Requires improvement

Dudley and Walsall Mental Health Partnership NHS Trust

Mental health crisis services and health-based places of safety

Quality Report

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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)
RKY34	Bushey Fields Hospital	Mental health crisis service and health based places of safety	DY1 2LZ
RKY34	Dorothy Pattison Hospital	Mental health crisis service and health based places of safety	WS2 9XH

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.

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.

Summary of findings

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	Requires improvement 
Are services safe?	**Requires improvement** 
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 Dudley and Walsall mental health partnership as requires improvement because:

- controlled drugs were not being appropriately recorded by staff
- trust policies were not followed when transporting medication
- access to resuscitation equipment was limited for the CRHT services
- management supervision was not occurring on a consistent basis care plans did not consistently include the views of the patient,
- joint risk assessments at the place of safety were not consistently recorded
- patients were not always being informed of their rights under the mental health act
- some information at the place of safety was recorded on out of date forms that did not incorporate the new code of practice
- the trust operational policy on the use of the place of safety had not been updated since 2011

However:

- environments were safe and clean
- there were three exits from the place of safety in line with the royal college of psychiatry guidelines
- we saw evidence of good multi-disciplinary team working
- there were minimal delays for patients who were waiting for mental health act assessments
- staff included patients in the discussion of their care
- appointment times were flexible to meet the needs of the patients
- there were robust systems in place for reporting, recording and learning from incidents

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff did not transport medication in locked containers or bags in line with trust policy. This meant staff's personal safety and security could have been at risk.
- Controlled drugs dispensed by the trust for patient to use in their own homes were not being recorded in a controlled drug register; therefore, there was no clear audit from dispensing to the patient.
- There were no robust plans in place for medical emergencies. Resuscitation bags belonged to other services in the building and access was limited due to distance from the outpatients to the clinic.

However:

- Each team had a shift co-ordinator who had an overview of staffing resources they would manage the caseloads and allocate the daily visits, which meant that they were able to ensure that the service would continue to function with minimal disruption.
- There were robust systems in place for reporting, recording incidents and sharing information from lessons learnt. Feedback took place in staff meetings by the clinical leads.
- Lone working protocols were in place the shift co-ordinator wrote details of visits and the name of staff members in attendance on a white board. Staff all had mobile phones and 'Screech' alarms, were available for staff to take on visits.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Although staff took part in mandatory training, not all staff were receiving regular management supervision every six to eight weeks. Clinical supervision was taking place however there were limited records of the frequency and identified supervisors.
- Staff were not recording the time when detentions under section 136 were in place in line with the Mental Health Act Code of Practice.

However:

Summary of findings

- The multi-disciplinary team worked well together.There were minimal delays for patients who were waiting for Mental Health Act assessments to take place. Staff was able to attend as and when required.
- Patient records were in the home treatment offices, which required a swipe card to gain access. The draws and cabinets were lockable.

Are services caring?

Good

We rated caring as good because:

- Staff were kind and caring towards patients and took into consideration all aspects of care and well-being. Patients felt respected and included in their care, staff were patient and ensured patients understood processes that were taking place.
- The trust had introduced the 'triangle of care' that brought together the patient, carers and professionals. It encouraged well-being by patients involving family or carers in the planning of their care.

Information was available for patients and carers regarding home treatment services. In addition to this information was available for advocacy, carers groups and complaints procedures. Experts by experience gave feedback on services and participated in formal meetings.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- A colour coded rating system was in place to manage referrals and to determine the level of risk apparent. The team saw patients within 24 to 48 hours of referral dependent on risk. This was a multi-disciplinary team decision, which also took in to consideration environmental risks.
- The teams were flexible and were able to see patients at times that would suit their needs and at different venues as appropriate, this aided engagement with the team.
- Information about the rights of detained patients was available in a range of different languages.

However:

- Although recent changes to the out-of-hours hours working had seen the liaison psychiatry move to a 24-hour service to support the crisis worker in home treatment, problems existed with crisis workers in the home treatment team returning crisis calls to patients and carers.

Summary of findings

- Staff in the crisis team did not always record the correct time they had received calls at the service. This meant that any data captured was incorrect and would affect the team returning calls in an acceptable period.

Are services well-led?

Good

We rated well-led as good because:

- The staff morale was good; people were encouraged by clinical leads and senior managers to develop their skills and knowledge. Secondment opportunities were available within the trust offering senior posts.
- Discussions took place in staff supervisions regarding the trust's vision and values and embedding them within the service. Teams had developed posters that described what the values meant to the team and how they would incorporate this in their daily work with patients and professionals.
- Staff knew who the senior managers were; they had attended handover meetings and conducted joint visits with the team. Staff including the clinical lead could access senior managers easily.

However:

- The inpatient wards and home treatment teams were not using the same recording systems; this caused delays in accessing information. Inpatient wards were using paper records, whereas home treatment team used electronic recording systems.
- Policies concerning the place of safety had not been reviewed therefore new guidance that had been implemented in April 2015 was not updated.

Summary of findings

Information about the service

The crisis resolution home treatment team at Bushey Fields in Dudley operated from a multi-purpose two storey building in the Henry Lautch centre.

The population of Dudley was 306,600; black minority ethnic communities made up 10%. The service provided support, care and treatment to adolescents from the age of 14 years old and adults who were suffering from an acute mental disorder. This took place as part of regular home visits as required with the patients. The team also operated crisis resolution; this took place if people's mental health had deteriorated to the point where coping mechanisms had failed. 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 CRHT service operated in the same way they worked from Dorothy Pattison hospital in Walsall were the population served had been 255,900. The region was one of the most deprived areas in England. The team supported adolescents from the age of 16 years and adults suffering with an acute mental disorder.

Both sites operated a place of safety; people arrived there via the street triage service or Police officers and were detained under section 136 of the Mental Health Act as they had been deemed to require input from mental health services. An assessment would take place to determine level of need for the person.

Our inspection team

The comprehensive inspection of Dudley and Walsall mental health partnership NHS trust was led by:

Chair: AngelaHillery, Chief Executive, Northamptonshire Combined Healthcare NHS Foundation Trust

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

Team Leader: Kathryn Mason, Inspection Manager, CQC

Sub team: Two inspectors, an expert by experience: a nurse and a Mental Health Act Reviewer.

Why we carried out this inspection

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

How we carried out this inspection

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

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

We carried out an announced inspection at the Crisis Resolution Home Treatment (CRHT) service at the Henry Lautch Centre, Bushey Fields Hospital in Dudley and Dorothy Pattison Hospital in Walsall. We also visited the place of safety at both sites.

During the inspection visit, the team:

- attended five home visits with staffand observed how staff were interacting with patients
- spoke with four patients who were using the service

Summary of findings

- spoke with the clinical leads for each of the crisis resolution home treatment service
- spoke with 18 other staff members this included doctors, nurses, domestics and approved mental health practitioners
- attended and observed two hand-over meetings and a review meeting

We also:

- looked at seven care records with the CRHT service and 41 within the places of safety at Bushey Fields and Dorothy Pattison hospitals
- carried out a specific check of the medication management on both sites.
- 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

We spoke with patients who use services they were pleased about the service they had been receiving from the team.

Patients told us that they found the staff respectful, approachable and helpful. Some said that they felt comfortable with staff, as they had made them feel at ease. Surveys completed 2015, locally by the CRHT team showed that overall people were satisfied with the service received.

Good practice

None noted

Areas for improvement

Action the provider MUST take to improve

- 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.

Action the provider SHOULD take to improve

- The provider should review all documentation relating to section 136 of the mental health act as the paperwork used was outdated. Information about rights being read to the patients were not being recorded.
- The provider should ensure that times are documented when patients attend the place of safety under section 136 of the mental health act. Staff were not documenting times when the patient had commenced on section 136 of the Mental Health Act. This was not in line with the Mental Health Act Code of Practice 16.59.

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
Crisis resolution home treatment team	Bushey Fields Hospital
Crisis resolution home treatment team	Dorothy Pattison 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.

In 27 of the cases that we viewed, the time spent in the place of safety could not be accurately calculated or had been miscalculated by staff. Section 136 of the mental health act has a time limited of up to 72 hours. The Mental Health Act Code of Practice 16.59 states, a record of the person's time of arrival must be made immediately when they reach the place of safety. As soon as a detention in a place of safety under section 135(1) or section 136 ends, the individual must be told, they are free to leave by those who are detaining them. The organisation responsible for the place of safety should ensure there are proper records of the end of the person's detention under these sections. In cases where alternative places of safety are used (such as the home of a relative or friend), local policies should define responsibilities to ensure that proper records are kept of the time of arrival and the time the detention ends.

There were no recordings of the beginning or ending of the person's detention under section 136 of the mental health act.

The documentation concerning the place of safety was out of date and the forms were incorrectly completed.

Detailed findings

The policy for the place of safety was due to have been reviewed in 2011, however the trust had not completed this therefore the Mental Health Act code of practice guidelines implemented in April 2015 had not been incorporated in the policy of 2011.

Mental Capacity Act and Deprivation of Liberty Safeguards

There were no applications for Deprivation of Liberty Safeguards at this service.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- The PLACE data 2015 for cleanliness at Bushey Fields hospital was 98% and 99% at Dorothy Pattison hospital. The overall trust scores were above the national average of 97%. At the Henry Lautch centre at Bushey Fields hospital, there were three members of the cleaning team working at different times of the day and as such, the area was clean and well maintained. The health-based place of safety attached to Wrekin ward was also visibly clean. At the CRHT service at Dorothy Pattison hospital, we saw that the trust had presented the cleaning schedule on the entry to each ward. The manager and supervisor on site representing the cleaning company said they were responsible for cleaning of all departments in the hospital including the place of safety. The supervisor checked all areas to ensure cleanliness. However, there were no cleaning records in place at Bushey Fields or Dorothy Pattison hospital. This meant that staff were not able to monitor the environment or demonstrate when it had been cleaned and how often.
- Hand-sanitising gels were available at the entrance to both sites and around the buildings.
- The health-based place of safety at both sites had furniture that was visibly clean and in good condition
- Both places of safety had a separate entrance from the car park.
- Although patients' under the care of the CRHT service were regularly seen at home, we were told by staff that at times they would also see patients' within the CRHT team premises. There were no alarms in the rooms used in the outpatients' services and at both sites. However, staff did have access to personal alarms and would complete risk assessments prior to the assessment.
- The clinical lead for Dudley CRHT, told us that staff had mobile phones. The trust lone working policy stated that they provided staff with mobile phones. Walsall CRHT also had personal alarms and mobile phones to use when lone working.
- The CRHT services at Bushey Fields did not have clinic rooms exclusively for their use butwere able to use the clinic rooms at Birch day hospital. The staff from the day hospital carried out the audits of the clinic and its contents. The clinic rooms were visibly clean; there were hand-washing facilities available. Most of the equipment was in the CRHT offices such as the thermometer, alcohol, saturation and the blood pressure monitor. One of the clinics had scales and a height measure. There were no urine pots or needles/syringes present in clinics. There were no dedicated clinic rooms for people admitted to the place of safety at either Bushey Fields or Dorothy Pattison hospitals.
- We asked to see the emergency resuscitation bags at Bushey Fields. However, not all staff were able to tell us where these were located. The clinical lead told us that the resuscitation bag was in one of the clinics aligned to Birch day hospital. Staff at the day hospital had the keys for the clinic. Birch day hospital was situated in the Henry Lautch centre with CRHT services however; staff would have to locate the member of staff responsible for holding the keys to gain access to the clinic and resuscitation bag. The preferred option was for staff to use the red phones situated in the reception of the outpatients' service to alert the emergency team. We saw that the emergency resuscitation bag in the clinic had been checked and signed; the bag was sealed on 27 January 2016. All contents were in date and there was a list of items contained in the bag. The blood pressure monitor was checked and due to be serviced on the 7 October 2016. At the CRHT team at Dorothy Pattison hospital, staff told us that the emergency resuscitation bag was located in the outpatients department. We visited the outpatients department to view the bag; it was located in the kitchen in a cupboard, there was a label on the door of the cupboard. The resuscitation bag was checked and sealed; it was due for another check on 11January 2016. However, during the responsive inspection on 12 February 2016 the staff on duty did not know where the emergency bags were kept. Staff said if there was an emergency during an assessment they would either sound their personal alarms (Shreek alarm) or contact the emergency team by phone.

Safe staffing

Requires improvement

Are services safe?

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

- Between 1 July 2015 and 30 September 2015 the key staffing indicators across the core service were as follows:

- Team

Establishment - Registered Nurses

Establishment - Healthcare assistants

CRHT Bushey Fields Hospital

16 WTE

4 WTE

CRHT Dorothy Pattison Hospital

18WTE

2 WTE

- Team

Vacancies – Registered Nurses

Vacancies – Healthcare assistants

CRHT Bushey Fields Hospital

5 WTE

0.6 WTE

CRHT Dorothy Pattison Hospital

0.6 WTE

1.0 WTE

- Both hospitals had a place of safety; this was not staffed unless it was being used. At Bushey Fields hospital, health care assistants from Wrekin ward provided refreshments to the patient. The CRHT crisis worker at Walsall would be responsible for refreshments and welfare of the patient. The street triage team would notify both crisis workers at CRHT if they had a patient detained under section 136 of the mental health act. They would arrange the attendance of the approved mental health professional (AMHP) and the doctor.
- The CRHT services used the same agency staff there were a total of four working with CRHT at Dorothy Pattison hospital and they covered the vacant posts. During the period from 1 July 2015 to 30 September 2015, bank staff covered four shifts at CRHT Walsall. No shifts remained unfilled at any of the either services.
- The clinical leads for both of the CRHT services told us that there were no safer staffing tools used to estimate establishment or shift levels.
- During our visit, we viewed the rotas for both services Dudley CRHT had seven qualified staff in the morning and two in the afternoon with one support worker. There was an additional staff member on call, to carry out urgent crisis visits in the event that the crisis worker was unavailable. We viewed rotas for December 2015 and January 2016. The staffing had ranged from nine to six staff in the mornings and three in the afternoon. In both service, one qualified nurse worked out-of-hours to cover the crisis part of the service.
- 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.
- The CRHT services were commissioned for 49 unique episodes. This meant that the caseload each month for both services would be 49. Patients referred to the service more than once would have each referral identified as a separate (unique) episode. We viewed the key performance indicators for CRHT Dudley for January 2015 to March 2015. The unique episodes were 72, 83 and 79 respectively. Dependant on the unique episodes / caseload, staff were allocated between three to six visits per day. Fewer visits were allocated if there were new referrals to allow for a full assessment. The key performance indicators for CRHT Walsall for April 2015 to December 2015 varied. The unique episodes ranged from the lowest at 53 in April 2015 to the highest of 75 in May 2015. The clinical lead told us that the staff had seven to eight visits a day. This meant that both services had been performing above the commissioned 49 unique episodes. However, on the day of our visit both services had unique episode / caseloads of 49 and below. Despite the services working above commissioned targets, there was no evidence that this was having a detrimental effect on patient care.
- Medical staff attended Mental Health Act assessments at the place of safety when required. Staff from both services told us that there was an immediate response from psychiatrists when required.

Requires improvement

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- There were average rates across the CRHT service for mandatory training of 75%.

Assessing and managing risk to patients and staff

- We viewed seven care records across the CRHT services we found that all risk assessments were completed to a good standard and were updated regularly. We observed risk assessments taking place as part of the home visits and also as part of handover. During the handover, patients' risk would be discussed and assessed regarding future visits and whether they required daily or less frequent interventions from staff.
- If the patient's mental health deteriorates during the working hours of 08:00 to 17:00, the CRHT staff would see the patient at their home address dependent on risk assessments. After 17:00, the patient would be invited to attend either Dorothy Pattison hospital or Bushey Fields, as there would only be one crisis worker for each service. Although there was one crisis worker at the CRHT services at Dudley, other services were available within the premises. There was mental health urgent care service, an approved mental health professional and liaison psychiatry services that would see patients referred for urgent assessments.
- The CRHT services did not operate a waiting list; patients referred were seen within 24 to 48 hours.
- Within the CRHT based at Bushey Fields 83% of staff had completed safeguarding adults training and 89% had completed safeguarding children training. The team at Dorothy Pattison Hospital had a completion rate of 81% for adults and 86% for the children training. All of the completion rates were for level two training. The trust had a safeguarding team. Staff were aware of the processes to report safeguarding. The clinical lead at Dudley CRHT service told us that staff had brought safeguarding concerns to their attention. Discussions also took place within the handover meetings. We observed safeguarding concerns being raised in the handover meeting at Dudley CRHT service. Staff had discussed the risks that involved a referral for children's safeguarding. Information from the trust showed that from November 2014 to October 2015 the mental health community crisis and place of safety teams had made a total number of 27 safeguarding referrals for children and 29 referrals for adults.
- Medication was not administered on either of the CRHT team's premises; staff ordered and collected medication from the pharmacy. There was no secondary dispensing as the staff delivered the medication straight to the patient. However, we observed that some patients own medication dispensed by the trust for self-medicating patients had not been entered into a controlled drug register. This meant that it would not have been possible for a clear audit path to be maintained from the dispensing of the controlled drug to the patient. The chief pharmacist was made aware of this and said the medicine management review committee would review the trust policy in order to improve the process and audit trail. We found that staff had incorrectly completed the patient's own controlled drug register and the administration section for the destruction of controlled drugs by staff had been wrongly completed. The chief pharmacist had agreed to provide training for staff on the correct use of the controlled drug register before the end of February 2016. The transportation of medication by the CRHT team at Bushey Fields was carried out without the use of a locked bag. At Dorothy Pattison, the team had a rucksack that was locked. The trusts medication management policy stated that medicines must be carried in a lockable container.
- Lone working took place both at the CRHT Walsall and Dudley services. The name of the member of staff and allocated patients' for visits, were recorded on white board by the shift co-ordinator. We saw the signing in and out folder that staff used which was completed and up to date. Staff at Walsall had code words that they were to use if there were any difficulties during their visits. We asked three members of staff if they were aware of the code words; although they knew of the codes words were in existence they were unable to quote them.
- Risk assessments including environmental assessments, were obtained prior to seeing any patients' in the community or within the CRHT premises. The clinical lead for Walsall CRHT told us that there had been an increase in patients' seen in outpatients by CRHT staff. This was due to a number of patients being of no fixed abode.
- Alarms were available to staff at the place of safety. At Dorothy Pattison hospital, staff provided police officers with alarms and swipe cards to operate the exits to the

Requires improvement

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place of safety. There were three exits in total from the place of safety and two exits from the assessment room. This met the standard set out in the Royal College of Psychiatry guidance.

- We looked at 41 records at the places of safety at Bushey Fields and Dorothy Pattison hospitals. The section 136 monitoring form included a section for healthcare staff and the police to record the joint assessment of risk. The healthcare professionals had completed the joint risk assessment in only two of cases assessments that we viewed.
- We did not see any recording of patients who had made advanced decisions.

Track record on safety

- There were eight serious incidents recorded between 26 August 2014 and 28 August 2015 for mental health crisis and health-based place of safety. The serious incidents were in relation to unexpected or avoidable death and severe harm of one or more patients', staff or members of the public.

Reporting incidents and learning from when things go wrong

- The national safety thermometer recorded ten incidents from October 2014 to September 2015, there were no recorded incidents for this service during this time.
- Safeguarding incidents were reported for both children and adults. During the periods of 1 November 2014 to 22 November 2015, the trust data showed a total of 27 referrals for children and 29 for adults.
- The minutes of the Walsall CRHT staff meeting in January 2016 showed documented concerns from the clinical lead about incidents not being reported. Staff were reminded that incidents should be recorded on the trust safeguard system and risk assessments should be updated as applicable.
- The trust had an embedding lessons group of senior staff who would send the outcome of the investigations and lessons learnt to the professionals that were involved. The clinical leads discussed the feedback in staff meetings. The governance and embedding lessons team received copies of the minutes of the meetings using a unique incident number. This showed that the trust had developed a structure to ensure that information was shared and lessons learnt were evidenced to show that all staff had been informed.
- Staff received debriefs from incidents in emails from the manager also discussed during handover. This was reported by staff as supportive.
- Staff who were asked about incident reporting and duty of candour told us that they understood what it meant and gave examples.

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

- CRHT services completed comprehensive initial assessments that were holistic. It covered in detail a balanced a view of what was happening for that patient at the time. The assessments were carried out 24 to 48 hours after referral dependent on the apparent risks identified.
- We attended five visits with the CRHT team, during a review meeting we found that staff included the patients' in the planning of their care. It was holistic and took in to consideration physical health, medication, goals, diet, occupation and friends. Although we saw and heard evidence of holistic care planning and discussions with patients there was no documentation highlighting this in the care plans. We viewed the minutes of the staff meetings from April and October 2015 at the Walsall CRHT team. The team had been reminded to ensure that all patients' had care plans that were regularly reviewed and updated to reflect the patients' circumstances and need. The clinical lead had been monitoring the quality of the care plans in terms of quality and meeting individual needs. The monitoring was part of a clinical audit but at the time of our inspection; the results had not been published.
- The recording of care and treatment in the place of safety was limited. We looked at 24 records at the place of safety at Bushey Fields and 17 at Dorothy Pattison hospital. In three cases, we found a clinical note that had recorded basic information such as whether the person had been offered food or drink. In five cases, we found a full record of the Mental Health Act assessment.
- The CRHT services used the oasis database to record information. Inpatient wards used paper records; this meant CRHT would access the records when patients were referred to the service. The paper records were used for information gathering some of the information would be added to the oasis database by CRHT staff. At CRHT Dudley, the records were kept in lockable cabinets in the main office. Access was obtained using a swipe card held by professionals working in the service. At Dorothy Pattison, the area leading to their offices was also accessed using a swipe card. The section 136 monitoring forms were stored in paper form in the CRHT team offices.

Best practice in treatment and care

- The staff at the mental health urgent care centre at Bushey Fields hospital gave us examples of support and information they had provided to patients around housing. As we arrived, a patient had been given information to contact the housing team, as they were homeless. Staff stated that they would contact the patient the next day for an update. This was a regular occurrence for the team.
- Patients were routinely asked about blood tests received. The information was also available from the care records or letters on the oasis database. CRHT doctors in Walsall, referred patients to the well-being clinic at Dorothy Pattison hospital.

Skilled staff to deliver care

- As part of the trusts induction, new staff were enrolled on to the relevant mandatory training programme. The new staff shadowed their colleagues for a period of a month and became familiar with the processes and systems involved within CRHT and the crisis service. The induction could be extended depending on staff individual needs.
- The CRHT team at Dorothy Pattison hospital comprised of registered nurses, consultant psychiatrists and medical staff. There was access to approved mental health practitioners for mental health act assessments via the duty rota. At Bushey fields' hospital, the CRHT team comprised of qualified nurses, support worker, occupational therapist, approved mental health practitioner and consultant psychiatrist. The pharmacist provided the service with a weekly input. Although crisis access services were in existence, there were planned changes for the service to operate 24-hours. CRHT would become more treatment focused and would work closely with the wards around discharge.
- Information supplied by the trust showed the total numbers of appraisals for non-medical staff in the past 12 months. Eighty seven per cent of the staff in the team at Bushey fields' hospital had received an appraisal in the past 12 months whereas 68% had been appraised in

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.

the team based at Dorothy Pattison hospital. Although staff told us that clinical supervision was occurring on a 6-8 week basis, documented evidence of this was sparse. This also applied to managerial supervision.

- We looked at eight staff records concerning supervision, which was sporadic with some staff having waited four to nine months before having their next meeting.

  One staff member told us peer supervision for the approved mental health practitioners was taking place every six to eight weeks. This was supplemented with clinical supervision with their substantive line manager from the local authority and in line with the section 75 agreement between the two organisations. The staff who covered the place of safety as part of the CRHT said that they met bi-monthly for peer supervision and they had regular supervision with the clinical lead.

- Staff received training in eye movement desensitisation and reprocessing (EMDR), which was a psychotherapy treatment used in diagnosis such as post-traumatic stress disorder. They also received training in dialectical behaviour therapy (DBT) this was a specific type of cognitive behavioural psychotherapy, its development had been used with diagnosed personality disorders. Health care training was available for support workers who felt supported. The clinical leads had also arranged a number of training events for staff that included physical health venepuncture, suicide response training and the nursing and midwifery council (NMC) revalidation

Multi-disciplinary and inter-agency team work

- The CRHT team at Dorothy Pattison hospital attended the multi-disciplinary team (MDT) meetings on the inpatient wards two to three times weekly. The team also attended care programme approach and section 117 aftercare / discharge meetings. For the team based at Bushey fields' hospital, consistent attendance at the MDT meetings did not take place, as the CRHT team were not always invited to attend by the wards. This meant that some opportunities for joint working and information sharing might have been missed or delayed.

- We observed hand over meetings at both locations. The consultants led the hand over meeting at Dudley CRHT team and staff provided information from visits attended in the morning. At the handover meeting at Dorothy Pattison hospital, information was updated as the patients' risks were discussed. Staff did not focus solely on medication but in addition looked at supportive and protective factors such as family dynamics and therapy, housing, benefit difficulties and referrals to the citizen advice bureau.

- We saw evidence of joint working with community teams and CRHT; for example, the community recovery teams (CRS) attended visits with the CRHT team where necessary. If the patient had a care co-ordinator within the community recovery team, they remained involved and attended joint visits when necessary.

- 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 west midlands police, ambulance service, nurses, and consultant psychiatrists and approved mental health professionals.

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

- The MHA was not part of the mandatory training outlined by the trust. The clinical leads said that although the MHA was not mandatory it was seen as essential training. The trust provided training on a frequent basis.

- Staff based at the places of safety told us they had not received specialist training in the use of section 136 of the MHA.

- Staff said that following an assessment at the place of safety, any documents were taken to the mental health act office for checks to be completed.

- At the time of our visit the CRHT, services did not have any patients on section 17 leave or a community treatment order (CTO). If any of the patients were assessed as requiring a CTO, the assessment took place on the wards prior to any referrals to the team.

- CRHT staff and doctors worked together to decide on matters in relation to the MHA. Doctors said that staff knew about the process of mental health act assessment as at times assessments had taken place within the CRHT service. There were yearly refresher

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.

courses for both doctors and approved mental health professionals for the MHA and code of practice. There had been an advert on the trust intranet for nurses to attend MHA training.

- There was no evidence of staff administering medication to patients in the place of safety. Staff were aware they did not have authority to administer medication to anyone detained under section 136 of the MHA.
- Mental Health Act procedures were not always being followed in the place of safety. Staff had not been completing all sections of the section 136 monitoring form. 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 recording when people had been detained under section 136 in line with the Mental Health Act Code of Practice.
- It was not clear if all patients were informed of their rights whilst detained under section 136 of the MHA. Some records stated that staff had told patients about their rights but had not given written information. This did not meet the guidance in the mental health code of practice 4.9. We found 29 incidents where staff had not informed patients of their rights whilst detained in the place of safety.
- The trust operational policy on the use of the place of safety was applicable to both Bushey Fields and Dorothy Pattison hospital. We saw that the policy had not been reviewed since 2011. This meant that it had not reflected the guidance in the revised Mental Health Act Code of Practice introduced in April 2015 and therefore staff using the place of safety were not fully informed.
- There were no records of patients under the age of 18 years being assessed at the place of safety.
- 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, they could request access to an advocate if they were to be assessed under the Mental Health Act process. Staff were able to print information about the patients' rights whilst under section 136, however we found no recorded evidence that this had been offered.

Good practice in applying the Mental Capacity Act

- Eighty-four per cent of eligible staff at Walsall CRHT team had completed mental capacity act training. However, only 64% of eligible staff at the Dudley CRHT team had completed the training.
- Although not a mandatory requirement, MCA training was available through e learning which was accessible through the electronic staff record (ESR). There were various components to the training such as capacity, consent and deprivation of liberty safeguards. The safeguarding training also included a general awareness of mental capacity.
- Staff told us that patients had to have capacity to be referred to the CRHT services. During medical reviews, capacity was always assessed as a standard part of the process.
- One member of staff told us they had received training and understood the working principles around the Mental Capacity Act. They used this in practice when they engaged with patients who had been referred. There was a mental capacity lead within the trust and staff suggested the approved mental health practitioners were a good source of information.
- Staff said that information and support were available from the clinical lead at the CRHT team in Walsall and the mental health act and mental capacity act office based at Dorothy Pattison hospital.

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

- We spoke with four patients; one told us that the CRHT team for Dudley had been very helpful; they felt like they were treated as a person and not an illness. Patients said that staff were respectful, patient and approachable and ensured that all questions were answered prior to leaving. Patients and carers told us that the doctors were considerate and involved.
- Patients told us when staff who they had not met before attended their homes the staff members would introduce themselves and make them feel comfortable.
- Information on how the CRHT services maintained confidentiality was presented the information packs. The pack discussed the care records, the information they contained and the trusts adherence to the data protection act.

Section 136 monitoring form did not include space to document people's individual needs in any detail. There was little or no information on oasis in the clinical record regarding additional notes about people's individual needs. However, in one case we found a record of staff who had responded empathetically to the needs of someone with claustrophobia.

The involvement of people in the care that they receive

- In 2015, the CRHT service had carried out an internal satisfaction survey and team evaluation for patients. Walsall CRHT services received 23 completed questionnaires; 82% of patients felt that they had been listened to during their time with the service. More than half of the patients were satisfied with arrangements and times of visits, 61% strongly agreed that they had been treated with dignity and respect. There were some negative responses around involvement in care planning and the usefulness of the information pack although some patients suggested that they had not received a copy. Dudley CRHT received a low response with only 12 questionnaires being received from patients. Patients fed back a 100% satisfaction concerning being given a copy of the discharge plan, being seen weekly by doctors, visits had been arranged to meet patient needs and being provided with enough information to meet their needs. Forty one per cent of patients said they had not received a copy of their care plan. We attended home visits and reviews with the staff and observed good interactions with the patients. Staff demonstrated a professional attitude and were respectful to patients and carers. They provided practical and emotional support and communicated with language that patients could understand and time was taken to explain all necessary information.
- Patients were given information packs that provide information on the CRHT service such as contact details, complaints procedure, advocacy and care programme approach (CPA). There was also information for carers regarding the carers support services. Patients said they felt included in their care and were encouraged to include family members. Although we saw staff including patients in the planning of their care, the care records we viewed showed no evidence of patient views.
- Advocacy was available to patients through 'POhWER'; leaflets were in the introduction pack given to patients at the start of their time with the CRHT services.
- The trust had an introduced 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.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The crisis resolution home treatment operational policy stated that as part of the criteria for inclusion patients had to be diagnosed with a mental disorder and be experiencing a mental health crisis. At the CRHT service in Walsall, patients were seen from the age of 16 years old. The CRHT service in Dudley would see patients from the age 14 years old that were under the care of mental health service in Dudley. Patients would have a GP or would be living within the geographical area served by either Dorothy Pattison hospital or Bushey Fields. 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 CRHT or crisis interventions.
- Referrals to the CRHT services were received though the place of safety, the early access service, liaison psychiatry, inpatient wards and general practitioners. Referrals were initially triaged and a response time allocated using a RAG rated system, Red (high risk), amber (medium risk) and green (low risk). Patients' names were added to the referral board and were seen within 24 to 48 hours of referral depending on the urgency. The trust did not monitor the time taken from initial assessment to the onset of treatment. There were no targets in place nationally or locally in relation to this.Referrals were discussed at each handover session and staff were allocated to carry out the home visits.
- The CRHT services were flexible with the appointment times and arranged them to suit the patient. We saw evidence of this within visits that we had attended and when patients had contacted the team asking to be visited at a relative's house. The shift co-ordinator made contact with staff to inform them of the change of address for the visit that morning.
- After 5pm, the entire crisis calls for CRHT services for Dudley and Walsall were diverted to the reception staff at Dorothy Pattison hospital. The calls were logged and contact made with the respective teams in order to alert the crisis workers. We saw call logs for Walsall CRHT from patients and carers.
- We looked at the recordings by the crisis workers on the oasis database at Walsall CRHT. We found that there had been long time lapses between returned calls to patients and carers in relation to when the call had first been registered. In some cases, there were no records of the person being contacted. We saw records on oasis from a general practitioner concerned that they had made an urgent crisis referral and no one had made contact with the patient. The last recording of this kind was on the 15 January 2016. It is not clear whether these issues had been logged as incidents and we were unable to determine a total figure of how many times this had occurred. We discussed our findings with staff and saw documented evidence of previous concerns raised by staff in relation to this matter. This was recorded in the September 2015, minutes of the team meeting for Walsall CRHT team. At the time, this was attributed to the time that staff had to spend undertaking assessments in the accident and emergency department. Staff said that patients had also made verbal complaints about response times to calls. Some staff who covered the night shift, were staying over there designated working hours in order to complete their work. Because of our concerns, we asked the trust for a response.The Trust undertook a twelve-month review off call logs, complaints and incidents data.During this period, there were 2 complaints received in relation to "Timeliness of Response" for Walsall CRHT. Only one of these complaints (received in July 2015) was subsequently investigated, upheld and addressed by the Trust (the other complaint was investigated but not upheld) and this was relating to a delay in response due to the CRHT worker carrying out an assessment in accident & emergency at that time. The Trust can confirm that there have been no further formal or informal concerns raised since in relation to this area or any clinical incident forms submitted by staff. The Trust has also ensured that the outcome of the complaint investigation has been considered by the local clinical commissioning groups.The Trust also enabled the senior nurse at Dorothy Pattison hospital to be able to support the Walsall CRHT at times of high demand.
- CRHT services discussed patients who do not attend appointments as part of the multi-disciplinary team (MDT). An MDT plan would be put in place following two to three non-attended appointments. Risks would be discussed and identified and other forms of contact or moving appointment times.

Are services responsive to people's needs?

Good

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

- Safe and welfare checks would be carried out for those who did not attend appointments.The urgency of the checks would be dependent upon the risks identified.

The facilities promote recovery, comfort, dignity and confidentiality

- The PLACE scores for privacy, dignity and well-being at Bushey Fields hospital were 93% and 82% at Dorothy Pattison. The trust average was 88%, which was below the national average of 91%.
- The health-based places of safety at both Bushey Fields and Dorothy Pattison hospitals had en-suite toilets and washing facilities.
- Both places of safety were sufficiently apart from other areas of the hospital and ensured confidentiality during mental health act assessments.
- Teams displayed information leaflets in a range of different languages for patients regarding their rights whilst detained under section 136.

Meeting the needs of all people who use the service

- Access to the place 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.
- The clinical lead for CRHT Dudley told us there was an established interpreting service used by the trust where advanced bookings were made for patients. If an interpreter was required at short notice could take a few hours dependent on the language skills required.
- Information packs were prepared and given to patients referred to the CRHT services. It included a range of information about the service and how it worked and how it could be accessed, medication and discharge.

Listening to and learning from concerns and complaints

- Leaflets were available in the information pack regarding NHS complaints advocacy services and the service experience desk. The service experience desk discussed how to make a complaint and support the patient could obtain.
- In the 12-month period prior to our inspection, 13 complaints were made to the trust for crisis and health-based places of safety. Ten of the complaints related to the CRHT team in Walsall; three related to the CRHT team at Bushey Fields hospital. Seven of the complaints were partially upheld; none of the complaints were referred to the parliamentary and health services ombudsman.
- Staff told us that they were aware of the complaints procedures; some examples were given where staff were involved in managing complaints such as not returning patient or carer calls. They were able to demonstrate knowledge of the complaints management procedure.
- Feedback from complaints and any subsequent investigations following a complaint was discussed in staff meetings.

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

- The trusts' vision and values: Integrity, caring, quality &collaborative (ICQC) were discussed regularly in team meetings and in supervision sessions.We saw posters within the team's bases that demonstrated how the services objectives reflected both the vision and values of the organisation. The Walsall CRHT team had been involved in the launch of the trusts visions and values. The team were featured on the trust intranet site where they discussed how the team met the visions and values.
- Staff knew who the senior managers were. The interim chief executive and the head of acute mental health had both visited the CRHT team in Walsall and joined staff during home visits.

Good governance

- Supervision was not taking place on a routine or consistent basis within the teams.
- Doctors completed prescription and medication audits.A care plan audit had been completed by the clinical lead, however not all staff routinely completed clinical audits.
- The trust used key performance indicators managed by the performance team.
- The clinical governance team would highlight any risks for the risk register to the clinical leads.
- Incidents were reported and discussed in team meetings. There were robust systems to learn from incidents and complaints; the trust had an embedding lessons team who disseminated information.
- Staff knew about local safeguarding procedures, referrals had been made for both adults and children deemed to be at risk of abuse.
- Staff had received training for the mental capacity act and were aware of the procedures; they could seek guidance from the clinical leads, doctors and approved mental health professionals.
- Mental health act procedures were not always being adhered to in the places of safety.
- Not all mandatory training was above the trust target.
- Clinical leads said that they felt supported in their role by senior managers. They were encouraged to attend supervision training, leadership training and coaching.

Leadership, morale and staff engagement

- The total percentage of permanent staff sickness for from October 2014 to September 2015 was 5% for the Dudley CRHT team and 3% in the Walsall CRHT team.
- The trust had implemented the "Speak up campaign" in order to improve concerns raised by staff in the preceding years with regards to bullying and harassment. The trust had introduced initiatives such as work place advisors and engagement champions in order to improve the culture; the staff that we spoke with were in general positive about the changes made. The executive team viewed improving the workplace culture and staff engagement as key outcomes on their strategic priorities for 2015/16.
- There was good positive promotion of development of staff and opportunities for secondment to senior posts in different teams and leadership courses were available. Postgraduate medical education took place weekly within the service.
- There was evidence of good working relationships within the CRHT service and with the clinical leads. Staff worked together to complete home visits, support had been more apparent during out-of-hours hours in both areas. Although the service operated differently during this time, the support available to them was used positively.
- Staff gave examples of being open, honest and transparent with patients when something had gone wrong. The clinical leads said they had spoken to staff regularly about duty of candour and the trust had been proactive in promoting this value.
- The clinical leads said the trust had implemented the 'Speak up' campaign, which concerned anti bullying and whistle blowing. One member of Staff said they had been aware of this. They did not feel intimidated and found their team diverse and helpful.

Commitment to quality improvement and innovation

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.

- The clinical leads at the CRHT service were researching different methods of electronic recording systems. Presentations were scheduled for the management team to show case the best systems and how it would benefit the service.

The trust had carried out local and national audits concerning safeguarding, triangle of care and psychological therapies.

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 18 HSCA (RA) Regulations 2014 Staffing Staffing The trust must ensure staff receive regular management supervision. This was a breach of regulation 18 (2)(a)under staffing regulation 18 (2)(a)

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment This was a breach under regulation 12(2)(g) The trust must ensure that controlled drugs dispensed by the trust for the patients use at home are recorded in a controlled drug register. The trust must ensure medication transported in locked containers or bags at Bushey Fields hospital.

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.