18	Lack of capacity within trust wide Adult Community Mental Health Services		31/08/2018
14/02/2017	1103/02-17	Lack of formal physical health monitoring for patients newly prescribed antipsychotic medication		20/06/2018
	1226/03-18	Utilisation of Paris and paper records across the community and physical health pathway		20/06/2018
17/07/2017	1558/07-17	There is a risk of failure of the estate of PCs/ laptop/ tablets (end user device)		05/07/2018
03/07/2017	1147/07-17	Manual locking systems on bedroom doors on inpatient wards		20/06/2018
27/04/2017	1121/04-17	EIT Delivering a NICE compliant service and achieving access and waiting time targets		30/06/2018
30/08/2016	1062/12-16	Not achieving / delivering CQC recommendations / targets		30/06/2018

Pennine Care NHS Foundation Trust has submitted details of 22 external reviews commenced or published in the last 12 months [1 May 2017 to 30 April 2018]:

CQC core service	Ref number	Team / Ward unit	Recommendation	Actions taken	Outstanding actions
CHS - Children, Young People and Families	A18	Bury – Health Visiting	New SCR so no recommendations as only scoping completed.	Early findings – training for staff to ensure they consider all children within the family when siblings are living at different addresses.	Review only just commissioned, currently ongoing
MH - Community-based mental health services for adults of working age	DHR-AC	Oldham - CMHT	Appropriate information at MARAC. Agencies to apply DA guidance equally to men and women. Training in relation to DA, substance misuse and mental health. All agencies to comply with the Care Act 2014 requirement in relation to DA.	Review of multiagency training to incorporate inter-dependent relationships where violence embedded. Review of PCFT Adult Level 3 safeguarding training and Domestic Abuse training to incorporate recommendations. 7-minute briefing to be shared across services and agencies.	7-minute briefing
CHS - Adults Community	DHR-FCS	Oldham – district nursing	7-minute briefing in relation to low mood with no explanation of cause.	7-minute briefing cascaded out to all teams.	None
MH - Community-based mental health services for adults of working age	DHR-DR	Oldham – Access Team	DHR only just commenced so no recommendations as findings not yet completed.	Findings not yet completed	Review currently ongoing
MH - Community-based mental health services for adults of working age	SAR-SG	Oldham – Criminal Justice Team and CMHT	DHR only just commenced so no recommendations as findings not yet completed.	Findings not yet completed	Review currently ongoing
MH - Community-based mental health services	DHR-SA	Stockport – CMHT Not seen by PCFT for over 12 years	PCFT submitted an IMR as patient had been known to PCFT 12 years previous to incident. No	N/A	N/A

CQC core service	Ref number	Team / Ward unit	Recommendation	Actions taken	Outstanding actions
for adults of working age			recommendations for PCFT due to historical input only.		
MH - Mental health crisis services and health-based places of safety	SAR-KW	Stockport – RAID team Patient not on PCFT caseload at time of incident	Early findings: Identification of self-neglect Information sharing between agencies Staff understanding of the Looked After Children Process	Review ongoing Multi-agency learning event 7-minute briefing to share across PCFT	Review currently ongoing
Unknown	SCR-KG	Not known to PCFT but linked to SAR-KW as this was KG mother	Early findings: Role of the father Role of the grandmother Looked after children processes	Review ongoing	Review currently ongoing
MH - Community-based mental health services for adults of working age	SAR-SH	Stockport - CMHT	Early findings: Multi-agency staff ability to recognise self-neglect Capacity vs unwise choices Nutrition not monitored by care	Review ongoing	Review currently ongoing
MH - Community-based mental health services for adults of working age	DHR-ME	Stockport - CMHT	Historical input from PCFT – not early finding as process just started.	Review ongoing	Review currently ongoing
CHS - Children, Young People and Families	Child E	HMR – health visiting	SOP for non-engagement with Early Help Assessments. Early Help Assessment tool to be implemented within universal services. Record Keeping. Training. Caseload supervision. Review of level 3 Child Safeguarding.	All recommendations currently being implemented via single agency action plan. SCR not yet published.	None
CHS - Children, Young People and Families	Child M	HMR – health visiting and school health	Professional curiosity. Hidden male. Safeguarding supervision model review. Early Help	All recommendations currently being implemented via single agency action plan. SCR not yet published.	None

CQC core service	Ref number	Team / Ward unit	Recommendation	Actions taken	Outstanding actions
			Assessments and training.		
MH - Specialist community mental health services for children and young people	Child L	HMR – Healthy Young Minds (CAMHS)	Safeguarding supervision – strengthen. Robust processes to ensure long standing agency staff receive safeguarding supervision and training. Escalation processes for front line staff. Information sharing across agencies. Safeguarding escalation policy to be reviewed against findings.	Multi-agency learning event. 7-minute briefing to share across PCFT. All recommendation currently being implemented and monitored via the SCB.	None
MH - Community-based mental health services for adults of working age and CHS - Children, Young People and Families	Child Z	HMR – CMHT and Health visiting	Impact of parental mental health on children. Mother's mental health not fully understood by health visiting. Communication between mental health and health visiting. Interpreters not used by PCFT staff. No clarity between roles and responsibilities within the CP process within PCFT. Conflicting views in relation to health diagnosis. Supervision. No medical oversight. Escalation processes.	All recommendations currently being implemented via single agency action plan. SCR not yet published.	None
MH - Community-based mental health services for adults of working age	DHR - NW	HMR – CMHT and EIT	To ensure robust assessments of domestic situations within patient profile. To consider current training needs. Establish closer links with EIT and CMHT services.	All recommendations currently being implemented via single agency action plan. SCR not yet published.	None

CQC core service	Ref number	Team / Ward unit	Recommendation	Actions taken	Outstanding actions
			Review of Trust Policies.		
Unknown	RB	Unknown	Murdered by her son in law. This case has only been to 1st Panel concerns around Honour Based Abuse. Child of victim known to School Health team but not open at the time of homicide. Daughter of victim (wife of perpetrator) seen once by mental health services and information still being gathered in relation to this contact.		
CHS - Children, Young People and Families	EM	HMR – health visiting	It was not clearly documented within the health records regarding whether routine enquiry of domestic abuse took place at core contacts No action recommended for this as record keeping procedure have already changed since these contacts took place	N/A	N/A
CHS - Children, Young People and Families	Child X1 and X2	HMR – health visiting	Health assessments need to be more indicative of ongoing neglect. Escalation policy not utilised. Delay in referral to paediatricians. Family moved frequently – historical information to taken into account. Early Help Assessment and training.	All recommendations currently being implemented via single agency action plan. SCR not yet published.	
CHS - Children, Young People and Families	MSCB S1	Trafford – school health	Manchester child but SCR being supported by Trafford. No recommendation/early findings as process	Findings not yet completed	Review currently ongoing

CQC core service	Ref number	Team / Ward unit	Recommendation	Actions taken	Outstanding actions
			currently delayed due to criminal proceedings.		
CHS - Children, Young People and Families	Child N	Trafford – health visiting	Review internal policies and procedures in relation to violence and aggression.	All recommendations implemented and monitored via the SCB.	
MH - Community-based mental health services for adults of working age	Child N	Oldham - Psychological therapies	Case currently being screened so no recommendations or early findings.	Findings not yet completed	Review currently ongoing
CHS - Adults Community	Mrs Green	Trafford – tissue viability team and podiatry	Review of care plans due to change of medical circumstances. Awareness of national protocol on pressure ulcers and interface with safeguarding. Workforce development in relation to raising safeguarding alerts and referrals in nursing and care homes.	All recommendations currently being implemented via single agency action plan. SAR not yet completed.	Review currently ongoing

The trust had structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures. However, several of these were newly implemented and not yet fully embedded within the trusts processes. There was an acknowledgement throughout all conversations at different levels in the trust that there was a needed to provide support and training to managers at differing levels that was not yet developed or adopted.

The trusts Board Assurance Framework (BAF) had been updated in September 2018. Two of the six high risk areas had improved with a lower risk and significant assurance noted. However, four areas remained high risk with limited assurance available. No new risk had been identified and previous risks whilst under review had not received sufficient assurance to remove as a risk.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. These were readily available on the trusts website for public review for public meetings.

Non-executive and executive directors were clear about their areas of responsibility.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to act as needed. However, there was no cross-location learning in place as a result, inconsistencies in practice, quality and implementation of processes were occurring. The trust had appointed quality managers to work in a more collaborative way in order that shared learning could be more readily accessed and implemented.

There was inconsistency in staff at all levels of the organisation understanding their roles and responsibilities and what to escalate to a more senior person. Staff were unclear as in some areas feedback from issues escalated was not made available to staff.

The trust was working with third party providers effectively to promote good patient care.

The trust provided a mental health liaison service. However, it was not a member of the Psychiatric Liaison Accreditation Network (PLAN).

The governance framework addressed the need to meet patients' physical health care needs. However, there were inconsistencies with the trust as to how physical health needs were recognised and appropriate support made available. We saw an area of outstanding practice within Adults of working age wards. This practice was not replicated in other areas of the trust and was a practice in one locality.

Management of risk, issues and performance

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of identifying an incident.

Between 1 May 2017 and 30 April 2018, the trust reported 179 STEIS incidents. The most common type of incident was 'apparent / actual / suspected self-inflicted harm' with 66 (37%). Thirty-two of these incidents occurred in MH – Community-based mental health services for adults of working age.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Pennine Care NHS Foundation Trust reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the same period on their incident reporting system. The number of the most severe incidents was not comparable with the number the trust reported to STEIS. The trust reported 171 serious incidents, compared to 179 on the STEIS reporting system, using the same period. The trust stated this was either due to some incidents being declassified on STEIS or due to a difference in the recoded reported date between the two systems. From the trust's serious incident information, five of the seven unexpected deaths were instances of 'apparent / actual / suspected self-inflicted harm' and two of these occurred in MH – Acute wards for adults of working age and psychiatric intensive care units.

Type of incident reported on STEIS	CHS - Adults Community	MH - Community-based mental health services for adults of working age	MH - Mental health crisis services and health-based places of safety	MH - Acute wards for adults of working age and psychiatric intensive care	MH - Wards for older people with mental health problem	CHS - Children, Young People and Families	MH - Community-based mental health services for older people	MH - Specialist community mental health services for children and young	CHS - Community Inpatients	MH - Child and adolescent mental health wards	MH - Secure wards/Forensic inpatient	MH - Long stay/rehabilitation mental health wards for working age adults	Other	MH - substance misuse	Total
Apparent/actual/suspected self-inflicted harm meeting SI criteria	2	27	14	6	2	1	7	4			2	1			66
Pressure ulcer meeting SI criteria	50								1						51
Confidential information leak/information governance breach meeting SI criteria	3	2				4		1					2		12
Sub-optimal care of the deteriorating patient meeting SI criteria	6								1						7
Slips/trips/falls meeting SI criteria					5				2						7
Abuse/alleged abuse of child patient by third party		2				4									6
Apparent/actual/suspected homicide meeting SI criteria		2	1	1										1	5

Type of incident reported on STEIS	CHS - Adults Community	MH - Community-based mental health services for adults of working age	MH - Mental health crisis services and health-based places of safety	MH - Acute wards for adults of working age and psychiatric intensive care	MH - Wards for older people with mental health problem	CHS - Children, Young People and Families	MH - Community-based mental health services for older people	MH - Specialist community mental health services for children and young	CHS - Community Inpatients	MH - Child and adolescent mental health wards	MH - Secure wards/Forensic inpatient	MH - Long stay/rehabilitation mental health wards for working age adults	Other	MH - substance misuse	Total
Abuse/alleged abuse of adult patient by staff	2	1		1											4
Abuse/alleged abuse of adult patient by third party	1			2	1										4
HCAI/Infection control incident meeting SI criteria				1	3										4
Disruptive/ aggressive/ violent behaviour meeting SI criteria				1	1							1			3
Failure to obtain appropriate bed for child who needed it										3					3
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria				1											1
Commissioning incident meeting SI criteria							1								1

Type of incident reported on STEIS	CHS - Adults Community	MH - Community-based mental health services for adults of working age	MH - Mental health crisis services and health-based places of safety	MH - Acute wards for adults of working age and psychiatric intensive care	MH - Wards for older people with mental health problem	CHS - Children, Young People and Families	MH - Community-based mental health services for older people	MH - Specialist community mental health services for children and young	CHS - Community Inpatients	MH - Child and adolescent mental health wards	MH - Secure wards/Forensic inpatient	MH - Long stay/rehabilitation mental health wards for working age adults	Other	MH - substance misuse	Total
Environmental incident meeting SI criteria				1											1
Operation/treatment given without valid consent						1									1
Pending review (a category must be selected before incident is closed)						1									1
Substance misuse whilst inpatient meeting SI criteria											1				1
Treatment delay meeting SI criteria					1										1
Total	64	34	15	14	13	11	8	5	4	3	3	2	2	1	179

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. They do not report staff incidents, health and safety incidents or security incidents to NRLS.

The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 May 2017 to 30 April 2018 were 'Patient accident', 'Self-harming behaviour' and 'Disruptive, aggressive behaviour'. These three categories accounted for 4132 of the 6933 incidents reported. Self-harming behaviour accounted for 46 of the 97 deaths reported (50 were classified as 'other').

Ninety-two percent of the total incidents reported were classed as no harm (61%) or low harm (31%).

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Patient accident	1056	595	194	0	0	**1845**
Self-harming behaviour	668	707	131	0	46	**1552**
Disruptive, aggressive behaviour (includes patient-to-patient)	539	184	11	1	0	**735**
Other	293	207	66	1	50	**617**
Access, admission, transfer, discharge (including missing patient)	525	40	12	1	0	**578**
Medication	500	33	5	0	0	**538**
Implementation of care and ongoing monitoring / review	1	315	19	0	0	**335**
Treatment, procedure	143	50	14	0	1	**208**
Documentation (including electronic & paper records, identification and drug charts)	187	2	0	0	0	**189**
Patient abuse (by staff / third party)	123	27	4	0	0	**154**
Consent, communication, confidentiality	130	4	0	0	0	**134**

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Infrastructure (including staffing, facilities, environment)	19	1	0	0	0	**20**
Medical device / equipment	13	1	0	0	0	**14**
Infection Control Incident	5	9	0	0	0	**14**
Total	**4202**	**2175**	**456**	**3**	**97**	**6933**

Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

Pennine Care NHS Foundation Trust reported fewer incidents from April 2017 to September 2017 compared with the previous 12 months.

Level of harm	April 2016 to September 2016	April 2017 to September 2017 (most recent)
No harm	2,711	2,155
Low	1,279	1,169
Moderate	353	206
Severe	0	2
Death	35	22
Total incidents	4,378	3,554

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems. The patient safety lead was proactive in their approach and enthusiasm, in assuring that patient safety was identified with lessons learnt. However, lessons learnt and feedback to staff from incidents varied throughout the trust as such there was an inconsistency in the recognition of appropriate incident reporting and how lessons learnt could be utilised to improve the quality of the service provided.

Leaders were not satisfied that clinical and internal audits were sufficient to provide assurance. The Trusts BAF reflected where limited assurance was identified and highlighted that safety risks and quality of service if this persisted. The board had recognised areas where they were unable to

gain suitable assurance and as a result they had undertaken to devise and deliver a new strategy for the delivery of the service. This included concentrating on mental health and reviewing the trusts ability to deliver a cost effective high quality community physical health needs service. The board had recognised the potential risks this may have in relation to the trusts sustainability.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance.

Staff concerns did not consistently match those on the local risk register. The trusts risk register identified and took account of local identified risks.

Staff had access to the risk register either at a team or division level and could effectively escalate concerns as needed.

The trust board had sight of the most significant risks and mitigating actions were included.

There were plans in place for emergencies and other unexpected or expected events. For example, adverse weather, a flu outbreak or a disruption to business continuity.

Where cost improvements were taking place, there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability.

Where cost improvements were taking place, the board had plans in place to mitigate risks to patient care.

Information Management

There was a holistic understanding of performance across all sectors.

The board received information on service quality and sustainability. This information was utilised to identify and amend the strategic approach from the trust.

The trust was aware of its performance using key performance indicators and other metrics. This data fed into a board assurance framework.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.

The board and senior staff expressed some confidence in the quality of the data and welcomed challenge. There was an electronic system for patient records in the community known as PARIS. This provided a level of scrutiny and reassurance to the board as to outcomes for community patients. However, inpatients records were not electronic and the same level of reassurance was not available for the board. There were ongoing plans to implement an electronic system but these had no definite date or implementation structure.

Information was in an accessible format, timely, accurate and identified areas for improvement.

IT systems and telephones were working well and they helped to improve the quality of care.

Leaders submitted notifications to external bodies as required.

Information governance systems were in place including confidentiality of patient records.

The trust learned from data security breaches. The trusts risk register including planning and understanding of the risks from Cyber-attacks.

Staff had access to the IT equipment and systems needed to do their work. However. Patients records were not in electronic form this had increased the risks in staff identifying patients with an ongoing history or special needs.

Engagement

The ward/service team and division had access to feedback from patients, carers and staff and were using this to make improvements.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Friends and Family test results were published on the trust website monthly, the trust consistently scored 95% as an average for recommendations as to the care patients received. However, responses from patients persistently remained below 10% of patients receiving care from the trust.

The trust did not have a structured and systematic approach to engage with patients and staff in a range of equality to them and their representatives. There was no clear overarching strategy in place that would support ingoing and clear engagement. There was limited information regarding local communities' stakeholders and no structure programme as to how to engage with hard to reach groups.

The trust offered public Governors (in foundation trusts), training on appointment. They were actively involved in the operation of the trust. The governors were actively involved in monitoring the performance of the board, However, it was acknowledged by the governors that their equality and diversity did not reflect the local community. They were reviewing arrangements as to how the governors could better reflect the communities that the trust served.

Staff were consulted regarding about changes to the trust services. The trust was undergoing a significant strategic change, information regarding this and changes to the value and culture had been communicated to staff. This included but not limited to; cascade via management, Chief Executive blogs, intranet newsletters and the trust website,

Patients, staff and carers were supported to meet with members of the trust's leadership team and governors to give feedback. Each board meeting started with a patient care case study to maintain patients experience at the heart of the boards' actions.

Division leaders/middle managers, on behalf of front line staff, engaged with external stakeholders such as commissioners and Healthwatch.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans.

External stakeholders said they received open and transparent feedback on performance from the trust.

Learning, continuous improvement and innovation

Finances overview[1] (Remove before publication)

	Historical data		Projections	
Financial Metrics	Previous financial year (2 years ago)	Last financial year (1 April 2017 to 31 March 2018)	This financial year	Next financial year (1 April 2019 to 31 March 2020)
Income	£273,633	£267,507	£267,857	£241,900
Surplus	£5,180	-£2,209	-£6,369	-£9,000
Full costs	-£268,453	-£269,716	-£274,226	-£250,900
Budget	£2,295	-£6,600	-£6,369	-£9,000

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.

The table below shows services across the trust awarded an accreditation (trust-wide only) and the relevant dates.

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
Improving Quality in Physiological Services Accreditation Scheme (IQIPS)	CHS – Adults Community	Audiology Bury, Oldham and Heywood, Middleton and Rochdale.	Achieved an accreditation of good. Re-accreditation is taking place May-July 2018. Evidence submitted week of 21/5/18
ECT Accreditation Scheme (ECTAS)		Oldham	
Accreditation for Psychological Therapies Services (APPTS)			Aim for existing therapy staff will be involved in peer review schemes to enhance care delivery.
Accreditation level 3 award in measurement of body symmetry	CHS - Children, Young People and Families	Paediatric physiotherapy	2017
UNICEF Baby Friendly Reaccreditation	CHS - Children, Young People and Families	Family Nurse Partnership	1/10/2017

[1] Universal PIR finances

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
Health Visiting Infant Feeding Unicef Accreditation		Health visiting and School nursing	Achieved in 2015 and reaccreditation achieved in July 2017

The trust actively sought to participate in national improvement and innovation projects.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented.

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning.

The trust was actively participating in clinical research studies.

There were inconsistent organisational systems to support improvement and innovation work.

Staff had inconsistent training in improvement methodologies and used standard tools and methods.

Effective systems were in place to identify and learn from unanticipated deaths. However, these arrangements were not consistently supported throughout the trust, lessons learnt were not consistently feedback to staff throughout the trust. Some managerial, nursing and medical staff spoken with were unaware of the arrangements for reviewing deaths and lessons learnt. Meetings reviewing deaths did not fully explore themes in order t0 take forward lessons learnt.

. Individual staff and teams received awards for improvements made and shared learning.

Staff were aware of their contribution to cost improvement objectives.