Good

Dudley and Walsall Mental Health Partnership NHS Trust

Mental health crisis services and health-based places of safety

Quality Report

Trust Headquarters
Trafalgar House,
47 – 49 King Street,
Dudley,
West Midlands,
DY2 8PS
Tel: 0300 5550262
Website:
www.dwmh.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RYK10	Dorothy Pattison Hospital	Mental health crisis service and health based place of safety	WS2 9XH
RYK34	Bushey Fields Hospital	Mental health crisis service and health based place of safety	DY1 2LZ

This report describes our judgement of the quality of care provided within this core service by Dudley and Walsall Mental Health Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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

Where applicable, we have reported on each core service provided by Dudley and Walsall Mental Health Partnership NHS Trust and these are brought together to inform our overall judgement of Dudley and Walsall Mental Health Partnership NHS Trust.

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated mental health crisis services and health based places of safety as good overall because:

- During this most recent inspection, we found that the services had addressed most of the issues that had caused us to rate mental health crisis and health-based places of safety as requires improvement following the February 2016 inspection.
- Secure, lockable rucksacks were now in use in the crisis teams, which meant staff could safely transport medication to patients' homes. The teams were monitoring and recording when controlled medications were dispensed to patients, which meant staff were now following the trust policy.
- Managers had made a number of changes to the procedures that staff should follow when responding to crisis calls. Staff responded to calls in a more timely manner and effective systems were in place to monitor calls received and the response time. This had ensured that there was a consistent approach to staff response to crisis calls across the services.
- Staff were receiving supervision more regularly and the trust had implemented a standard form, which ensured there was consistent approach to supervision for all staff across the trust and had systems in place to monitor compliance.

However:

- Despite the joint agency paperwork used in the health-based places of safety being updated, the majority of records we reviewed were incomplete or missing. This meant the trust could not monitor how long a person had been in the place of safety and whether they received their rights under the Mental Health Act.
- There was a lack of effective audits or processes in place to monitor the quality of the recorded information in the health-based places of safety.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Despite having vacancies, both teams utilised current staff and agency nurses effectively to provide a safe and efficient service that met the needs of their patients with minimum disruption.
- Staff used lockable bags to transport medication to patient's homes safely, and recorded use of controlled medicines given to patients in the community. This was in line with their trust policies and procedures.
- Staff in the crisis team always undertook a thorough risk assessment of each patient, and discussed patients' risks at each handover, planning care and treatment accordingly.
- The places of safety appeared clean and were appropriately furnished.
- There were robust systems in place for reporting and recording incidents, and any lessons learnt were cascaded to staff in team meetings
- There were effective lone working protocols in place that staff followed. All staff had access to mobile phones.

However:

Risk management plans contained basic information and lacked sufficient detail.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- The majority of records within the health-based places of safety were incomplete or missing. This meant the trust could not monitor how long a person had been in the place of safety and whether they had received their rights.
- Patients under the care of the crisis teams did not have access to a psychologist to offer national institute of clinical excellence (NICE) recommended therapies.
- There were no effective audits or processes in place to monitor the quality of the recorded information in the places of safety. The multi-agency operational policy remained out of date. This did not meet the guidance in the Mental Health Act Code of Practice. This was a West Midlands wide policy and not the direct responsibility of the provider inspected.

However:

- Joint agency paperwork for use in the places of safety had been updated to incorporate amendments to the Code of Practice.

Summary of findings

- Staff in the crisis teams completed holistic, recovery focused assessments that aided their knowledge of their patients.
- Managers and staff in the crisis teams regularly completed care plan audits to improve the quality of documentation and encourage and promote consistency of patient involvement in their care.
- Improvements had been made to the supervision procedures and the crisis teams had developed supplementary methods for staff such as group and peer supervision.
- There was good communication between all members of the multidisciplinary team and colleagues in the wider trust, which ensured staff, gave consistent care and treatment to their patients.

Are services caring?

Good

We rated caring as good because:

- Staff were kind, caring and respectful. Patients felt included in their care and the majority had received care plans.
- Carers felt listened to and staff sought their views. They were provided with relevant information so they felt involved in the planning of care.
- Staff encouraged feedback and the trust would collate responses received and provide staff with comments made.

However:

- Staff did not routinely record if patients had received or signed a copy of their care plan within the electronic patient record. This meant the trust could not monitor whether patients had been involved in their care.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The trust had made improvements to processes that staff followed when responding to crisis calls.
- Staff responded to all referrals to the crisis team quickly and triaged them appropriately and discussion occurred regularly in the multi-disciplinary team.
- Staff in the crisis team were flexible and proactive when arranging patient visits and patients had choice about when and where visits took place.
- Arrangement of assessments' in the places of safety happened quickly so patients' did not have to wait.

However:

Summary of findings

- There was no lock on the toilet door in the place of safety at Dorothy Pattison. This could compromise patients' privacy and dignity.

Are services well-led?

Good

We rated well-led as good because:

- Staff were familiar with the vision and values of the trust and they told us that these values related well to the team's objectives.
- Staff received adequate supervision and training to provide a good service to their patients.
- Staff at all levels regularly carried out audits. Outcomes were monitored and shared with staff in a meaningful way. This helped staff identify where improvements were needed to develop their skills.
- Incident reporting systems were in place and staff knew how to report incidents. Staff received information from incidents to help improve their practice.
- The crisis teams used key performance indicators to monitor their effectiveness, which they were meeting.
- Staff morale was good and all members of the multi-disciplinary team supported each other and worked well together.

Summary of findings

Information about the service

The mental health crisis service at Bushey Fields in Dudley was based in the Henry Lautch centre.

The service provided support, care and treatment to people from the age of 14 years old that were suffering from an acute mental disorder or were in a mental health crisis. The service provided rapid access to assessments and would remain involved until the needs identified had been resolved or care transferred to a more appropriate setting or service.

The Walsall mental health crisis service operated in the same way and was based at Dorothy Pattison hospital in Walsall, serving a population of 255,900. The region was one of the most deprived areas in England. The team supported people from the age of 16 years upwards.

Both sites operated a place of safety that was only staffed when in use.

People arrived there via the street triage service or the police and were detained under section 136 of the Mental Health Act as they had been deemed to require an assessment from mental health services.

Our inspection team

This unannounced, focused inspection of Dudley and Walsall Mental Health Partnership NHS trust was led by:

Head of inspection: James Mullins, Head of Hospital inspections, CQC

Team Leader: Kathryn Mason, Inspection Manager, CQC

The team that inspected this core service comprised two inspectors and one nurse specialist advisor.

Why we carried out this inspection

We undertook this un-announced inspection to find out whether Dudley and Walsall Mental Health Partnership NHS Trust had made improvements to their mental health crisis services and health-based places of safety since our last comprehensive inspection of the trust in February 2016.

When we last inspected the trust in February 2016, we rated mental health crisis services and health-based places of safety as **requires improvement** overall. We rated the core service as requires improvement for safe and effective and good for caring, responsive and well-led.

Following the February 2016 inspection, we told the trust it must take the following actions to improve mental health crisis services and health-based places of safety:

- The provider must ensure that regular supervision is taking place for all staff.
- The provider must ensure that all medication transported from the premises is in lockable bags or containers.
- The provider must ensure that all controlled drugs dispensed by the trust for patient use in the home are recorded in a controlled drug register.
- These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014; Regulation 18 Staffing and Regulation 12 Safe care and treatment

Summary of findings

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- spoke with the managers of both crisis teams
- spoke with eight patients who were using the service
- spoke with three carers
- spoke with 11 other staff members; including doctors, nurses, occupational therapist and social workers
- attended and observed two hand-over meetings
- attended and observed one assessment and one home visit
- looked at the environment at the health-based place of safety
- looked at 10 medicines charts of patients in the crisis team
- looked at 15 patient records within the crisis service and 15 within the places of safety.
- carried out a specific check of the medication management on both teams
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Both patients' and carers' were positive and complimentary about the crisis service they received. Patients' we spoke with said they felt involved in their care and the majority received their care plan. They said staff treated them with respect and offered practical and emotional support. Carers' felt listened to, included and well informed.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that effective processes are in place to monitor the quality of recorded information for all patients' assessed in the health-based places of safety. Staff were not recording consistently that they had given information to patients' about their rights when they commenced on section 136 of the Mental Health Act. This was not in line with the code of practice.
- The provider must ensure all care plans are personalised to the patients' individual needs and staff and patients' work collaboratively to produce them.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure more detailed risk management plans are developed following risk assessment.
- The provider should ensure patients' receive crisis plans in addition to their care plan.
- The provider should have consideration for patient's privacy and dignity by ensuring patients are able to lock the toilet door in the health –based place of safety at Dorothy Pattison hospital.
- The provider should ensure that people who use crisis services have access to psychology based therapies

Dudley and Walsall Mental Health Partnership NHS Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Mental health crisis service and health based place of safety	Dorothy Pattison hospital
Mental health crisis service and health based place of safety	Bushey Fields hospital

Mental Health Act responsibilities

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

Of the 15 cases we reviewed, the time spent in the place of safety could only be calculated for six patients. There was inconsistency in recording the beginning or ending of the person's detention under section 136 of the mental health act, and the majority of the forms were incomplete or missing.

Recording of whether a patient had received their rights was missing in ten cases.

The multi-agency operational policy on the use of the place of safety remained out of date and did not reflect the guidance in the revised Mental Health Act Code of Practice introduced in April 2015; therefore staff using the place of safety were misinformed. This was West Midlands wide policy and not the direct responsibility of the provider inspected.

Staff knew how to contact the Mental Health Act team for advice when needed. This meant that staff could get support and legal advice on the use of the MHA when needed.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with showed a good understanding of the Mental Capacity Act. We saw documented in care notes whether a patient had capacity or not.

Training records indicated that 91% of staff had received training in the Mental Capacity Act and were aware of the trust policy and had awareness of where to seek advice from when unsure.

Staff told us that prior to referral to the team, patients should have the capacity to agree to the assessment and transfer of care. Staff understood that patients should be supported to make decisions independently before they were assumed to lack the mental capacity to make those decisions.

When patients lacked capacity, decisions were made in their best interest. Staff gave examples of when this happened. Staff recognised the importance of patient wishes, feelings, culture and history and this was documented in patient care records.

Patients had access to an independent mental capacity advocacy service (IMCA). IMCA services provide independent safeguards for people who lack capacity to make certain decisions and have nobody, such as friends and family to support them.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

Mental health crisis services

- None of the interview rooms at Bushey Fields or Dorothy Pattison hospital had alarms. Staff did have access to personal alarms and would complete risk assessments prior to meeting with patients.
- Neither of the crisis teams had access to a dedicated clinic room for patient physical examination. If required, the Dudley team could use the clinic room on birch ward. Both teams had basic physical health equipment such as blood pressure machines and thermometers, which staff would use to take out to patients' homes.
- We observed that both crisis team offices were clean and well maintained. The trust contracted a cleaning company and it was their responsibility to ensure that all areas were clean.
- Handwashing facilities and hand sanitizer gels were available on all sites for staff use. We saw handwashing posters across the sites.
- Staff within the crisis services had access to resuscitation equipment that was located near to patient accessible areas. Neither team was responsible for the maintenance or checking of this equipment. Staff we spoke to were aware of where the equipment was kept if they needed it in an emergency.

Health-based places of safety

- Access to the health-based place of safety at Bushey Fields was through a secure door off Wrekin ward. The place of safety at Dorothy Pattison hospital was adjacent to the reception area. This area was alarmed, although on the day of inspection, the alarms activated themselves when we walked in which showed a fault within the system. We reported this to the manager on the day of inspection.
- There were no dedicated clinic rooms for people admitted to the place of safety at either Bushey Fields or Dorothy Pattison hospitals. If required, staff could access one of the clinic rooms on site.
- We observed that places of safety were clean and well maintained.
- The health-based place of safety at both sites had furniture that was visibly clean and in good condition.
- The places of safety had access to resuscitation equipment that was located at nearby wards.

Safe staffing

Mental health crisis services

- Staffing levels for Dudley crisis team at time of inspection were as follows: one whole time equivalent (WTE) band seven team manager, one 0.5 band seven clinical lead, one WTE band seven occupational therapist, seven WTE band six nurses, three WTE band five nurses, four WTE band three health care assistants.
- Staffing levels for Walsall crisis team at time of inspection were as follows: one WTE band seven team manager, one 0.5 band seven clinical lead, 8.4 WTE band 6 nurses, 2.7 band five nurses. There were no band three health-care assistants.
- Sickness rates from November 2015 to October 2016 for the teams were higher than the national average at 6% in the Dudley team and 8% in Walsall. This was mainly due to long-term sickness.
- Both teams had vacancies of three band six nurses each.
- The Walsall team used three band six agency nurses, and the Dudley team used two agency band six nurses to cover existing vacancies. The agency nurses worked regular shifts with the teams and were familiar with the staff, policies and procedures and the patients. Staff could also work extra shifts if they wanted to as overtime. Team managers were able to provide cover for unfilled shifts and thought that staffing was sufficient to cover tasks required.
- During our visit, we viewed the rotas for both services. Staff worked a shift system, across three shifts per day, including one qualified nurse who worked out-of-hours to cover the crisis calls and assessments. Each team had a shift co-ordinator who had an overview of staffing resources and would manage the caseloads and allocate visits for the day. They would have information of any staff sickness or shortages, which meant that they were able to ensure that the service would continue to function with minimal disruption.
- At the time of the inspection, the Dudley crisis team had a caseload of 46 patients and Walsall had 63 patients.

Good

Are services safe?

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

Staff would typically see four to six patients per shift, the allocation of which would be dependent on staff skills and patient need. Staff managed and assessed the team caseloads during handovers and made decisions regarding frequency of visits, treatment and discharge planning. Following assessment, staff allocated patients a nominated clinician to help coordinate their care, although the whole team took responsibility for the caseloads.

- Staff from both crisis services told us that there was an immediate response from psychiatrists when required.
- Mandatory training for all staff included fire safety, equality, diversity and human rights, health and safety, infection control, moving and handling, and safeguarding adults and children. Data the trust provided showed an average training compliance rate of 80% for Dudley and 77% for Walsall.

Health-based places of safety

- Staff did not work in the places of safety, and they were only in use when a person detained under a section 136 or 135 arrived. The street triage or police officers would notify both crisis teams if they had a patient detained under section 136 of the Mental Health Act. It was the responsibility of the crisis teams to notify and arrange attendance of the approved mental health professional (AMHP) who would then co-ordinate the assessment. Crisis team staff were not required to participate in the assessment, which meant only the medical staff and AMHPs were present.
- Medical staff attended Mental Health Act assessments at the place of safety when required.

Assessing and managing risk to patients and staff

Mental health crisis services

- We viewed 15 care records across both crisis teams. We found that all risk assessments were present and completed during the admission stage. Most were up to date; however, one required updating following a change to the patient's risk status. All risk assessments included risk management plans, although the majority of these were basic and lacked detail. However, we observed that staff assessed risk on every visit and recorded this within the ongoing care notes. Staff would increase or decrease patient visits dependent on their current risks.
- Consideration of patient advance decisions or statements was evident within the patient care records.
- Patients told us they received a copy of their care plan, which contained information about how to contact the team in a crisis. However, staff told us patients did not receive a specific crisis plan.
- All patients on the crisis team caseload could contact the team at any time and were encouraged to do this, especially if there was deterioration in a patient's health. Staff could arrange for the patient to seen as soon as possible when necessary, at home during hours, or at Bushey Fields or Dorothy Pattison after 17.00.
- The crisis services did not operate a waiting list. Patients who were referred were seen within 24 to 48 hours, dependent on their needs and risks. Treatment would commence immediately following assessment and agreement of the care plan between clinician, patient and carer.
- Safeguarding training up to level two was mandatory for all crisis team staff. Compliance within the Dudley team was 77% and 76% for adult and children respectively. The Walsall team were 93% and 86% compliant. All clinicians were also required to complete up to level three for safeguarding adults and children. Staff were 100% compliant with this training in both teams. Staff were aware of the processes to report safeguarding and knew they could seek advice from the trust safeguarding team. Team managers told us that staff had brought safeguarding concerns to their attention and we saw safeguarding discussions recorded in supervision notes. We observed safeguarding concerns being raised in the handover meeting at Dudley crisis team, and saw this reflected within patient's care notes. Information from the trust showed that from November 2015 to October 2016, the crisis and place of safety teams had made a total number of 11 safeguarding referrals for children and two referrals for adults.
- Lone working took place at both crisis teams. We saw effective protocols in place, such as recording staff visits on a white board and a signing in and out system. The shift co-ordinator remained at staff base and could monitor if staff had not returned on time. Both teams had a code word that they were to use if there were any difficulties during their visits. We saw the code word displayed within the staff base, which staff were aware of. All staff had access to mobile phones. Both teams were working in line with the trust lone working policy.

Good

Are services safe?

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

- Staff ordered and collected medication from the pharmacy and delivered it to the patient at home. They did not administer or dispense medication on trust premises. For patients deemed to be at high risk of not taking their medication, or taking too much, staff could dispense medication on a daily basis. We saw medication was stored appropriately and safely within the teams designated medication cupboards. Both teams disposed of medicines that were no longer required. Both teams received daily input from pharmacists who requested a medicines reconciliation from each patient's GP. This ensured staff had awareness of current medicines and dosages. We reviewed ten patient medicine charts from both crisis teams. Nurses had signed to state when they had dispensed medication to patients and medical staff had completed them appropriately. At the time of our previous inspection in February 2016, staff in the mental health crisis services did not transport medicines securely between the team bases and patients' homes. By the time of the most recent inspection, the trust had issued staff with lockable rucksacks. This meant that staff could transport medicines securely. Both teams had a number of rucksacks with combination locks that staff could use. We also found during the previous inspection that staff in the mental health crisis services did not record controlled medicines for use in the patient's home in the controlled drug register. At the most recent inspection, we found that both teams had addressed this issue and recorded all controlled drugs within the controlled drug register. This meant that staff could maintain a clear audit trail from the dispensing of controlled drugs to the patient home.
- The team at Walsall administered depot injections, so needles and syringes were kept on site. We saw these were in date and appropriately stored within the clinic room. Both teams monitored the room temperatures where medicines were stored on a daily basis and were aware of what to do if the temperature exceeded the normal range. The medication cupboard used by the Dudley team was in the team office, but was relocating to the clinic room on Birch ward. One of the reasons for this was to maintain a more consistent temperature for medicine storage.

Track record on safety

Mental health crisis services

- The trust reported one serious incident between November 2015 and October 2016 relating to the death of a patient on hospital leave in the Dudley team. We reviewed the serious incident case review completed by the trust, although there were no recommendations made and the care plan was considered to be appropriate.

Reporting incidents and learning from when things go wrong

Mental health crisis services

- Data provided by the trust showed the crisis teams had reported 19 incidents for the months of September and October 2016. The majority related to clinical incidents, self-harm incidents, behaviour and aggression.
- Staff showed awareness of how and when to report incidents, and the need to be open and transparent to patients and carers when things had gone wrong.
- Staff received feedback through team meetings and email, which included any learning from trust wide incidents.
- Team managers provided support and debriefs to staff following serious incidents. Staff told us they found this supportive.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

Mental health crisis services

- We looked at 15 care records across both teams. All contained a comprehensive up to date functional assessment of the care environment (FACE) assessment, which was holistic and personalised. Documentation of the assessment took place within 24 hours, which ensured that other members of the team had relevant and up to date information.
- Records contained care plans that were recovery orientated, included a description of patient needs, interventions required to meet these needs and expected outcomes. However, of the 15 sets of care plans that we looked at, only four of these were personalised. This meant the patient had been involved in writing it and was written in their voice. The other 11 were more generalised and not individualised.
- The crisis teams inputted onto an electronic record system to record information. They also made use of paper records and printed information, such as care plans, to give to the patient during visits. Team bases kept the paper records in a secure area and were only accessible to team staff. All staff within the trust could access the electronic record, although in-patient staff were only able to complete risk assessments onto it. Therefore, the crisis team staff ensured that they obtained a thorough handover from in-patient staff prior to the team taking patients for leave or discharge.

Health-based places of safety

- Police completed a joint assessment form with the approved mental health practitioner (AMHP) for all patients assessed in the health-based places of safety. We looked at 15 forms, of which six were fully completed, and nine were incomplete or missing. There was no requirement to complete any other clinical notes.

Best practice in treatment and care

Mental health crisis services

- Medical staff followed national institute of clinical excellence (NICE) guidance when prescribing medicines such as low dose prescribing of anti-psychotic medication, which was evident on medicine charts we reviewed.
- Neither crisis team had access to a psychologist to give direct input into patient care. The occupational therapist based within the Dudley team provided low-level cognitive behavioural therapy. The lack of psychological input meant that teams could not offer a range of NICE recommended interventions.
- Staff regularly provided information on employment, housing and benefits and would signpost patients to agencies that could offer support and assistance. We saw this reflected within patients' care records.
- Consideration of patients' physical health needs was evident within the care records. Teams worked closely with patients' GPs to ensure appropriate tests and results were obtained when necessary. Crisis staff performed basic physical health checks such as blood pressure, pulse and temperature. Staff in the Walsall team could refer patients to the well-being team at Dorothy Pattison hospital. The Dudley team did not have access to a physical health clinic.
- Staff used recognised rating scales to assess and record severity and outcomes such as health of the nation outcomes scales which measures the health and social functioning of people with severe mental illness. We saw evidence of this within all of the care records that we looked at.
- Staff participated in regular clinical audits such as looking at the quality and comprehensiveness of patient care records. The audit looked at ensuring that patient goals were measurable, recovery focused and that there was evidence of patient involvement in the care planning process. Managers discussed results with staff in supervision and in team meetings. Staff made improvements based on areas identified, and managers monitored progress made. Other disciplines provided audits also, such as the pharmacy department, who regularly audited medicine charts. Medical staff had also completed documentation audits.

Skilled staff to deliver care

Mental health crisis services

- The Dudley team consisted of doctors, nurses, an occupational therapist, social workers and health care

Are services effective?

Requires improvement

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assistants. The Walsall team consisted of doctors and nurses. Both teams received input on a daily basis from the pharmacy department. Staff were experienced and some staff had worked within crisis services for a number of years.

- All new starters received a trust induction, which included training and awareness of trust policies and procedures.
- When the trust was last inspected, we found that staff did not receive regular supervision. Since then, the trust had made changes to supervision documentation, which has ensured that there was a consistent approach to the supervision process across all teams. Managers were now required to complete a regular supervision log, which the trust compliance department audited. This ensured the trust were able to monitor that staff were being supervised. Managers provided regular supervision to their staff at a frequency of every 8 weeks. The trust policy standards stated staff should receive supervision no less than eight times a year. Data supplied by the trust showed that at the time of the inspection, the Dudley team had a supervision compliance rate of 91% and Walsall team was 100%. We looked at completed supervision forms in both teams. They showed discussion of a range of topics including trust values, mandatory training, knowledge and skills, responsibilities and working within a team. The team manager at Dudley was introducing a cascade system to the supervision process. This meant that delegation of supervision to other team members would ensure staff received supervision that is more regular. The Walsall team had started peer supervision for small groups of staff for reflection and case discussion. Medical staff had agreed to facilitate the groups initially. The Dudley team were starting a reflective practice group, facilitated by a psychologist. This could also encompass case formulations and discussion of challenging patients.
- Managers provided staff with an annual personal development plan (PDP). Data received from the trust showed all staff had received a PDP from November 2015 to October 2016.
- Staff were able to access specialist training. At the time of inspection, staff were attending courses on nurse prescribing, leadership and distress tolerance.
- The trust had a policy in order to support managers dealing with poor performance. At the time of the inspection, managers were not dealing with any staff performance issues.

Multidisciplinary and inter-agency team work

Mental health crisis services

- There were good handover systems in place to ensure work was communicated between each shift. There were three handovers a day within each team at the end of each shift. We observed two handovers and saw they were task orientated, identified risks and addressed issues such as safeguarding and social problems. Staff used the handover at 14.00 as a multi-disciplinary team meeting.
- The crisis teams had developed good relationships with their colleagues within other teams; specifically those that they received referrals from. This meant that staff were able to liaise effectively with colleagues regarding patient care.
- We saw evidence within the patient care record of joint working with community teams. If a patient had a care co-ordinator from a community team, they remained involved and attended joint visits whenever necessary and when ready for discharge from the crisis team.
- The crisis team provided an early discharge facility to the in-patient wards. Staff attended ward rounds when required to discuss discharge arrangements with patients', carers and ward staff.
- The teams provided written information to the patient's GP on discharge from the crisis team. This included information on progress, medication and future care plan.
- Staff worked closely with police, social services and other external agencies.
- Team meeting minutes showed regular discussion with staff regarding the need to provide more personalised and holistic care plans.

Health-based places of safety

- Police contacted the crisis teams when they needed to use the places of safety, who then made arrangements with the approved mental health practitioner assessment under Section 136.
- A local strategy group had been set up in order to monitor and ensure collaborative working between agencies in relation to the 136 suites. The group was attended by the West Midlands police, ambulance service, nurses, consultant psychiatrists and approved mental health professionals.

Are services effective?

Requires improvement

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

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

Mental health crisis services

- The trust had a Mental Health Act office and the administrator was responsible for collating and monitoring information to make sure patients' rights were protected.
- All clinical staff were required to complete Mental Health Act (MHA) training on a three yearly basis. At the time of inspection, 56% of eligible staff were up to date with this training, which was equal to 23 staff members. Staff told us this did not include specialist training in the use of section 136 of the MHA.
- At the time of our visit, the crisis teams did not have any patients on section 17 leave or on a community treatment order. If any patients required assessment for a community treatment order, the assessment took place on the ward prior to any referrals to the team.

Health-based places of safety

- It was the responsibility of the crisis staff to complete a monitoring form for every person subject to a section 135 or 136 within the place of safety suite. This included basic demographic information and outcome of the assessment, which staff sent to the trust Mental Health Act office. This allowed the trust to determine how often the places of safety were used and also to gather data on the assessment outcomes.
- Staff were aware that they did not have the authority to administer medication to anyone detained under section 136 of the MHA.
- At our previous inspection, the trust multi-agency operational policy on the use of the place of safety had not been reviewed since 2011. During this inspection, we found that the policy remained out of date. This meant the policy did not reflect changes to the way in which services should care for patients detained under section 136. The policy set out the areas the trust and partner agencies should audit in order to meet the guidance in the MHA Code of Practice and other best practice guidance, such as that issued by the Royal College of Psychiatrists. However this was West Midlands wide policy and not the direct responsibility of the provider inspected.
- When the trust was last inspected in February 2016, we found paperwork was outdated and was not in line with the Mental Health Act Code of Practice. In addition, there was a lack of consistent recording about when patients received their rights when detained under a section 136. This did not meet the guidance in the Mental Health Act Code of Practice 4.9. During our most recent inspection, we found that the trust had updated their joint paperwork to a good standard. The updated paperwork was available for staff to use from October 2016. Unless the patient being assessed was admitted, no other paperwork was completed.
- There were 15 new forms across both sites for us to review. There was inconsistency in recording of people receiving their rights. Staff had recorded that one person had received their rights in verbal and written form, four people received only verbal rights and ten people had not received their rights at all.
- During the last inspection, we found that Mental Health Act procedures were not always being followed in the place of safety. Staff had not been completing all sections of the 136 paperwork. Paperwork reviewed at this inspection showed completion of six forms to a good standard and nine were incomplete, or missing. Although there had been audits of the use of section 136, there were no effective audits or processes in place to monitor the quality of recorded information.
- Staff were not always recording when people had been detained under section 136 in line with the Mental Health Act Code of Practice. This was missing in nine out of the 15 reviewed forms. This meant we could not determine if staff followed guidelines set out by the Royal College of Psychiatrists and the Code of Practice.
- People detained in the place of safety under section 136 are not eligible for services from an independent mental health advocate (IMHA) as defined in the Mental Health Act Code of Practice. However, patients could request an advocate if they were to be assessed under the Mental Health Act process. Staff we spoke with were not aware of how to access written information about patients' rights whilst under section 136 and we saw no evidence that this had been offered, apart from one occasion.

Good practice in applying the Mental Capacity Act

Mental health crisis services

Are services effective?

Requires improvement

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

- All clinical staff were required to complete Mental Capacity Act training on a three yearly basis. At the time of inspection, 91% of eligible staff had completed Mental Capacity Act training, which was equated to 41 staff.
- Staff we spoke with had an understanding of the guiding principles of the Mental Capacity Act. We saw this reflected within the patient record, and all records we reviewed had considered patients capacity.
- Part of the inclusion criteria for referral to the crisis team was that patients were deemed to have capacity. During medical reviews, staff always assessed capacity as a standard part of the process. Staff understood that patients should be supported to make decisions independently before they were assumed to lack the mental capacity to make those decisions.
- Staff had opportunity to discuss capacity within handover and make decisions in the patient's best interests, if capacity was deemed to be lacking.
- There was a trust policy on Mental Capacity Act including DoLS, which staff were aware of and could refer to on the trust intranet. Staff could also discuss any MCA matters with medical staff and the trust lead.

Health-based places of safety

- At times, staff assessed people under the age of 16 in the health-based places of safety. Staff who provided assessment to people under section 136 showed an understanding of Gillick competence for young people.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

Mental health crisis services

- We observed one home visit and one assessment whilst on inspection. We saw that staff were respectful and compassionate towards their patients'. Staff demonstrated a professional attitude and provided practical and emotional support. They communicated with language that patients' and carers' could understand and took time to explain all necessary information.
- We spoke with seven patients' on the telephone. All were complimentary about staff and said they treated them with respect and empathy. They felt staff were knowledgeable and took time to understand their individual needs. One patient gave an example of staff being proactive to contact him when he needed it and we heard about staff being responsive to patients' and carers' when they needed support or advice.
- We attended two handovers where staff would discuss patients' progress and needs. Staff were responsive, respectful, and sought ways to offer support and improve patient circumstances. They showed an understanding of the individual needs of each patient.
- We saw team meeting minutes from the Walsall crisis team, which included recent feedback from patients and carers, which had been positive.
- We observed staff discussing confidentiality with a patient. Within the care records, staff had noted patients' wishes of whom they can or cannot communicate with regarding their care. Information within the leaflets given to patients' explained how the crisis services maintained confidentiality.

The involvement of people in the care they receive

Mental health crisis services

- When we spoke with patients', seven of them told us they had been involved in their care plan and staff had offered them a copy. One patient told us they were not aware of the contents of their care plan and staff had not offered them a copy. However, staff did not record within their electronic care notes when patients' received a copy of their care plan, or if they had refused it. This meant that the trust could not determine whether patients' had been involved in their care and had received any documentation.
- We reviewed 15 sets of patient care records. Information provided within care plans differed, dependent on the clinician involved. We saw four written in the patient voice and only one signed by the patient. The majority were fairly generic and not recovery orientated although interventions described did differ from each patient, which showed consideration of individual needs.
- We spoke with three carers. All were positive about the service and had felt involved and listened too by staff. We observed staff discussing carers support options and offering advice about this. One patient told us the team had taken time to explain and educate her carer about her illness. Staff ensured they had consent from patients' to discuss their care with others and recorded who their main carer was. The trust promoted the use of the 'triangle of care', which ensured carers' involvement and prompted staff to discuss carers' issues and assessments.
- Patients' had access to advocacy if they required this service. We saw posters displayed with this information in patient accessible areas.
- The trust had introduced a scheme that involved experts by experience providing feedback on services. The experts attended and participated in formal meetings, provided advice on the development of policies and participated on the recruitment of trust staff and induction process. This provided inclusiveness and a holistic approach to the development of services and staff within mental health.
- Information given to patients' at the start of their involvement with the team advised on how to provide feedback about the service. Patients received user satisfaction questionnaires when they exit the service, which the trust audited. We reviewed the data collated from eight surveys in the Dudley team, which showed patients' were 100% satisfied with their care and treatment. However, 38% said they had not received a copy of their care plan.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Mental health crisis services

- The crisis teams received referrals from the community teams, place of safety, early access service, liaison psychiatry, inpatient wards and GPs. Referrals were initially triaged and a response time allocated using a RAG rated system; red (high risk), amber (medium risk), and green (low risk). Staff assessed each referral within 24 to 48 hours, dependant on the urgency. The trust did not monitor the time taken from initial assessment to the onset of treatment, although the teams would start treatment following assessment. At each handover, staff discussed the referrals and allocated the tasks.
- Managers and staff told us they responded appropriately to patients who required crisis interventions and routine care. The teams were accessible 24 hours every day. Staff saw patients in their homes or at the teams' bases. All patients we spoke with told us they received contact numbers to speak with a member of the team straight away.
- When the trust was last inspected in February 2016, we found that crisis calls were not always returned to patients in a timely manner and, on occasions, not at all. The trust had made a number of changes to improve this. Staff were required to complete a crisis call log to show when they received the call and the response time back to the patient. The trust had set a target that staff responded to all calls within one hour, and the trust would monitor the results. We reviewed the latest completed audit for the month of August 2016. Between both teams, staff had received 580 calls. Dudley team had an average response time of seven minutes and Walsall was 25 minutes. Dudley had two calls, which took over one hour, and Walsall had 26. This was equivalent to 5% of the total calls received. Staff were required to complete an incident form, when calls were not returned within one hour. This meant there were effective processes in place to monitor the teams' response time and patients received an improved service when contacting the team in a crisis.
- According to the trust operational policy inclusion criteria, the crisis teams would see all patients diagnosed with a mental disorder, or who were experiencing a mental health crisis. The Walsall team saw patients' from the age of 16 years old; the Dudley team from 14 years old. Although the operational policy describes set criteria, it also allowed staff a degree of flexibility in order to avoid excluding people who may be in need of the service.
- Staff were proactive and flexible with patients who were harder to engage. Patients' could attend the team base, or be seen at home, dependant on their choice. Staff told us that they provided patients' with a time slot for home visits rather than an exact time to allow for flexibility with patient visits. Patients' could request changes to their visiting times and staff would accommodate this.
- When patients missed their appointment or were not at home, staff would re-allocate the visit to later in the day and would attempt to make contact over the telephone. This would also apply if staff had to re-arrange a patient visit.

Health-based places of safety

- From November 2015 to October 2016, Bushey Fields place of safety had 75 referrals and Dorothy Pattison place of safety had 110. Both teams had dedicated approved mental health practitioners (AMHP) to co-ordinate, respond quickly and organise the assessment. Access to medical staff was prompt and a system was in place for access out of hours.
- We reviewed 15 records from the places of safety. Due to incomplete records, we could only determine the length of stay for six patients. We saw that four patients were assessed within the four-hour period and two took five hours. Conclusion of the assessment under section 136 should be within four hours, or as near as possible, according to standards set out by the Royal College of Psychiatrists.

The facilities promote recovery, comfort, dignity and confidentiality

Mental health crisis services

- Staff saw patients' who attended appointments with the crisis teams at Bushey Fields or Dorothy Pattison sites in comfortable, soundproofed interview rooms. Both places of safety were sufficiently apart from other areas of the hospital and ensured confidentiality during Mental Health Act assessments.
- The crisis teams gave out information leaflets to all new patients about their service, including information

Are services responsive to people's needs?

Good

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

about maintaining confidentiality and advice on how to provide feedback. The Walsall team had developed a comprehensive information pack, which also consisted of leaflets on safeguarding, carers support, care programme approach and useful telephone numbers on local and national services.

Health-based places of safety

- The health-based places of safety at both Bushey Fields and Dorothy Pattison hospitals had en-suite toilets and washing facilities. However, the toilet at Dorothy Pattison did not have a lock, which could affect patients' privacy and dignity. Neither of the two clocks displayed on the walls within the place of safety at Dorothy Pattison were working when we inspected. Staff fixed the clocks when we informed them.
- Both places of safety had outside entrances, so people detained on a section 136 did not have to walk through other areas of the hospital. This met the standard set out in the Royal College of Psychiatrists' guidance.
- We did not see any information within the places of safety regarding patients' rights. Staff we spoke with were not familiar with, or had not seen patients' rights information leaflets, which should be given to all patients', brought to the place of safety on a section 136 or 135.
- Forms completed within the places of safety did not reflect whether patients' received food and drink. Staff told us they were able to access refreshments from neighbouring wards.

Meeting the needs of all people who use the service

Mental health crisis services

- When crisis team staff saw patients at their base, it was within one of their dedicated outpatient rooms, which were accessible to disabled people.
- Staff told us that information leaflets were accessible in other languages when required, although we did not see any readily available at the time of the inspection.
- The trust used an established interpreting service and staff made advance bookings for patients. If an interpreter was required at short notice, this could take some time, dependent on the language skills required.

Health-based places of safety

- Access to the places of safety was step free and had sufficient space to manoeuvre a wheelchair in the assessment areas. However, the toilet at Dorothy Pattison hospital was not easily accessible for wheelchair users.

Listening to and learning from concerns and complaints

Mental health crisis services

- Between November 2015 and October 2016, the trust had received 21 complaints related to the crisis service. The Walsall team received 13 complaints; Dudley team received eight. The common theme was around lack of access and lack of support. The trust upheld one complaint and partially upheld five. None of these complaints were referred to the parliamentary ombudsman.
- Information on how to make a complaint or raise a concern was included in the service information leaflets given to every patient. The trust service experience desk discussed what support the patient could obtain if they wished to make a complaint. We saw 'You said, we did' posters displayed within patient accessible areas, which referred to patient feedback, complaints and actions that the trust had taken to make improvements.
- Staff that we spoke to were aware of the complaint process and their responsibilities in adhering to trust policy.
- Managers discussed feedback from complaints and any subsequent investigations with staff in team meetings.
- **Health-based places of safety**

  No complaints were received for the health-based places of safety between November 2015 and October 2016.

Are services well-led?

Good

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

Our findings

Vision and values

Mental health crisis services

- The trust values at the time of the inspection were; caring, integrity, quality and collaborative. Staff showed awareness of the values and the trust had involved staff when discussing what the values of the trust should be.
- Managers discussed the values within team meetings and reflected on how they could use them more effectively. We saw the values reflected within staff personal development plans and discussed within supervision. Staff were required to show how they were meeting the values of the trust in their day to day work.
- Staff were aware of the senior managers within the trust. The chief executive and chair of the trust had attended handovers. Staff were able to attend the chief executive team brief and could email him through a page on the trust intranet.

Good governance

Mental health crisis services

- Staff were adequately trained, and managers promoted the need to attend mandatory training.
- Staff received annual personal development reviews and the frequency of management supervision had increased since our last inspection.
- Appropriate numbers of staff were available and staff told us that direct patient care was their priority.
- All incidents and complaints were analysed and reviewed in the trust quality and safety committee and investigations took place when necessary. Team managers would disseminate shared learning with staff in team meetings.
- Within the crisis teams, staff were able to participate in clinical audit if they wanted to.
- Procedures relating to safeguarding were widely followed and staff knew how to raise an alert.
- Staff had received training on the Mental Capacity Act and Mental Health Act, and were aware of the procedures and that they could seek guidance from senior staff and the trust leads.
- The crisis teams used key performance indicators to measure their performance. They included seven-day follow up, home treatment episodes and gatekeeping. Both teams were meeting their targets. Staff were able to access this information through the trust information system and managers discussed results in team meetings.
- Both crisis team managers felt they had enough authority to make suggestions and improvements when needed, and had good administration input.
- Managers were able to submit items to the trust risk register. Items relating to the crisis teams had been resolved, such as a high referral rate for the Walsall team.

Health-based places of safety

- There were no effective audits or processes in place to monitor the quality of the recorded information in the places of safety.

Leadership, morale and staff engagement

Mental health crisis services

- The total percentage of permanent staff sickness from November 2015 to October 2016 was 6% for the Dudley team and 8% for the Walsall team.
- There had not been any bullying or harassment cases within the team and staff we spoke with felt confident to raise concerns if they needed to.
- Staff were aware of the whistle-blowing process and would use it if required.
- Both crisis teams worked well together and supported each other. Morale was good and staff that we spoke with said they all worked well as a team. The medical staff, clinical lead and team managers worked together to provide strong leadership and were committed to raising standards, particularly with care planning.
- Staff had opportunities to progress. Some staff were attending leadership programmes and managers encouraged staff to participate in tasks such care plan audits.
- Staff gave examples of being open, honest and transparent with patients when something had gone wrong. Team managers said they regularly discussed the duty of candour in team meetings.
- Team managers attended monthly acute service meetings, which gave an opportunity for them to feedback their team's performance, concerns and issues and to participate in any shared learning or experiences from their colleagues and managers.

Are services well-led?

Good

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

- Due to vacancies within the trust higher management structure, crisis team managers had to report into director level of management. This meant the crisis managers did not receive regular managerial supervision and lacked day-to-day managerial support. However, managers told us they utilized peer supervision and met regularly, and when required, senior managers made themselves available.
- Staff had opportunities to feedback on service development. The trust encouraged staff to submit their 'bright ideas' which are considered by senior staff. The crisis team had already suggested an implemented idea, which ensured ward staff now provided a follow up telephone call to out of area patients instead of the crisis team. This ensured continuity of care from the ward staff as the crisis team did not know the out of area patients.

Commitment to quality improvement and innovation

- Neither crisis team was accredited by the Royal College of Psychiatrists' HTAS scheme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good Governance** **The provider must ensure effective processes are in place to monitor the quality of recorded information for all patients assessed in the health-based places of safety.** **Staff were not consistent in recording that they had given information to patients about their rights when they commenced on section 136.** **This is a breach of Regulation 17 (2) (a,c) Good governance**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014** **Person Centered Care** **The provider must ensure all care plans are personalised to the patient's individual needs and staff and patients work collaboratively to produce them.** **This is a breach of Regulation 9 (3) (a,b)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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