Dudley and Walsall Mental Health Partnership NHS Trust

Trust Headquarters

Quality Report

Trafalger House
47-49 King Street
Dudley
DY2 8PS
Tel: Trust switchboard 0300 555 0262
Website: www.dwmh.nhs.uk

Date of publication: 14/05/2014
Date of inspection visit: 25 and 26 February 2014

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

Summary of findings

Contents

Summary of findings

Overall summary

The headquarters of Dudley and Walsall Mental Health Partnership NHS Trust is in Dudley. This is where all of the trust's community activities are registered to, but the services are in various locations across Dudley and Walsall.

The community services we visited were :

- Children and adolescent mental health service
- Community services for older people
- Adult community-based services
- Community-based crisis services
- Specialist eating disorder services
- Other specialist services (Military veterans, Substance Misuse and the Recovery Intervention service)

We found that safeguarding and systems for reporting incidents were robust and ensured people were safe.

There was a consistent assessment approach across community teams, and information could easily be understood and transferred between the types of services.

There was a single assessment tool which ensured continuity and consistency of care.

Across the community services, we found good risk assessment in place, as well as systems for flagging where more than one member of staff needed to attend.

There was no formal induction programme in place for agency staff and they were not always aware of the trust's lone working policy.

There was a lack of out-of-hours and crisis intervention services for children and young people. Waiting times from initial assessment were lengthy.

There was good evidence of multi-agency and cross-sector working.

We saw good examples of learning from audits and incidents being shared across the trust, and practice being changed as a result.

There were inconsistencies in how the teams we visited obtained people's views.

We saw good examples of the executive team visiting local delivery teams, as well as positive involvement of non-executive directors.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Children and adolescent mental health service

We found that the trust's safeguarding systems were robust and were understood by staff. Safeguarding training was provided for all administrative staff and to temporary agency staff as well. Staff were able to tell us the name of the nominated lead for safeguarding within their team, and the trust.

Staff were able to describe to us in detail the process for reporting any serious incidents and confirmed they received feedback about reported incidents via their managers and in team meetings.

All new referrals to the service were screened daily by staff to assess the priority of children and young people's needs, and urgent appointments could be allocated if necessary.

We found that any potential risks to children and young people were assessed by staff, and there was a completed risk assessment in all 11 patient care records we reviewed.

Services for older people

We saw that a detailed risk assessment was completed for each person who attended the day hospitals. This assessment included the risks posed to people's physical health and the risks people posed to themselves and others.

The day hospital staff had access to the community services' computerised care records system, so they could access people's' previous and current community-based risk assessments. Staff were aware of people's risks.

We saw that people's risks were reviewed during their attendance at the day hospital. The nursing staff, medical team and care coordinators were all involved in reviewing these risks.

The managers of both day hospitals told us that they had staff vacancies, but this did not compromise people's safety as staff from the inpatient wards were occasionally used to fill any gaps.

Minutes of older people's services managers' meetings confirmed that staffing levels were currently under review.

The day hospital managers and community mental health teams told us that incidents were discussed in staff meetings.

Adult community-based services

Staff in all the teams we visited told us that they received safeguarding vulnerable adults and children training each year.

We were told that risk assessments were completed for each person using the service. Regular reviews took place with clinicians to assess their ongoing care and support needs. The risk assessments considered risks to the person, staff or from other people. There was a process in place to work positively with the person to enable them to recognise triggers and signs that would indicate they were at risk.

Managers told us that incidents were discussed and monitored on a monthly basis at the Quality and Governance meeting. Most staff we spoke with told us that they received feedback on incidents at local team meetings from their managers.

There was a lone working policy and procedure in place with a traffic light system to highlight where people presented a risk to staff safety.

However, the lone working policy was not always being followed. Staff working in the liaison team told us that they would see people on their own in the interview rooms in the A&E departments. We observed that these rooms did not have panic alarms and staff did not carry these.

Community-based crisis services

Staff told us that they received training each year on safeguarding vulnerable adults and children. They told us about their responsibility to refer any potential abusive situations to the relevant departments.

Every call to the crisis team was logged. Information was then passed to staff to assess and take the required action based on priority. Other agencies would be contacted if an urgent and emergency situation was identified.

An assessment was made of the level of risk people presented, and this was recorded on the assessment document. We saw plans in place to describe what actions staff and the person could take if there were elevated risks. We saw that all risks were recorded and the plans in place to minimise and manage risks.

Staff told us that at times, especially at weekends, they were very busy and more nurses would be beneficial. The crisis resolution and home treatment team (CRHT) were using agency staff due to staff vacancies; however there was no formal induction programme in place for agency staff and staff were unable to show us any documentation that induction had taken place.

Managers told us that incidents were discussed and monitored on a monthly basis at the Quality and Governance meeting.

Specialist eating disorder services

Staff received regular training in how to protect both adults and children, which was updated every three years.

Staff reported that they had confidence in the trust's incident reporting system. Lessons learned from any serious incidents were made easily available to staff via team meetings or the trust's intranet.

The level of risk to people's physical health was monitored closely and reviewed by the clinical nurse specialist during each appointment.

Other specialist services

Staff told us that individual concerns were discussed at their team meetings. They confirmed that they were encouraged to report incidents and 'near misses'.

Staff confirmed that the trust had an online reporting system to report and record incidents and near misses. We saw that the services had had three serious incidents that related to self-harm in a 12-month period, and that lessons that had been learned had been discussed in the team.

Each member of staff we spoke with told us that they received clinical, managerial and group supervisions from their line manager as required.

We saw that one team had vacancies and that another team had three people who were leaving shortly.

Senior staff informed us that, where agency staff were used this was usually the same people.

Are services effective?

Children and adolescent mental health service

Children and young people had access to a range of health and social care professionals within teams who were able to offer a range of therapeutic interventions.

Summary of findings

We found that evidence-based models of treatment were used to support children and young people, and staff reported that NICE (National Institute of Clinical Excellence) guidelines informed their protocols and procedures.

The service were using established clinical outcome measures to assess the effectiveness of treatment provided to children and young people. It had also developed a strong culture of audit and outcome monitoring.

Staff reported that they had good opportunities for training and development which informed their practice.

We found that waiting times for children and young people were long and varied within the service.

In order to address these long waiting times, the service had introduced a number of measures to support children and young people while they waited for further specialist services.

The number of referrals received had increased by 40% between 2012 and 2013 and this, combined with a reduction in clinical sessions in the last 18 months, were putting additional strain on waiting lists.

Services for older people

We saw that care and treatment at the day hospitals, community mental health teams and the memory service was based on national standards and guidelines.

The staff worked with other health and social care professionals to ensure that information about people's need was gained on admission and given on discharge.

Patient meetings were held in the day hospitals. These meetings focused on gaining people's opinions about the quality of the service.

We saw that the Walsall memory service had been accredited by the Royal College of Psychiatrists to the Memory Services National Accreditation Programme (MSNAP). We saw that recommendations from the MSNAP review had been formulated into an action plan that detailed how the service would improve.

Staff were able to give us information that demonstrated they understood the needs of the older people using their service. This included an understanding of the condition of dementia and the behaviours it could cause.

Adult community-based services

Staff reported close working relationships with the home treatment, out-of-hours and crisis teams.

Systems were in place for sharing information between these teams.

We were told that the way consultants refer people to the service, without discussion, is poor, but a regular meeting to discuss referrals is being developed.

Each referral was assessed by senior clinicians to establish what care and support the person may need. We observed a multi-disciplinary meeting where referrals were considered. We saw that risks were considered and also if other agencies would be of benefit to the person. After the initial referral, the same assessment format was used by all teams.

We observed a range of multi-disciplinary meetings and handover meetings. We found that multi-disciplinary teams communicated and worked well together to ensure coordinated care.

Formal reviews of care programmes were held every six months with clinicians, the person concerned and their representative.

We were told that regular random audits of the quality of Care Programme Approach (CPA) documentation was carried out by managers.

Summary of findings

In all of the teams we visited, staff told us they had access to regular training. We saw that participation in mandatory training was monitored and delays in attending training were followed up through staff supervision.

Community-based crisis services

Staff working in the crisis team were also part of the home treatment team. They told us they also worked very closely with the early access team.

Staff told us that there were times when they were extremely busy and the workload was high. They told us, and we saw, the systems in place for gaining help and support from other professionals if and when this was needed.

Each referral was assessed by senior clinicians to establish what care and support the person may need. We observed a multi-disciplinary meeting where referrals were considered. We saw that risks were considered and also if other agencies would be of benefit to the person.

We attended four visits to people's homes with members of the Crisis Resolution Home Treatment team, who talked with the person to ensure they were clear about how to access care and support if they needed it.

In care plans, we were able to see how referrals to other organisations had been completed with the person to address a variety of social, financial and physical health needs.

Specialist eating disorder services

Staff had manageable caseloads of about 18 to 20 people, allowing them to get to know people well and monitor their needs closely.

Staff were able to offer a range of interventions depending on the type of eating disorder people experienced, including dietary counselling, cognitive behaviour therapy and interpersonal psychotherapy.

The clinical nurse specialist told us that most people received treatment for 8 to 10 months, which was in line with NICE (National Institute for Clinical Excellence) guidelines for treating eating disorders.

Staff were supported by the trust to keep their skills and knowledge up to date.

Overall, people felt their treatment had been effective and had helped them gain and maintain their weight.

Other specialist services

From the evidence we saw and the discussions we had with managers and frontline staff, we saw the trust could demonstrate that people received care and treatment in line with the current best practice. The newly reorganised Recovery Intervention Services (RIS) gave people with chronic and long-standing mental health conditions an opportunity to attend skills-based, psychologically informed groups.

We saw that the trust worked collaboratively with a number of other providers within this service.

We received a clear description of how the military veterans' team worked closely with the trust and third sector providers to promote the mental health and other needs of military veterans.

People had signed their own care plans, which were then scanned into their computerised records.

The shared care team were able to give us examples of how they reached out to 'difficult-to-reach' groups.

We saw evidence that the trust's substance misuse care and treatment plans were being monitored and supported by senior staff and by external agencies specialising in drug treatment services.

Staff confirmed that they had received adequate training and support to prepare them for their role.

Summary of findings

Staff training was then embedded into individual's practice and assessed through a variety of methods.

Senior staff informed us that caseloads were monitored through clinical leadership and supervision. We were told that any concerns about caseload sizes had been identified, raised and addressed through the trust's risk register.

Are services caring?

Children and adolescent mental health service

Children and families told us that staff were professional, respectful and compassionate.

We saw that one clinician actively ensured she had full consent from young people for a student nurse to be present during their appointment. Parents said that they had received good support from staff. Most parents felt they had been consulted in the decisions affecting their child's care.

Staff told us that children and young people were offered a copy of their care plan that described the treatment and support they would receive. However, none of the parents and young people we spoke with appeared to know about their formal care plan and did not recall ever being offered, or given, a copy of it by staff.

Services for older people

Staff had the knowledge and skills to assess people's individual abilities to make decisions about their care and treatment.

People were involved in discussions about their assessment and treatment through their reviews and individual meetings with health professionals.

We saw that people could make decisions about their meals and could participate in activities of their choice.

We were unable to speak with people who received care from the community mental health team and the memory service, but the staff told us that people were involved in decision making.

Staff told us, and we saw, that people received regular reviews by the multi-disciplinary team.

We observed staff helping people to understand information appropriately.

We saw staff and people who use services interacting positively with each other. For example, we saw that the staff started conversations with people and they listened and responded well to their comments.

We looked at care records and spoke with a relative of one person who used the memory service. We saw that the person and their relative received appropriate assessment, treatment, monitoring and support from the staff. People who attended the day hospital told us they were treated with respect.

Adult community-based services

Staff told us that the lengths of the appointments with the clinicians were set to meet each individual's needs, so that they had enough time to discuss and agree their care and support needs.

Everyone we spoke with told us they had been involved in the care planning process and had been given copies of their care plans.

Community-based crisis services

Everyone we spoke with told us they had been involved in the care planning process and had been given copies of their care plans. However, care plans were written in an overly clinical way.

Summary of findings

We attended four visits to people in their homes with members of the crisis resolution and home treatment team. People were regarded with respect and talked to openly.

People knew where to contact staff if they needed urgent support. People were positive about their experiences of receiving community mental health services.

Specialist eating disorder services

We conducted telephone interviews with five people who used the service and received many positive comments from them about the quality and compassionate attitude of staff. We saw staff and people who used the service interacting well together, and the clinical nurse specialist worked collaboratively with people to help them manage their illness.

Other specialist services

We noted a wide range of information was available for people at each location we visited. The treatment records we saw demonstrated a person-centred approach to care but that, where applicable, carers' involvement was recorded if people who used the service wanted this.

We saw good examples of joint working arrangements with third sector providers.

People who used these services had the opportunity to discuss their care, support and treatment with their key worker and care co-ordinator where applicable.

Staff told us that they had received 'equality, diversity and human rights' training. We observed staff interacting positively with people.

Are services responsive to people's needs?

Children and adolescent mental health service

We found committed staff who could respond quickly and effectively when children and young people needed immediate support.

However, the service was only available between 9am and 5pm and was not commissioned to provide evening and weekend clinics.

Clinicians told us they often worked additional hours to avoid out-of-hours admissions to hospital, which had an impact on their time for routine work.

We found evidence of good multi-agency working to provide support for children and young people. Children and adolescent mental health service staff visited hospital wards to support staff caring for children and young people while they waited for a specialist inpatient service.

Staff told us that interpreting and translation services were easy to access and could be organised quickly to support people whose first language was not English. However, we did not see any posters or information in any other languages.

Parents and young people were given an information pack with good information about the trust's service experience desk.

Services for older people

The staff who worked within community services for older people worked with inpatient staff to ensure people received care and treatment in the most appropriate environment.

The staff and relatives we spoke with told us there was no dedicated out-of-hours crisis service for older people. One relative confirmed that they were unable to access specialist out-of-hours support when their relative became unwell.

Summary of findings

We observed a patient meeting, which are designed to seek feedback from patients in the day hospitals. We saw that people were asked to give their feedback on the performance of staff, the groups and the food.

There was a complaints system in place that people who use services and their representatives could use.

Adult community-based services

Staff told us the Early Access Service was the single point of contact with the service during office hours. Generally, people in crisis were referred via their GP, the police or other professionals.

The professionals within this team work closely with people in their own homes in an attempt to reduce the need for hospital admission.

People were referred to the Community Recovery Service by the Early Access Service. Staff told us that there were difficulties with referring people back to primary care services, which could affect the length of time a person used this service.

In the liaison services, most people we spoke with could not remember being formally asked to share their views of the service.

Out-of-office-hours support was provided to people through a crisis resolution team. Each person we spoke with knew how to contact this team.

We were told that access to cognitive behavioural therapy is a problem for people in primary care.

A clear complaints system was in place, which fed back at the end of any investigation to the relevant groups so that they could learn from the complaints, or bring about changes in practice.

Community-based crisis services

The crisis team is based at two locations; one in Dudley at Henry Lautch centre at Bushey Fields Hospital and the other one in Walsall at the Dorothy Pattison Hospital. There is only one member of staff on duty from 9pm to 8am at each hospital.

We saw a record of a call from a person who was in crisis and had thoughts of self-harm. We saw that the call was answered and responded to within one minute and swift action was taken to reduce the risk.

We found that inpatient services used a paper-based recording system and did not put information into the electronic care planning and recording system used by the community mental health services. One staff member gave us an example where a person had been discharged without any care programme approach paperwork.

Staff told us that people had a review of their care, as often as required depending on people's care needs and their level of risk. Records indicated that where concerns had been identified, when nurses were out on visits, a review with the doctors was immediately carried out.

Mobile phones were provided to all members of the crisis team so that they could be contacted when a referral to the service was made. The trust's website included information on the service and the action people can take in a crisis.

Specialist eating disorder services

There were no waiting lists for the service and people told us they had been seen quickly by the clinical nurse specialist once they had been referred to the service.

We found that staff responded quickly when people's physical or psychological needs changed and referred them for additional support when necessary.

Summary of findings

We found there was good collaboration with a number of relevant agencies to ensure people's needs were met.

There were established links with children and adolescent mental health teams so that young people continued to receive support with their eating disorder when they moved to adult services.

People were also asked if they wanted to receive copies of letters sent about them to health and social care professionals so they were aware of any communication about them. However, people did not receive a copy of their initial assessment, or sign it to show that it was an accurate representation of their needs.

Other specialist services

We saw examples of where people had self-referred or been referred by their families to the Military Veterans' service. Staff reported that the building at Lantern House was not suitable; for example, accessibility for the disabled. They told us that this was on the trust's risk register.

We saw evidence in some care plans of people's cultural needs being assessed and discussed with them. The records showed us that people were well supported when and if they moved from one provider to another.

We saw close working between the military veterans' service and the substance misuse services.

Staff were aware of the trust's complaints policy and confirmed that any complaints are addressed through the trust's complaint procedure. They confirmed that complaints handling was part of the trust's 'customer care training'.

We saw a number of posters around the locations we visited welcoming the views of people and referring them to the trust's service experience desk

Evidence of trust-wide learning from complaints and incidents was demonstrated through the 'Wednesday Wire' and the monthly 'team brief'. These included updates and 'key messages' for staff.

Are services well-led?

Children and adolescent mental health service

We found that senior executives and managers actively engaged with staff in a number of ways. Staff told us that senior managers regularly visited the service so that they had a better understanding of how it operated.

A staff member told us that some board meetings were held at the community clinic in Walsall, making senior executives visible and accessible to staff.

We found cohesive teams who were supported well, both formally and informally. Staff sickness and turnover rates were low within the service.

We found significant variations in service provision between the Dudley and Walsall children and adolescent mental health services. This resulted in differing referral and screening processes, clinician profiles and waiting times.

We were told that there was active engagement with the commissioners to address the lack of provision in out-of-hours and crisis intervention services for children and young people.

Feedback about the service was collected through satisfaction surveys and it was used to improve the service. We saw that the waiting area in the Dudley Clinic was undergoing some refurbishment following suggestions from families.

Services for older people

All the staff we spoke to told us about changes in the way some of their services were being commissioned, which was improving care, but they also told us they were unclear about the future of the services.

Summary of findings

The staff told us they had regular team meetings where they discussed service improvement at a team and trust level. Most staff felt they were engaged in service improvement.

Leadership teams met monthly to discuss quality issues. The minutes of the meetings confirmed that representatives from community services for older people attended.

The trust had recently identified concerns with the leadership and management of services for older people, and a new management structure had recently been put in place.

Adult community-based services

Most of the staff we spoke with told us they felt well supported by their managers.

Regular team meetings were held with minutes of the meetings completed.

Senior managers told us that a wide range of professionals from across all disciplines attended a meeting known as the Quality and Governance meeting.

A focus group with community workers was held as part of this inspection. Staff were generally positive about the recent changes but some reported they felt 'disaffected' and 'unsupported'.

Staff told us that communication about the trust reconfiguration was not good.

We were told that supervision is very good and specifically considered personal development.

They told us that senior managers and members of the Board had engaged them, provided information and consulted with them in a variety of formats. Staff reported to us that morale in teams was high.

Staff reported that waiting lists were effectively managed. Higher levels of caseload numbers were escalated to board level for a risk management discussion to take place and action plan development.

Community-based crisis services

Staff told us that they felt well supported by their managers and peers. Regular team meetings were held with minutes of the meetings completed.

Some staff from the community reported that neither they nor people who used the service had been sufficiently engaged in the transformation process of the service.

Specialist eating disorder services

Staff felt that senior managers had a good understanding of the service they offered and were responsive to their concerns.

Senior managers regularly visited the service and the trust's head of governance and the head of estates had recently visited the Walsall service.

We found that staff received good clinical supervision of their work, which was provided by specialist eating disorders professionals outside the trust.

We found no evidence that people had been involved in the design and delivery of the eating disorders service.

Other specialist services

The service was involved in the quarterly clinical governance meetings held with public health and attended by other partners, including general practitioners and charitable providers.

Summary of findings

Each member of staff spoken with told us that they received clinical, managerial and group supervisions as required

Staff confirmed that members of the executive team visit monthly and that the non-executive directors took an interest in their service.

The service is currently recruiting a specialised 'experts by experience' group.

A trust-wide risk register was in place and senior staff told us that this was generally an effective tool for capturing ongoing concerns.

Some staff expressed concerns about the service transformation process. Other concerns were identified about the tender process which had led to the loss of the substance misuse service from one part of the trust to an independent provider.

Summary of findings

What we found about each of the main services at this location

Child and adolescent mental health services

Overall, we found that children and young people received their care from well trained and qualified staff who understood their needs.

Staff were committed to, and enthusiastic about, their work and received good support and supervision. However, some children and young people waited a long time for a full assessment of their needs, and for access to specialist therapies. We found significant gaps in the service as there was no access to services out of hours, or intensive homecare provision to support children and young people in a crisis. IT systems were time consuming and frustrating for staff, and hindered their ability to work effectively.

Services for older people

People were assessed to establish if they were a risk to themselves or others. Where risks were identified, plans described how the risks should be managed. This meant that plans were in place to protect people from receiving unsafe or unsuitable care.

We saw that the care and treatment provided was based on national guidance, and therefore followed current good practice. Staff showed us that they had the specialist knowledge and understanding to meet people's needs.

We saw that people were treated with dignity and respect and care and treatment was provided in a caring and compassionate manner.

People's feedback was sought to measure the quality of care. Action was taken to respond to feedback in a prompt and effective manner.

Systems were in place to enable people to be transferred and discharged from the services. We saw that staff worked well with people who use services, their representatives and other professionals to ensure people received the right care in the right environment.

We identified that there was no dedicated service to meet the needs of older people who were in crisis out of standard working hours. This meant that some people and their relatives did not receive the right support at the right time.

Staff told us the future of community services was unclear, but most of the staff told us they felt engaged in discussions about future services.

The trust told us they had recently implemented a new management structure within older people's services in response to quality concerns. This meant that the trust had taken appropriate action to address the concerns that had been raised.

Adult community-based services

Community Recovery Service for people in Walsall

The staff team consisted of clinicians and professionals who were well trained and knowledgeable.

Referrals to the service were responded to quickly, and action was taken according to the person's level of risk.

Records were made of contacts with each person to ensure a detailed account of the support provided was available for other professionals involved with their care.

Links with other community services had been established to support people with their individual needs and to reduce the need for hospital admissions.

Summary of findings

Community Recovery Service for people in Dudley

The team is caring and works well with other teams and agencies. The team is responsive to service user needs.

Early access service

The staff team consisted of clinicians and professionals who were well trained and knowledgeable.

Referrals to the service were responded to quickly, and action was taken according to the person's level of risk.

Records were made of contacts with each person to ensure a detailed account of the support provided was available for other professionals involved with their care.

Some people who used the service were positive about the staff, saying they were helpful, friendly and supportive. Other people were not so positive and reported not being listened too or supported as they felt they should be.

Liaison services

All of the staff that we spoke with were familiar with incident reporting, safeguarding people and risk assessing. There was a lone working policy in place; however this was not always being followed, which meant there was a risk to the safety of staff and people using the service.

There was an effective assessment procedure in place, as well as effective multi-disciplinary working. Staff were able to access training and support.

People were involved in the care planning process. Care plans were clear, goal oriented and included people's views.

Feedback about the service at a local level was not being sought, which meant it could not inform service planning for the local community. There was a clear complaints system was in place.

Most of the staff we spoke with told us they felt well supported by their managers. Clinical audit was carried out periodically throughout the year.

Community-based crisis services

The community based crisis team is staffed by well-trained, skilled professionals. Referrals to the service were responded to quickly and action taken according to the person's level of risk.

Records were made of each contact with the person to ensure a detailed account of the support provided was available for other professionals involved with their care.

On-call doctors and senior nurses were available to support staff with decision making in the event of an emergency.

It was reported that at times the service was extremely busy and, with high workloads, additional staff may be beneficial.

Community-based crisis team out-of-hours service

The service was staffed by well-trained skilled professionals. Referrals to the service were responded to quickly, and action taken according to the person's level of risk.

Records were made of each contact with the person to ensure that a detailed account of the support provided was available for other professionals involved with their care.

On-call doctors and senior nurses were available to support staff with decision making in the event of an emergency.

It was reported that at times the service was extremely busy and, with high workloads, additional staff may be beneficial.

Crisis Resolution Home Treatment Team (CRHT)

Summary of findings

All of the staff that we spoke with were familiar with incident reporting, safeguarding people and risk assessing.

There was an effective referral and assessment procedure in place, as well as effective multi-disciplinary working. Staff were able to access training and support.

People were involved in the care planning process. Care plans were clear, goal oriented and included people's views.

Feedback about the service at a local level was not being sought, which meant that it could not inform service planning for the local community. There was a clear complaints system was in place.

Most of the staff we spoke with told us they felt well supported by their managers. Clinical audit was undertaken periodically throughout the year.

Specialist eating disorders services

Overall we found that people experienced responsive care that promoted their physical and psychological recovery. People's needs were fully assessed and any physical risks they faced were closely monitored. Staff worked well with other agencies to ensure that people received additional support when necessary. Staff told us they enjoyed their job and received good supervision of their work. They reported that senior managers were easy to engage with and took their concerns seriously. However, we found that the quality of the service was not routinely monitored or assessed to determine its overall effectiveness.

Other specialist services inspected

The provision of these services was safe. The trust had good systems in place to review incidents and near misses. This included a formal debrief for staff and discussion during clinical, managerial and group supervisions for frontline staff. We saw that people's treatment records clearly identified current concerns and assessed risks. These had been reviewed based on an evaluation of each specific treatment episode. Comprehensive risk assessments were seen and these included assessments of the person's physical health and their risks to themselves or others where applicable. We saw evidence of the active involvement of the person in assessing risks for themselves – for example, associating with certain groups of people. The trust was actively recruiting to staff vacancies.

The effectiveness of these services was good. For example, we saw that the trust's substance misuse care and treatment plans were being monitored and supported by the National Drug Treatment Management Services (NDTMS). We noted that the service monitored their care outcomes via the 'treatment outcomes and program performance system'. This was a specific outcome measure used to monitor treatment effectiveness. We identified good examples of collaborative working with stakeholders and other partners. Staff told us that they had received their mandatory training and we saw good examples of additional skills-based training for specific team members.

The services provided were caring. This was confirmed by our observations and discussions with frontline staff during our inspection. Additional evidence to support this was individual treatment records, feedback received from people and the trust's and external agencies' quality monitoring systems. We saw good examples of individualised and person-centred care being provided. We saw that staff were engaged at a local level. They felt that they were doing the best they could for people. They told us that they felt that people got a 'good service'.

The service's ability to respond to people's needs was good. We saw a number of posters around the locations we visited welcoming the views of people and referring them to the trust's service experience desk. Staff at one location explained how they worked closer with independent advocacy services to try and support people. We saw examples of where the military veterans champion had supported people to access support from war veterans' charities where this was

required. Staff informed us that local actions were taken to address any informal complaints in a prompt manner. For example, if a person wanted to change their therapist or key worker this would be discussed within the team. However, the trust should be aware that the results of the recent patient survey were being collated and were not available for inspection.

Local leadership was proactive and we saw good examples of service leadership that led to effective service delivery. We saw some good examples of the executive team visiting local delivery teams and the positive involvement of non-executive directors where applicable. However, the trust should be aware that some staff expressed concerns about the service transformation process and about 'change exhaustion'. Other concerns were identified about the tender process which had led to the loss of the substance misuse service from one part of the trust to an independent provider.

Summary of findings

What people who use the location say

As part of this inspection we looked at survey results, held groups with people using the services and their relatives, spoke with some individuals who requested to speak to us individually and used comment cards before and during the inspection.

Community Mental Health Patient survey 2013

The Community Mental Health survey is sent to people who received community mental health services from the trust.

This survey was conducted to find out about the experiences of people who receive care and treatment. Those who were eligible for the survey were receiving specialist care or treatment for a mental health condition, aged 18 and above and had been seen by the trust between 1 July 2012 and 30 September 2012.

Analysis of data from the Community Mental Health Patient Experience Survey 2013 shows that the trust is performing 'about the same' as other trusts in all nine areas.

Listening Events

We held a number of listening events over two days before our inspection.

We held a public listening event at Walsall Football club, where we received lots of positive comments about activities in the community and the caring staff that work there.

All of the positive comments about the inpatient wards were about the caring staff that supported people at the right time and helped people to recover.

Some negative comments were about staff seeming to be stretched, fear of making complaints in case of staff reprisal, concern that staff did not fully consider cultural issues and the impact on care and treatment. Some people raised issues about the environment as they said everywhere was locked.

We also ran three listening events for detained patients and people subject to a Community Treatment Order. At these events, people told us that the staff were caring and respectful. They told us they are encouraged to write issues down for multi-disciplinary team meetings and reviews so that they do not forget what they want to discuss. Some people told us they know what their care plan is and that they were involved in their care. People living in the community were very positive about the support given to them after they had been discharged from hospital. People said they were helped to find accommodation and work

However, they also said there were not enough staff, which meant sometimes they could not speak with staff when they wanted to. Lots of patients said that often there were not enough staff to facilitate Section 17 leave. Some people found that living in a mixed sex unit was difficult and not helped by the way wards are staffed. People also said there were few activities on the wards. People were concerned about access to services, especially crisis services and access to psychological therapies.

Dudley Mind focus group

Before the inspection, Dudley Mind facilitated a focus group so that people who use, or have used, the services provided by the trust could share their experiences of care. This group provided a wide range of responses to the five questions that we always ask about services.

The majority of people felt that the services were safe and that they were kept safe.

Most people felt that the care and treatment they received was effective, if not always at the right time. Some people were concerned about the lack of access to psychological therapies and the length of time it could take to see a psychologist.

There were some very positive comments about staff; how caring and committed they were and how they would try to make sure that all needs were met, either in the community or in the inpatient wards.

Some people felt that services were responsive to people's needs, but there was a lot of negative feedback about the responsiveness and effectiveness of crisis services. People said that when they rang the crisis line, they were often advised to go straight to A&E or to make an appointment with their consultant psychiatrist the next working day.

Summary of findings

Comment cards
We left comment cards at three hospital sites and community locations before and during the inspection.

Of the 72 comment cards returned, 16% (12) were illegible.

81% (59) mentioned the staff in a positive way: for example, comments included 'staff are lovely', 'staff always treat me well', 'staff are good to me'.

Of the 59 comment cards that spoke of staff positively, 71% (42) also stated that they thought there should be more staff available.

One card expressed a negative opinion about the service and this person felt that not enough notice was taken of patients' opinions and there was not enough to do.

Areas for improvement

Action the provider SHOULD take to improve

- Develop robust induction procedures for all agency/ bank staff, especially when working within community teams.
- Reduce the waiting times for children and adolescent mental health service patients, following their initial assessment to receiving clinical interventions and treatment.

Action the provider COULD take to improve

- The trust should agree and implement a plan to provide access to the full range of evidence-based psychological therapies that are provided through the trust, as these are an integral part of people's care and treatment.
- Work with commissioners of services to ensure a more responsive children and adolescent mental health service out of hours.

Good practice

Our inspection team highlighted the following areas of good practice:

- Communication and information sharing across the community teams and with the inpatient services.
- Strong multi-agency and cross sector working.
- There was a single assessment tool that ensured continuity and consistency of care.

Trust Headquarters

Detailed Findings

Services we looked at:
Child and adolescent mental health services; Services for older people; Adult community-based services; Community-based crisis services; Specialist eating disorder services; Other specialist services inspected

Our inspection team

Our inspection team was led by:

Chair: Angela Greatley, Chair, The Tavistock and Portman NHS Foundation Trust

Team Leader: Jenny Wilkes, Mental Health Act Operations Manager, CQC

The team included CQC Inspectors, Mental Health Act commissioners, a pharmacist inspector and two analysts.

We also had a variety of specialist advisors which included consultant psychiatrists, psychologists, senior nurses, student nurses, social workers, senior managers and a GP.

We were additionally supported by two Experts by Experience who have personal experience of using or caring for someone who uses the type of services we were inspecting.

Background to Trust Headquarters

The Trust's Headquarters is located in Dudley. This is the registered location for all of the trust's community-based services.

While the services are registered to this location, many of the services are located throughout Dudley and Walsall.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

One reason for choosing this trust was because they are a trust that has applied to Monitor to have foundation trust status. Our assessment of the quality and safety of their services will inform this process.

How we carried out this inspection

To get to the heart of people who use services' experiences of care, 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?

Detailed Findings

- Is it well-led?

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew about the provider.

We held a public listening event on the 12 February 2014 and also met with groups of detained patients on 12 and 13 February at all the hospital locations.

We carried out an announced visit on 25 and 26 February 2014. We undertook site visits at all the hospital locations. We inspected all the acute inpatient services and crisis teams for adults of working age and older people. We also visited the specialist inpatient services and a sample of the community teams.

During the visit we held focus groups with a range of staff in the location, such as nurses, doctors, therapists, allied health professionals. We talked with people who use services and staff from all areas of each location. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences receiving services from the provider. We carried out an unannounced visit on the evening of 28 February 2014 and a follow up announced visit on the 11 March 2014.

Child and adolescent mental health services

Information about the service

Children and Adolescent Mental Health Service (CAMHS) is a multi-agency and multi-disciplinary service which specialises in the assessment and treatment of moderate to severe mental health difficulties that children and young people experience. The service is operated from two community clinics; one at Canalside in Bloxwich and other at The Elms Health Centre in Dudley.

Summary of findings

Overall, we found that children and young people received their care from well trained and qualified staff who understood their needs.

Staff were committed to, and enthusiastic about, their work and received good support and supervision. However, some children and young people waited a long time for a full assessment of their needs, and for access to specialist therapies. We found significant gaps in the service as there was no access to services out of hours, or intensive homecare provision to support children and young people in a crisis. IT systems were time consuming and frustrating for staff, and hindered their ability to work effectively.

Child and adolescent mental health services

Are child and adolescent mental health services safe?

We found that the trust's safeguarding systems were robust and were understood by staff. Staff confirmed they received training in safeguarding people which was regularly updated. Safeguarding training was provided for all administrative staff and to temporary agency staff as well. Staff were able to tell us the name of the nominated lead for safeguarding within their team, and the trust. They reported they had good support from their manager if they needed to discuss any safeguarding concerns and were also able to seek advice from social work colleagues in their teams. Staff reported that trust's newly implemented safeguarding database allowed them easy access to guidance and on-line reporting forms.

Staff were able to describe to us in detail the process for reporting any serious incidents and confirmed they received feedback about reported incidents via their managers and in team meetings.

All new referrals to the service were screened daily by staff to assess children and young people's priority of need and urgent appointments could be allocated if necessary. There was a specific rota of staff who could respond within 24 hours Monday to Friday to any children and young people admitted to paediatric wards following self-harm and staff were able to provide additional follow up support within seven days to ensure their safety if needed.

A duty consultant was appointed each day to provide immediate advice and support to young people, children and staff during working hours. However, as there was no access to CAMHS out of hours, this meant that children and young people presenting in mental health crisis were managed by adult mental health services, A&E departments, paediatric or emergency services.

We found that any potential risk to children and young people were assessed by staff and viewed completed risk assessments in all eleven patient care records that we reviewed. Staff we spoke with told us they had received regular training in assessing risks to children and young people, including specific training in suicide risk assessment and management. Weekly meetings were held to review complex cases to ensure that any emerging risks to children and young people were identified and responded to swiftly by staff.

Are child and adolescent mental health services effective?
(for example, treatment is effective)

Children and young people had access to a range of health and social care professionals within teams including social workers, occupational therapists, nurse specialists, psychologists and psychiatrists who were able to offer a range of therapeutic interventions. One young person told us, "I've done family therapy, DBT (dialectical behaviour therapy) and I get support from the eating disorders nurse. The DBT is the best; it's definitely turned things around for me".

We found that evidence based models of treatment were used to support children and young people, and staff reported that NICE (National Institute of Clinical Excellence) guidelines informed their protocols and procedures. Consultant psychiatrists reported that established clinical outcome measures were used to assess the effectiveness of treatment provided to children and young people and that a strong culture of audit and outcome monitoring had been developed within the service. Clinicians were aware of the importance of audit in improving practice. However we heard from the team manager and other staff that, although pre-and post-treatment forms were completed, these were not analysed in order to assess the effectiveness of clinicians or the service. The manager stated that he hoped this would be remedied once the new IT system was fully operational.

Staff reported that they had good opportunities for training and development which informed their practice. One family therapist reported she had received recent training in EMDR (eye movement desensitisation reprocessing) which had helped her work more effectively with young people who had experienced trauma.

Parents and young people we spoke with during our inspection told us that the treatment they had received had been effective. One parent reported, "The service has helped the whole family a lot. The speech and language therapist arranged lots of different assessments: the diagnosis took ages to get, but the wait was worth it". One young person told us that he had been taught specific techniques to manage his anger which had resulted in less

Child and adolescent mental health services

fights with his parents and school friends. However, we found evidence in the case notes we reviewed of very long engagements with some young people, with no clear plan or focus for their discharge from the service.

In order to address long waiting times for people, the service had introduced a number of measures such as 'Choice plus' appointments and additional appointments with a partnership worker to support children and young people whilst they waited for further specialist services.

However, these measures impacted on the delivery of routine and planned interventions and tied up resources within the service that could have been used more effectively in active therapy for children and young people.

The service was also dealing with a number of pressures that were impacting on its overall effectiveness. The number of referrals received had increased by 40% between 2012 and 2013 and this, combined with a reduction in clinical sessions in the last 18 months, was putting additional strain on waiting lists. We were told that 40% of psychiatric clinic time was spent on straight forward medication reviews for children and young people alone, which impacted significantly on staff's workloads.

The trust's Oasis IT system was very time consuming for staff and entering information from children and young people's initial needs assessments often took longer to complete than the actual assessment itself. The team manager told us that IT system was not yet developed well enough to allow him to pull of analytical reports about the service in order for him to monitor it effectively.

Feedback about the service was collected via satisfaction surveys and used to improve the service. We saw that the waiting area in the Dudley Clinic was undergoing some refurbishment following suggestions from families. The service had recently commissioned 'Young Minds' (a charity that works on behalf of young people with mental health problems) to lead a consultation with parents and young people about the development of specialised services to meet the needs of those with more complex mental health needs. However, there were no clear benchmarks or key performance indicators in place for the service. Without these it was not clear how its effectiveness or quality was monitored to ensure that children and young people received a good service.

Are child and adolescent mental health services caring?

Children and families we spoke with reported that staff were professional, respectful and empathetic to their needs. Children and young people told us they had been listened to by staff and that staff had understood their worries. One young person reported, "I don't mind coming here at all, X (clinician) is great and just like really gets how I'm feeling". One parent told us, "I find X (clinician) very calm and reassuring: my son finds it easy to open up to her."

In interviews with staff we found they demonstrated a caring, respectful and thoughtful attitude to the families and young people they supported. During our visit to the Walsall clinic, we saw that one of the clinicians actively ensured she had full consent from young people for a student nurse to be present during their appointment.

Parents we spoke with reported that had received good support from staff. One parent told us she had been given, "a huge pack of information" about autistic spectrum disorders which had helped her better understand her son's behaviour. Two parents told us they had been given details about a parents' group that they could attend for additional support if needed. Most parents felt they had been consulted in the decisions affecting their child's care and that clinicians had given them an understanding of the help their child received. One commented, "I was a bit anxious about the medication, but the psychiatrist explained both the pros and cons for it, and I have to admit, it's really helped".

We saw that parents had been copied into all correspondence letters about their child, ensuring they were aware of any communication between health and social care professionals concerning their child.

Staff told us that children and young people were offered a copy of their care plan which described in detail the treatment and support they would receive. However, none of the parents and young people we spoke with appeared to know about their formal care plan and did not recall ever being offered, or given, a copy of it by staff. We found no formal care plans available in nine of the eleven patient care records we reviewed.

Child and adolescent mental health services

The premises at the Walsall site were not particularly welcoming for people. Signage indicating where the service was located was poor and the reception area was surrounded by thick glass, making it difficult for people to communicate with the staff behind it.

Are child and adolescent mental health services responsive to people's needs? (for example, to feedback?)

We found committed staff who were willing to go the extra mile to deal with crises and were provided with examples of where they had been able to respond quickly and effectively when children and young people needed immediate support. However, there was no specific crisis or intensive home treatment provision should children and young people's mental health suddenly deteriorate. Staff told us of an occasion where this lack of provision had resulted in one young person being cared for on a paediatric ward for four and a half weeks whilst they awaited an inpatient bed. Clinicians told us they often worked additional hours to pre-empt out of hours admissions to hospital which impacted on their time for routine work.

The service was only available between 9am and 5pm and was not commissioned for the provision of evening and weekend clinics, meaning that parents often had to take time off work to attend, and children and young people missed school. One parent told us that appointment times weren't provided consistently on the same day or at the same time, describing them as being 'scattered' across the week, making planning attendance at them very difficult. We found the large majority of therapeutic interventions for children and young people were only offered in the clinic itself, meaning some families had long and complicated journeys to attend them.

We found evidence of good multi-agency working to provide support for children and young people. For example, there were well established and effective links with the Early Intervention in Psychosis and Paediatric hospital teams. CAMHS staff visited hospital wards to support staff caring for children and young people whilst they awaited a specialist inpatient service.

We found that waiting times for children and young people were long and varied within the service. Children and young people in Walsall waited on average eight weeks from their initial referral to their first 'Choice appointment', those in Dudley waited 12 weeks. There were then additional waits for follow on 'Partnership' appointments of another eight weeks in Walsall and 12 in Dudley. This could be followed by much longer waits for specialist appointments such as psychology, speech and language therapy, and psychiatry. We found evidence in the case notes we reviewed of long waits for some children and young people before they received the most appropriate treatment. We found specific examples where these waits had led to deterioration in their mental health. Parents we spoke with told us about long delays in getting a diagnoses for their children and long waiting times to access specialist clinicians, causing them frustration and stress.

The trust had recently implemented a new protocol to improve the way young people transitioned into adult mental health services and staff were confident this would make the process much clearer and smoother for all. Young people with an eating disorder or those who required psychiatric input received continued support when they transitioned to adult mental health services. However, young people who required more specialist psychology input at secondary care level did not receive a service once they transitioned. Young people with complex mental health needs who received specialist psychological interventions while under the care of CAMHS were unable to receive the same level of support from adult mental health services. The exceptions were if the young person had a psychiatric diagnosis, and/or input from a psychiatrist while with CAMHS. Psychological therapies were available in adult services from primary mental health care; however, the mental health needs of this group of young people were usually too complex to be managed at primary care level.

Staff told us that interpreting and translation services were easy to access and could be organised quickly to support people whose first language was not English. However we did not view any posters or information in other languages in the reception areas we visited. There were a number of trust wide initiatives to engage people from black and minority ethnic communities, however there were no specific CAMHS projects in place to actively engage children and young people from these groups.

Parents and young people were given an information pack with good information about the trust's service experience

desk, where they could raise their comments or concerns. It also contained details of advocacy organisations and local support groups. We noted information about the trust's service experience desk on the walls of reception areas, making it easily available to parents and young people.

Are child and adolescent mental health services well-led?

We found that senior executives and managers actively engaged with staff in a number of ways. Staff told us that senior managers regularly visited the service so that they had a better understanding of how it operated. Key messages about the trust were communicated to all staff via monthly team briefs and regular 'Wednesday Wire' emails. One member of staff told us, "We're briefed about anything and everything we need to know" Two staff members told us about 'Ask Gary': an initiative which allowed staff to email the Chief Executive directly with any questions and concerns they had. One staff member was pleased to report that he had received a speedy response from Gary himself. Another staff member told us that some board meetings were held at the community clinic in Walsall, making senior executives visible and accessible to staff.

We found cohesive teams with significant levels of both formal and informal support for staff within them. Staff sickness and turnover rates were low within the service. Staff reported they received good leadership from the team manager who was described as, "accessible and supportive". They told us he was implementing good changes to address the differences between how the two CAMHS teams operated. However, the plans for redesign appeared to be formulated at a management level and not in partnership with staff or people who used the service.

There was a strong ethos of multi-disciplinary work within teams and staff appeared to have a mutual respect of each other's disciplines and skills. One staff member told us, "There is a lot of openness and I like that about this team. We can all be heard, and we do all respect each other".

We found significant variations in service provision between the Dudley and Walsall CAMHS teams, resulting in differing referral and screening processes, clinician profiles and waiting times. Until January of this year, the service's Dudley community clinic had been without a manager for two years leaving staff to appoint their own "self-styled" management team. However a new pan trust team manager had recently been appointed and plans were being considered for change to streamline the two services, and to strengthen leadership within them. There was also active engagement with the commissioners to address the lack of provision in out of hours and crisis intervention services for children and young people.

Services for older people

Information about the service

During our inspection we looked at the following community services for older people:

- Birch day hospital is located at Bushey Fields Hospital in Dudley and the Beeches day hospital is located at Bloxwich Hospital in Walsall. The day hospitals offer specialist assessment, care and treatment to people who are experiencing mental health difficulties over the age of 65, or in the case of organic illness may be under 65.
- The community mental health teams for older people provide care and support to patients in the Walsall and Dudley areas within their homes or local community.
- The Walsall memory service offers assessment and diagnosis to patients for whom memory problems are the primary symptom. They also provide treatment to patients who are diagnosed with dementia.

We did not look at the care and treatment that was provided by the Dudley memory service, but we will look at this service at our next inspection.

Summary of findings

People were assessed to establish if they were a risk to themselves or others. Where risks were identified, plans described how the risks should be managed. This meant that plans were in place to protect people from receiving unsafe or unsuitable care.

We saw that the care and treatment provided was based on national guidance, and therefore followed current good practice. Staff showed us that they had the specialist knowledge and understanding to meet people's needs.

We saw that people were treated with dignity and respect and care and treatment was provided in a caring and compassionate manner.

People's feedback was sought to measure the quality of care. Action was taken to respond to feedback in a prompt and effective manner.

Systems were in place to enable people to be transferred and discharged from the services. We saw that staff worked well with people who use services, their representatives and other professionals to ensure people received the right care in the right environment.

We identified that there was no dedicated service to meet the needs of older people who were in crisis out of standard working hours. This meant that some people and their relatives did not receive the right support at the right time.

Staff told us the future of community services was unclear, but most of the staff told us they felt engaged in discussions about future services.

The trust told us they had recently implemented a new management structure within older people's services in response to quality concerns. This meant that the trust had taken appropriate action to address the concerns that had been raised.

Services for older people

Are services for older people safe?

How are people's risks assessed and managed?

We saw that a detailed risk assessment was completed for each person who attended the day hospitals. This assessment included the risks posed to their physical health and the risks people posed to themselves and others. Staff told us that they communicated with other professionals, such as GPs and care coordinators to ensure that people's previous and current risks were shared. The day hospital staff had access to the community services computerised care records system, so the staff could access people's previous and current community based risk assessments. This meant that an effective system was in place to identify potential risks.

We saw that where risks had been identified, appropriate plans were in place to manage these risks. Staff we spoke with were aware of people's risks. This meant there was an effective system in place for the management of individual risk.

Every person who accessed the day hospitals had a care coordinator who monitored and coordinated people's care. We saw that people's risk was reviewed during their attendance at the day hospital. The nursing staff, medical team and care coordinators were all involved in reviewing these risks. This meant there was an effective system in place for the monitoring of people's risk.

Staff from the community mental health teams and the memory service told us that all people who accessed their services had a risk assessment which was recorded on the computerised care records system. We did not look at the care records to confirm this, but discussions with staff at the day hospital confirmed that risk assessments were in place for people who received care from these teams.

Do the staff and staffing levels protect people from harm?

The managers of both day hospitals told us that they had staff vacancies, but this did not compromise patient safety as staff from the inpatient wards were occasionally used to fill any staffing gaps. This meant that a system was in place to ensure that there was enough staff to ensure people's safety.

Staff from the community mental health teams told us there were staffing gaps due to sickness, maternity leave, secondments and a vacancy; but at the time of our inspection this had not had an impact on people's care as the teams reported there were no waiting lists to access their services.

Minutes of older people's services managers' meetings confirmed that staffing levels were currently under review. This meant that the trust was aware of the potential risks around staffing levels and were working to address this.

Following incidents is action taken to improve the standards of safety for people who use the service?

The day hospital managers and community mental health teams told us that incidents were discussed in staff meetings. The staff also told us the information detailing the actions put in place following incidents was kept in an embedding lessons folder. During our inspection we were unable to look at staff meeting minutes and the embedding lessons folder to confirm that this system was effective.

Are services for older people effective?
(for example, treatment is effective)

Are national standards and guidelines followed to ensure patient care is based on evidence based practice?

We saw that care and treatment at the day hospitals, community mental health teams and the memory service was based upon national standards and guidelines. Guidance from the National Institute of Health and Care Excellence (NICE) was followed. Examples of this included; the use of care coordinators to manage and coordinate patient care, provision of therapeutic cognitive stimulation groups and care support groups and the provision of early assessment and treatment for patients with mild cognitive impairment. This meant that people received care and treatment that was based on the best available evidence of good practice.

Do the staff work in partnership with others?

The staff worked with other health and social care professionals to ensure that information about people's need was gained on admission and given on discharge. Care coordinators attended meetings that were related to the care of their patients. This included attending ward reviews and discharge meetings if their patients were admitted to hospital.

Services for older people

Staff told us that they shared information about other agencies and organisations with people and their relatives. This included sharing the support services that were available to people and their carers from organisations such as Age UK.

The relative of a person who used the Walsall memory service told us, "I could phone any time about a problem and they would liaise with other services". This meant that the relative felt the service worked well with other services as required.

How is the quality of care assessed and managed?

Patient meetings were held in the day hospitals. These meetings focused on gaining patients opinions about the quality of the service. One person told us about a patient meeting they had attended. They said, "We were asked our likes and dislikes and we talked about the groups". This meant that people's opinions were sought in the assessment and monitoring of quality at the day hospitals.

We saw that the Walsall memory service had been accredited by the Royal College of Psychiatrists. This accreditation was called the Memory Services National Accreditation Programme (MSNAP). MSNAP is a standards based programme designed to improve the quality of memory services. The process involves a review of quality. This meant that the trust sought opportunities to have the quality of their service reviewed by others.

We saw that recommendations from the MSNAP review had been formulated into an action plan that detailed how the service would improve. This meant that the trust used feedback from the review to improve the service.

Are the staff suitably qualified and competent to meet people's needs?

We spoke with 14 staff who worked within community services for older people. All the staff told us they were up to date with mandatory training; however we were unable to view training records to confirm this. The staff we spoke with were able to give us information which demonstrated they understood the needs of the older people who accessed their service. This included an understanding of the condition of dementia and the behaviours it could cause. This meant that staff demonstrated that they were competent to meet patient needs.

Are services for older people caring?

Are people involved in making decisions about their care and treatment?

The staff had the knowledge and skills to assess people's individual abilities to make specific decisions about their care and treatment. Staff were also aware of their responsibilities to follow the principles of the Mental Capacity Act 2005 if people were identified as being unable to make their own decisions. This meant that the staff had the knowledge and skills to ensure that decisions were made in people's best interests when they were unable to make decisions for themselves.

During our inspection we saw that people who attended the day hospitals were consulted with about their care and treatment. People were involved in discussions about their assessment and treatment through their reviews and individual meetings with health professionals. One person told us, "I had a choice in whether I wanted to come here or not. I didn't have to come". We saw that people could make decisions about their meals and they could choose to participate in activities of their choice. This meant that people were involved in making decisions about their care and treatment.

We were unable to speak with people who received care from the community mental health team and the memory service, but the staff told us that people were involved in decision making.

Are people's needs reviewed regularly?

Staff told us and we saw that people received regular reviews by the multi-disciplinary team. Some of the topics discussed at reviews included; medication, mental capacity, risks, physical health and future needs. This meant there was an effective review system in place.

How do staff ensure people understand their care and treatment?

We observed staff helping people to understand information in a manner that reflected their level of understanding. For example, we saw staff used gestures and actions to assist people to understand verbal information. We also observed staff communicating with people who had hearing difficulties in an appropriate manner to enable them to hear more effectively.

Services for older people

Do people receive the support they require?

We spent time observing the care at both the day hospitals. We saw positive interactions between staff and people who use the service. For example we saw that the staff initiated conversations with them and they listened and responded well to the people's comments. This meant that people were treated with care and compassion.

We saw that care was delivered in line with people's support plans. For example, where people required assistance to access the toilet they had received this.

We looked at the care records and spoke with the relative of one person who used the Walsall memory service. We saw that the person and their relative received appropriate assessment, treatment, monitoring and support from the staff. The relative told us they were very happy with the care they had received. They said, "We are happy with the service. They come and visit us regularly at home".

At our pre inspection listening event one person shared their experience of accessing the Walsall memory service as a relative and carer. They said, "The memory service is absolutely excellent. We were able to access medications to slow down the process (dementia). My relative came out of residential care as a result", and, "They didn't just look after my relative; they looked after the family as well". This meant that the relatives we spoke with felt supported by the service.

Are people treated with dignity and respect?

People who attended the day hospital told us they were treated with respect. One person said, "The staff are kind". Another person said, "The staff are lovely and helpful". We observed people being assisted to access the toilet in a discreet and private manner. This meant that people were treated with dignity and respect.

Are services for older people responsive to people's needs?

(for example, to feedback?)

How do the staff facilitate transfers and discharges between services?

The staff who worked within community services for older people worked alongside inpatient staff to ensure people received care and treatment in the most appropriate environment. If a person's condition and behaviours deteriorated, admission to an inpatient mental health ward was arranged. This meant that people could receive the right care in the right environment.

Staff told us that if a person's condition was stable, they could be discharged to the care of their GP. A discharge summary would be sent to the GP to inform them of the care and treatment given and any follow up care that was required. This meant there was a discharge system in place to handover people's care.

The staff and relatives we spoke with told us there was no dedicated out of hour's crisis service for older people. One staff member said, "They (the patient or carer) may get a telephone response from the adult crisis team rather than a home visit. It's likely they would be advised to go to Accident and Emergency". One relative we spoke with confirmed that they were unable to access specialist out of hours support when their relative became unwell. They said, "I had to lock myself in the bathroom because X (the patient) became aggressive during the night. I phoned the number (the crisis team) and I was told they would ring back in three quarters of an hour. I ended up ringing 999 and they took X to A&E". This meant that there was no specialist out of hour's team for older people to offer assessment and support when people and their relatives were in crisis.

How do staff learn from feedback?

We saw that patient feedback was sought in the day hospitals through patient meetings. We observed a patient meeting that was held at Birch Day Hospital. We saw that people were asked to give their feedback on the performance of staff, the groups and the food. During this meeting some people told the staff that they did not know who their named nurse was. One staff member then offered to write a persons named nurses down for them. This meant that feedback gained from the meeting was used to improve the persons' experience.

There was a complaints system in place that people who use services and their representatives could use. The people and the relatives we spoke with who used community services for older people told us they would be happy to share their concerns with staff if they needed to. One person said, "I have nothing to say, they have all been very good to me". Staff and managers told us how they would manage a complaint to ensure that it was investigated and managed appropriately.

Services for older people

Are services for older people well-led?

Is there a clear vision for services for older people?

We spoke with 15 staff members who worked within community services for older people about the future of their services. All the staff told us about changes in the way some of their services were being commissioned, which was improving care, but all the staff also told us they were unclear about the future of the services. One staff member said, "We are still awaiting direction from the commissioners". Another staff member said, "I know what some of the plans are, but I'm not confident how or when the plans will be delivered. We are waiting for the commissioners to say what they want". This meant there was no clear vision outlining the purpose and future of community services for older people.

Are staff engaged in service improvement?

The staff told us they had regular team meetings where they discussed service improvement at a team and trust level. Most of the staff we spoke with felt they were engaged in service improvement.

Two of the staff told us they did not feel involved in service improvement or changes to services. One staff member said, "I want to be involved, but I haven't been invited". The staff also told us they were concerned that some of the senior managers who were making decisions about the services did not have older people's mental health experience. This meant that a small group of staff felt they were not engaged in service improvement processes.

Is effective leadership in place to ensure high quality care and treatment?

Leadership teams met monthly to discuss quality issues. The minutes of the meetings confirmed that representatives from community services for older people attended.

The minutes of the meetings showed that audits had been completed or were planned to be completed in a number of areas, such as; falls, infection control and record keeping. This meant that measurements of quality were taking place or were planned to take place.

The trust had recently identified concerns with the leadership and management of services for older people, and a new management structure had recently been put in place. This meant that the trust responded appropriately to address the concerns. At the time of our inspection it was too soon to identify whether the new structure was effective.

Adult community-based services

Information about the service

Community Recovery Service for people in Walsall

This service is the Community Recovery Service (CRS) for people in Walsall. It covers the north and west areas of the region and includes Bloxwich, Willenhall and Darlaston. The office is situated in Mossley Day Hospital, Bloxwich.

Community Recovery Service for people in Dudley

This service is the Community Recovery Service (CRS) for people in Dudley. It covers the east and south areas of the region. The office is situated at Halesview.

Early access service

This service is the early access service for people in Walsall and Dudley and operates during usual working hours, 9am – 5pm Monday to Friday. The office is in Sandringham Ward at Bushey Fields Hospital.

Liaison services

There are two dedicated psychiatric liaison teams, one for Dudley located at Russell's Hall Hospital and one covering Walsall based at Walsall Manor Hospital. The service is dedicated to assessing people who attend following a self-harm/ suicide attempt or who are presenting with symptoms that suggests they are suffering from a mental illness.

Summary of findings

Community Recovery Service for people in Walsall

The staff team consisted of clinicians and professionals who were well trained and knowledgeable.

Referrals to the service were responded to quickly, and action was taken according to the person's level of risk.

Records were made of contacts with each person to ensure a detailed account of the support provided was available for other professionals involved with their care.

Links with other community services had been established to support people with their individual needs and to reduce the need for hospital admissions.

Community Recovery Service for people in Dudley

The team is very caring and works extremely well with other teams and agencies. The team is responsive to service user needs.

Early access service

The staff team consisted of clinicians and professionals who were well trained and knowledgeable.

Referrals to the service were responded to quickly, and action was taken according to the person's level of risk.

Records were made of contacts with each person to ensure a detailed account of the support provided was available for other professionals involved with their care.

Some people who used the service were positive about the staff, saying they were helpful, friendly and supportive. Other people were not so positive and reported not being listened too or supported as they felt they should be.

Liaison services

All of the staff that we spoke with were familiar with incident reporting, safeguarding people and risk assessing. There was a lone working policy in place; however this was not always being followed, which meant there was a risk to the safety of staff and people using the service.

Adult community-based services

There was an effective assessment procedure in place, as well as effective multi-disciplinary working. Staff were able to access training and support.

People were involved in the care planning process. Care plans were clear, goal oriented and included people's views.

Feedback about the service at a local level was not being sought, which meant it could not inform service planning for the local community. There was a clear complaints system was in place.

Most of the staff we spoke with told us they felt well supported by their managers. Clinical audit was carried out periodically throughout the year.

Are adult community-based services safe?

Community Recovery Service for people in Walsall

Staff told us that they received safeguarding vulnerable adults and children training each year. They told us about their responsibility to refer any potential abusive situations to the relevant departments.

Referrals for the service were received directly from the Early Access Service with the main aim to keep people out of hospital and to reduce hospital admissions. Risk assessments were completed to the individual needs of people who used the service. Regular reviews took place with clinicians to assess the ongoing care and support needs.

On receipt of a referral the care and support needs were discussed and a plan of action agreed. An assessment was completed regarding the presenting level of risk and recorded on the document. Care plans were then formulated to correspond with the care and support that was identified. Staff told us that on each occasion of contact with the person, the care and support plan was updated. Formal reviews of the care and support plans were held every six months with the person concerned, their representatives and clinicians.

Staff we spoke with told us that they were aware of the whistleblowing policy and that they would feel comfortable and confident to report and refer concerns if it was needed. The whistle blowing policy was available on the hospital's intranet site for staff to refer to.

The service was staffed with doctors, nurses, support staff, psychologists, social workers and consultant psychiatrist. Staff told us that the service was fully staffed but at times they were exceptionally busy. One member of staff told us: "There are times when we are pushed to the limit and cannot cope with the increased workload".

Community Recovery Service for people in Dudley

We were told that safeguarding is prominent in clinician's minds and frequent referrals are made. Risk and safety are prominent in team. Lessons learned considered in a structured way at team meetings.

Some visits off site are isolated. Managing risk to staff is by calling the police.

Adult community-based services

Early access service

Staff told us that they received safeguarding vulnerable adults and children training each year. They told us about their responsibility to refer any potential abusive situations to the relevant departments. One member of staff told us that they would report any concerns to their line manager who would then take the necessary action to refer to the safeguarding lead at the hospital.

We attended a focus group prior to the inspection with people who used this service. A person who used the service at the focus group told us that staff were quick to respond to an emergency when it arose. They said: "They [the staff] were very helpful and listened to what I said".

Every call to the Early Access Service (EAS) was logged with the time of the call, name and contact details of the person concerned, a brief description of the concerns and presenting level of risk. Information was then passed to the duty nurse to assess and take the required action. The duty nurse explained that all urgent referrals were actioned immediately.

During our time in this department an urgent referral was received. This had been sent by a GP who had concerns regarding the safety of a person. Within four minutes of receipt of the referral the duty nurse contacted the person to ascertain the level of risk and to find out more information. With the permission of the person, other family members spoke with the duty nurse to obtain their view of the current circumstances and the presenting level of risk. Options were explained and offered. The person was satisfied with the contact and agreed a course of action.

On receipt of a referral for the service a check was made on the electronic system to ascertain if the person had previously received support or was known to the service. An assessment was completed regarding the presenting level of risk and recorded on the document. The agreed action to be taken would be discussed with the nursing and medical staff and the person concerned. Care plans were then formulated to correspond with the care and support that was identified. Electronic and paper based records were completed. Staff told us that on each occasion of contact with the person, the care and support plan was updated.

Staff we spoke with told us that they were aware of the whistleblowing policy and that they would feel comfortable and confident to report and refer concerns if it was needed. The whistle blowing policy was available on the hospital's intranet site for staff to refer to.

The service was staffed with doctors, nurses, support staff, psychologists, social workers and administration staff. Staff told us that generally staffing levels were sufficient to provide support to people in a timely way. At busy times staff told us that additional staff would be beneficial.

Liaison services

All of the staff that we spoke with were familiar with the electronic reporting system 'Safeguard' and how to report incidents. Staff were able to describe to us occasions when they had used the system. Managers told us that incidents were discussed and monitored on a monthly basis at the Quality and Governance Meeting. Most staff we spoke with told us that they received feedback on incidents at local team meetings from their managers.

Staff we spoke with confirmed they had received training in safeguarding vulnerable adults and where it was appropriate to their role safeguarding children. Safeguarding was also covered in the mandatory trust induction programme. Staff knew where to find the safeguarding procedures. We saw information relating to safeguarding and the procedures to follow which was available to staff on the trust intranet. During a visit to a person's home we observed safeguarding issues being identified by members of staff, documented and escalated appropriately to ensure that this was investigated.

There was a standardised risk assessment which was used throughout the trust. The assessment of risk included consideration to risks to themselves, staff or from other people. There was a process in place to work positively with the person to enable them to recognise triggers and signs that would indicate they were at risk. We saw plans in place to describe what actions staff and the person could take if there were elevated risks. We saw that all risks were recorded and the plans in place to minimise and manage risks.

There was a lone working policy and procedure in place. There was a traffic light system in place to highlight where people s presented identified risk to staff safety. We saw that the system indicated when staff should not undertake

visits alone. We also saw examples in care plans where it was recorded that staff should visit in pairs. We observed that staff visiting people in the community carried personal alarms.

The lone working policy was not always being adhered to. Staff working in the liaison team told us that they would see people on their own in the interview rooms in the A&E departments of the local acute hospitals where they were based. We observed that these rooms did not have panic alarms and staff did not carry these. One member of staff told us about an incident where they were cornered in the interview room they use but they managed to get away from the person unharmed.

This was reported as an incident but no action was taken in regard to lack of alarms or alert systems in the rooms being used (they use two or three different rooms on the Dudley site). A note had however been put on the person's file that they were not to be seen on their own in the future. Staff told us that they did feel safe however there was a risk that staff were vulnerable seeing people alone in the interview rooms.

Are adult community-based services effective?
(for example, treatment is effective)

Community Recovery Service for people in Walsall

Staff reported close working relationships with the home treatment teams, out of hours and crisis teams had been developed and sustained. Systems were in place for the sharing of information between the teams. Links with other community groups had been established and included the Hearing Voices groups, Perinatal Eating Disorders and the Improving Access to Psychological Therapies (IAPT) services.

Following the initial referral to this service and the assessment of the person's individual need, options and choices were offered appropriate to the needs of people. People were allocated a named worker to ensure continuity of care was maintained.

Staff reported that training opportunities were available in the mandatory and specialist topic areas. Staff were able to request Individual supervision sessions with their line manager if it was needed. Staff told us they worked closely as a team and there was always opportunity for discussion.

Formal care programme reviews were held every six months with clinicians, the person concerned and their representative.

Community Recovery Service for people in Dudley

We were told that the model of referral from consultants to the service without discussion is poor, but a regular meeting to discuss referrals is being configured.

Early access service

Staff told us of the recent meeting with the local general practitioners (GP) to further develop good working relationships. Many of the referrals received were from GPs so it was essential that collaborative working and communication between the agencies were effective.

Staff told us and we saw that close working relationships with the home treatment teams, out of hours and crisis teams had been developed and sustained. Systems were in place for the sharing of information between the teams.

Following the initial referral to this service and the assessment of the person's individual need, several courses of action were discussed and agreed. Staff told us that in urgent situations immediate action was taken to reduce the risk to the person. This may be contact with the emergency services or visits from members of this team, for example the consultant, nurses and other clinicians.

In non-urgent situations appointments were made with the clinicians and could be either at the person's own home or at the early access service clinic. Staff told us that the person's GP was always sent details of the course of action and plan of care.

Annual training in the mandatory topics was provided, for example health and safety, safeguarding vulnerable people and infection control. The training matrix identified the training staff had received and that which had been booked. Staff told us that they had an in-depth introduction to the team and the trust when they first employed. Training opportunities had continued in both the mandatory and specialist topics. There was no formal approach to supervision or one to one sessions with their line manager but staff said they could request a meeting with their line manager if and when they felt it was needed. This meant that systems were in place to ensure people had their needs met by suitably qualified and competent staff.

Adult community-based services

Liaison services

Each referral was assessed by senior clinicians to establish what care and support the person may need. We observed a multi-disciplinary meeting where referrals were considered. These considered the person and their needs in a respectful and holistic manner. We saw that risks were considered and also if other agencies would be of benefit to the person.

After the initial referral the same assessment format was used by all teams. This meant that a consistent approach was used and information could easily be understood and transferred between the types of service.

We saw that the assessment format considered people's healthcare needs, social needs and personal circumstances as well as their mental health needs. This ensured staff would be aware of significant aspects that may be affecting the person's mental health. Staff we spoke with told us how they supported and encouraged people to access healthcare services if they were needed.

We observed a range of multi-disciplinary meetings and handover meetings. We found that multi-disciplinary teams communicated and worked well together to ensure coordinated care.

During handover meetings we were able to see how people were discussed as a whole including their social, financial and physical health needs. Discharge arrangements to other step-down teams and to the person's GP were considered by staff.

Throughout the teams we visited staff told us they had access to regular training. Staff told us there was a range of mandatory training which was booked by their manager each year. Additionally staff told us they were able to access training which was specific to their role. We also saw evidence that participation in mandatory training was monitored and delays in attending training were followed up through staff supervision. People told us they had confidence that the staff who supported them were suitably knowledgeable and skilled.

Are adult community-based services caring?

Community Recovery Service for people in Walsall

Formal care programme reviews were held every six months with clinicians, the person concerned and their representative. People had the opportunity to discuss any issues with the support they received. In addition a medical review was held every three months. People had the added opportunity to discuss any issues with their care coordinator in between these formal reviews.

We attended a focus group prior to the inspection with people who used the community services. One person had a positive experience with this service and said: "I had a very good care coordinator; they gave me a lot of support. I have no complaints with this service".

Community Recovery Service for people in Dudley

Rate of referrals are currently high but this was being managed. Have also had to compensate for one long term sick and two maternity leave without any cover.

We were told that access to cognitive behavioural therapy is a problem for people in primary care.

We were also told by staff that choices are considered and available to service users.

The Transfer and Transition Team is helpful to some extent, but there is significant return of people using primary care.

Early access service

One person at the focus group said: "I didn't think the care plan was responsive to my needs it was a tick box exercise". Another person said they were kept fully involved with their care and support plan and felt that the 'service was well organised'. Staff told us that the lengths of time of the appointments with the clinicians were made to meet the needs of each individual so that they had sufficient time to discuss and agree their care and support needs.

We attended a focus group prior to the inspection with people who used this service. The experiences of people who used this service varied, with people reporting both negative and positive experiences. One person said: "The service I got was very good especially from the psychiatrist. They phoned me and sent an ambulance for me when I wanted to kill myself". Another person commented: "I phoned and the person I spoke with was polite but not very helpful. They kept asking me silly questions. I did not get enough support".

Liaison services

Everyone we spoke with told us they had been involved in the care planning process and had been given copies of their care plans. We saw some care plans that were clear, goal oriented and included the views of the person.

Adult community-based services

Are adult community-based services responsive to people's needs?
(for example, to feedback?)

Community Recovery Service for people in Walsall
People in the local community were referred to this service by the Early Access service. Information on the trust's website offered information and the purpose of the service. Staff told us that there were difficulties with referring people back to the primary care services which could affect the length of time a person used this service.

We saw that the provider had employed both male and female staff and from different ethnic backgrounds. This ensured that staff were able to support people with their gender, cultural and personal preferences.

Early access service
The Early Access service (EAS) provided a service to working age adults in the Walsall and Dudley areas. People over the age of 65 can use the service if previously they had had contact and support and were known to the service.

Staff told us the EAS was the single point of contact with the service during office hours. Generally people in crisis were referred via their GP, the police or other professionals. Occasionally people can make direct contact with the service.

The professionals within this team work closely with the person in their own home in an attempt to reduce the need for hospital admission. One person at the focus group commented: "They [the staff] give you a chance to express your feelings, it was very good".

We saw that the provider had employed both male and female staff and from different ethnic backgrounds. This ensured that staff were able to support people with their gender, cultural and personal preferences.

Liaison services
The majority of the people we spoke with could not recall being formally asked to share their views of the service they experienced. Managers we spoke with told us that they were aware of events held that involved engaging people across the trust but that they were not directly seeking feedback about their own team's performance from patients. This meant that feedback at a local level was not being sought to inform service planning specific to the local community. There were inconsistencies amongst the teams we visited with regard to gaining people's views in a systematic and regulated manner.

Out of office hours support was provided to people through a crisis resolution team. Each person we spoke with knew how to contact this team.

A clear complaints system was in place. Managers we spoke with were clear about their role and that of their staff in managing issues arising at the earliest opportunity before a formal complaint was made. We saw information displayed in areas accessed by people that provided information on how to make a complaint. Staff we spoke with said they would always encourage people to complain and supported them in this process where appropriate. This meant that the provider had an effective system in place to respond to complaints. A system for feedback to the relevant parties for learning or to bring about changes in practice, were shared at the conclusion of any investigation.

Are adult community-based services well-led?

Community Recovery Service for people in Walsall
People had the opportunity to speak with their care coordinator regarding the support they received. Every contact with the person was recorded so that staff had full details of the support people received.

Staff told us that they felt well supported by their managers and peers. One staff member said: "I feel well supported by my manager and able to discuss issues for improvement that may be beneficial for the service".

A focus group with community workers was held as part of this inspection. Staff from this service attended. Staff were generally positive about the recent changes but some staff reported they felt 'disaffected' and 'unsupported'.

Regular team meetings were held with minutes of the meetings completed. Business meetings were held every month which were open to all grades of staff to attend. They regularly covered issues such as service performance, sudden untoward incidents, complaints and health and safety.

Adult community-based services

Community Recovery Service for people in Dudley

The team lead and community psychiatric nurse told us that communication about the trust reconfiguration was not good. They were very positive about local managers and support in team but felt there were less links with and support from the wider trust. They told us that links to other clinical leads in the trust are good.

We were told that supervision is very good and specifically considered personal development. Training was available and staff were up to date with mandatory training.

Executive directors have visited service. Extensive joint working with other teams.

A critical friend role of clinical leads/managers has been introduced between services (Dudley and Walsall teams) but this has not yet been rolled out.

Early access service

Staff told us that some people called the service to request help and support but generally referrals were made by the person's GP. The expectation of the service was to make contact with people on the same day and on receipt of the referral. Every contact with the person was recorded so that checks could be made on this service performance indicator.

People at the focus group stated that staff were quick to respond, listened to what was said and dealt with issues promptly. Other people did not have the same experience, comments included that information was never passed on; no referral made to other services and that they were not listened to.

The provider's website includes information on the service 'The Early Access service will provide same day assessment for all urgent referrals and an assessment within 15 working days for priority referrals (non urgent)'.

Staff told us that they felt well supported by their managers and peers. One staff member said: "I feel well supported by my manager and able to discuss issues for improvement that may be beneficial for the service".

Regular team meetings were held with minutes of the meetings completed. Quality outcomes business meetings were held every month which were open to all grades of staff to attend. They regularly covered issues such as service performance, sudden untoward incidents and complaints.

Staff at the office during this inspection were positive regarding the Early Access Service and reported: "Good team work and a good service is offered to people".

Liaison services

Most of the staff we spoke with told us they felt well supported by their managers. They all spoke positively about their role and demonstrated their dedication to providing quality patient care. They told us that senior managers and the board members had engaged them, provided information and consulted with them in a variety of formats. Staff reported to us that morale in teams was high.

Senior managers told us that a wide range of professionals from across all disciplines attended a meeting known as the Quality and Governance meeting. These meetings incorporated discussion around current trust policies and identified work groups to review or write new policies. This meant that the engagement in policy development was encouraged from all levels within the organisation.

We were told that regular random audit of the quality of Care Programme Approach (CPA) documentation was undertaken by managers.

In addition to these themed auditing within the trust was undertaken periodically throughout the year.

Staff told us they felt coherent as a team and that all members were valued and respected regardless of discipline or level of seniority. We were able to observe teams working in collaboration and saw many examples of positive working relationships. Transfer of care between teams and shared care within teams was overall effectively managed. This enabled smooth transition between teams for the patient as part of their ongoing recovery. Staff we met with were clear about the lines of accountability and who to escalate any concerns to.

Staff reported good communications with regular handover/information sharing meetings being held. At team level we found that staff reported there was good morale and that staff were supportive of each other. The staff we spoke with were passionate about their role and were patient focused.

Staff reported that waiting lists were effectively managed. Higher levels of caseload numbers were escalated to board

level for a risk management discussion to take place and action plan development. Managers described how all people on the waiting list had been provided with an initial assessment of their needs.

Community-based crisis services

Information about the service

Community-based crisis services – Bushey Fields Hospital
The community based crisis team offer a 24-hour service, from Bushey Fields Hospital in Dudley.

Community-based crisis team out-of-hours service
The community based crisis team offer an out-of-hours service from 9pm – 8am. The office is based in Dorothy Pattison Hospital.

Crisis Resolution Home Treatment Team (CRHT)
The crisis teams are based at two locations, one in Dudley at Sandringham ward at Bushey Fields Hospital and the other one in Walsall at the Dorothy Pattison Hospital. There is only one member of staff on duty from 9pm to 8am at each location.

Summary of findings

Community-based crisis services – Bushey Fields Hospital
The community based crisis team is staffed by well-trained, skilled professionals. Referrals to the service were responded to quickly and action taken according to the person's level of risk.

Records were made of each contact with the person to ensure a detailed account of the support provided was available for other professionals involved with their care.

On-call doctors and senior nurses were available to support staff with decision making in the event of an emergency.

It was reported that at times the service was extremely busy and, with high workloads, additional staff may be beneficial.

Community-based crisis team out-of-hours service
The service was staffed by well-trained skilled professionals. Referrals to the service were responded to quickly, and action taken according to the person's level of risk.

Records were made of each contact with the person to ensure that a detailed account of the support provided was available for other professionals involved with their care.

On-call doctors and senior nurses were available to support staff with decision making in the event of an emergency.

It was reported that at times the service was extremely busy and, with high workloads, additional staff may be beneficial.

Crisis Resolution Home Treatment Team (CRHT)
All of the staff that we spoke with were familiar with incident reporting, safeguarding people and risk assessing.

There was an effective referral and assessment procedure in place, as well as effective multi-disciplinary working. Staff were able to access training and support.

Community-based crisis services

People were involved in the care planning process. Care plans were clear, goal oriented and included people's views.

Feedback about the service at a local level was not being sought, which meant that it could not inform service planning for the local community. There was a clear complaints system was in place.

Most of the staff we spoke with told us they felt well supported by their managers. Clinical audit was undertaken periodically throughout the year.

Are community-based crisis services safe?

Community-based crisis services – Bushey Fields Hospital

Staff told us that they received safeguarding vulnerable adults and children training each year. They told us about their responsibility to refer any potential abusive situations to the relevant departments.

Every call to the crisis team was logged with the time of the call, name and contact details of the person concerned and a brief description of the concerns. Information was then passed to staff to assess and take the required action according to the priority of needs. This always resulted in a return call to the person. Other agencies would be contacted if an urgent and emergency situation was identified.

The recording documents were analysed by a manager to identify any trends or themes that may emerge. For example, high numbers of calls at particular times of the day or night.

An initial assessment was made on each occasion of contact with the person in crisis. A check was then made on the electronic system to ascertain if the person was known to the service and whether they had previously received support. An assessment was made of the presenting level of risk and recorded on the assessment document. Care plans were then formulated to correspond with the care and support needs that were identified. The plan of care was always discussed with the person involved or their relatives where the person was unable to do so. People were asked if they would like a copy of the plan, some people did and some did not.

From 9pm to 8am there was one registered nurse. They told us about the on-call arrangements during the night where nurses and medics were available for support, help and guidance if needed. Junior doctors, registrars and consultants were rostered for a three tier system to support staff if the workload was high. A room was provided should the on-call doctor wish to stay overnight at the hospital. Staff told us that this happened sometimes but the doctor was always available via the telephone when needed. Dependent on the workload at the time of the call staff stated that there may be delays in face to face meetings.

Community-based crisis services

Staff stated that at times, especially at weekends, they were very busy and additional nurses would be beneficial.

A member of staff told us that they had a six month secondment with the crisis team before becoming a permanent member of staff. They told us that the work experience provided opportunity to work with other team members and gain an in-depth knowledge of the service.

Annual training in the mandatory topics was provided, for example health and safety, safeguarding vulnerable people and infection control. The training matrix identified the training staff had received and that which had been booked. Staff in the crisis team confirmed they had received training in lone working and personal safety. They went on to say that they were supported to attend other training such as suicide risk assessment and cognitive behavioural therapy to enable them to appropriately meet the needs of people.

Community-based crisis team out-of-hours service

Staff told us that they received safeguarding vulnerable adults and children training each year. They told us about their responsibility to refer any potential abusive situations to the relevant departments.

Every call to the crisis team was logged with the time of the call, name and contact details of the person concerned and a brief description of the concerns. Information was then passed to staff to assess and take the required action according to the priority of needs. This always resulted in a return call to the person. Other agencies would be contacted if an urgent and emergency situation was identified.

The recording documents were analysed by a manager to identify any trends or themes that may emerge. For example, high numbers of calls at particular times of the day or night.

An initial assessment was made on each occasion of contact with the person in crisis. A check was then made on the electronic system to ascertain if the person was known to the service and whether they had previously received support. An assessment was made of the presenting level of risk and recorded on the assessment document. Care plans were then formulated to correspond with the care and support needs that were identified. The plan of care was always discussed with the person involved or their relatives where the person was unable to do so. People were asked if they would like a copy of the plan, some people did and some did not.

From 9pm to 8am there was one registered nurse. They told us about the on-call arrangements during the night where nurses and medics were available for support, help and guidance if needed. Junior doctors, registrars and consultants were rostered for a three tier system to support staff if the workload was high. A room was provided should the on-call doctor wish to stay overnight at the hospital. Staff told us that this happened sometimes but the doctor was always available via the telephone when needed. Dependent on the workload at the time of the call staff stated that there may be delays in face to face meetings.

Staff stated that at times, especially at weekends, they were very busy and additional nurses would be beneficial.

A member of staff told us that they had a six month secondment with the crisis team before becoming a permanent member of staff. They told us that the work experience provided opportunity to work with other team members and gain an in-depth knowledge of the service.

Annual training in the mandatory topics was provided, for example health and safety, safeguarding vulnerable people and infection control. The training matrix identified the training staff had received and that which had been booked. Staff in the crisis team confirmed they had received training in lone working and personal safety. They went on to say that they were supported to attend other training such as suicide risk assessment and cognitive behavioural therapy to enable them to appropriately meet the needs of people.

Crisis Resolution Home Treatment Team (CRHT)

All of the staff that we spoke with were familiar with the electronic reporting system 'Safeguard' and how to report incidents. Staff were able to describe to us occasions when they had used the system. Managers told us that incidents were discussed and monitored on a monthly basis at the Quality and Governance Meeting. Most staff we spoke with told us that they received feedback on incidents at local team meetings from their managers.

Staff we spoke with confirmed they had received training in safeguarding vulnerable adults and where it was appropriate to their role safeguarding children. Safeguarding was also covered in the mandatory trust

induction programme. Staff knew where to find the safeguarding procedures. We saw information relating to safeguarding and the procedures to follow which was available to staff on the trust intranet. During a visit to a person's home we observed safeguarding issues being identified by members of staff, documented and escalated appropriately to ensure that this was investigated.

There was a standardised risk assessment which was used throughout the trust. The assessment of risk included consideration to risks to themselves, staff or from other people.

There was a process in place to work positively with the person to enable them to recognise triggers and signs that would indicate they were at risk. We saw plans in place to describe what actions staff and the person could take if there were elevated risks. We saw that all risks were recorded and the plans in place to minimise and manage risks.

There was a lone working policy and procedure in place. There was a traffic light system in place to highlight where people s presented identified risk to staff safety. We saw that the system indicated when staff should not undertake visits alone. We also saw examples in care plans where it was recorded that staff should visit in pairs. We observed that staff visiting people in the community carried personal alarms.

The CRHT team (crisis resolution and home treatment team) were using agency staff due to staff vacancies, however when we spoke to a member of agency staff we were told that they had not received formal induction around the lone working policy and were unfamiliar with the trust procedures on this. They told us that they had undertaken community visits alone since working at the trust. We asked the service manager about this who told us that although an informal meeting had taken place with the member of agency staff, there was no formal induction programme in place for agency staff and were unable to show us any documentation that induction had taken place.

We found three large bags of medication that had been taken from a person using the service in the community in the drug cupboard in the CRHT team office in Bushey Fields Hospital. The bags had no documented recording of their contents. We discussed this with the clinical lead who told us "they are for disposal but this hasn't been done yet".

These medications had been acquired from people using the service when they had been admitted to inpatient wards or to the CRHT team for support and had no further use.

We observed sharps containers that were sealed but had no date on them and had no staff signature. The fridges to store medications were being checked daily although nothing was being stored at the time of inspection. We observed that controlled drugs were checked weekly. We observed loose, unboxed and unlabelled strips of medicines in the medicine cabinet. The clinical lead was unable to identify who they belong to. People's medications or TTOs were all labelled and medicine cards evidence safe delivery to people using the service.

Are community-based crisis services effective?
(for example, treatment is effective)

Community-based crisis services – Bushey Fields Hospital

Staff working in the crisis team were also part of the home treatment team. They told us they also worked very closely with the early access team. This ensured continuity and consistency of care and support was provided because systems were in place for the regular sharing of information.

During the inspection we saw an Approved Mental Health Professional (AMHP) at the office. AMHP's are responsible for organising, coordinating and contributing to Mental Health Act assessments. They passed information to the crisis team to ensure the continuing support for a person was actioned the following morning.

Where people required additional health services during this period of crisis staff told us that they would advise the person where to find the services. In an urgent situation staff would contact and facilitate health services for them. For example a 999 call to the ambulance and police if the person was considered to be at significant risk of harm.

Staff told us that there were times when they were extremely busy and the workload was high. They told us they had the knowledge, training and skills to assess and

identify crises and were able to prioritise the work. They told us and we saw the systems in place for gaining help and support from other professionals if and when this was needed.

We attended a focus group for people who used the service before this inspection. People told us that at times they had difficulty accessing the crisis team as there was no answerphone facility.

We asked staff about this. They told us that the reception desk at the hospital was staffed over the 24 hour period with staff available to take calls. An answer phone facility was not used because there was a possibility that calls could be missed if messages were left. People could possibly be left without support. During this inspection we observed the reception area and staff were available to answer calls. We did not see or hear any delays. We sampled the records of call logs and found that all calls were responded to promptly.

Community-based crisis team out-of-hours service

Staff working in the crisis team were also part of the home treatment team. They told us they also worked very closely with the early access team. This ensured continuity and consistency of care and support was provided because systems were in place for the regular sharing of information.

During the inspection we saw an Approved Mental Health Professional (AMHP) at the office. AMHP's are responsible for organising, coordinating and contributing to Mental Health Act assessments. They passed information to the crisis team to ensure the continuing support for a person was actioned the following morning.

Where people required additional health services during this period of crisis staff told us that they would advise the person where to find the services. In an urgent situation staff would contact and facilitate health services for them. For example a 999 call to the ambulance and police if the person was considered to be at significant risk of harm.

Staff told us that there were times when they were extremely busy and the workload was high. They told us they had the knowledge, training and skills to assess and identify crises and were able to prioritise the work. They told us and we saw the systems in place for gaining help and support from other professionals if and when this was needed.

We attended a focus group for people who used the service before this inspection. People told us that at times they had difficulty accessing the crisis team as there was no answerphone facility. We asked staff about this. They told us that the reception desk at the hospital was staffed over the 24 hour period with staff available to take calls. An answer phone facility was not used because there was a possibility that calls could be missed if messages were left. People could possibly be left without support. During this inspection we observed the reception area and staff were available to answer calls. We did not see or hear any delays. We sampled the records of call logs and found that all calls were responded to promptly.

Crisis Resolution Home Treatment Team (CRHT)

Each referral was assessed by senior clinicians to establish what care and support the person may need. We observed a multi-disciplinary meeting where referrals were considered. These considered the person and their needs in a respectful and holistic manner. We saw that risks were considered and also if other agencies would be of benefit to the person.

After the initial referral the same assessment format was used by all teams. This meant that a consistent approach was used and information could easily be understood and transferred between the types of service.

We saw that the assessment format considered people's healthcare needs, social needs and personal circumstances as well as their mental health needs. This ensured staff would be aware of significant aspects that may be affecting the person's mental health. Staff we spoke with told us how they supported and encouraged people to access healthcare services if they were needed.

We observed a range of multi-disciplinary meetings and handover meetings. We found that multi-disciplinary teams communicated and worked well together to ensure coordinated care.

During handover meetings we were able to see how people were discussed as a whole including their social, financial and physical health needs. Discharge arrangements to other step-down teams and to the person's GP were considered by staff.

Throughout the teams we visited staff told us they had access to regular training. Staff told us there was a range of mandatory training which was booked by their manager each year. Additionally staff told us they were able to

access training which was specific to their role. We also saw evidence that participation in mandatory training was monitored and delays in attending training were followed up through staff supervision. People told us they had confidence that the staff who supported them were suitably knowledgeable and skilled.

We attended four visits to people in their homes with members of the CRHT team and there were open discussions with the person to ensure they were clear about how to access care and support if they needed it. People's social, financial and physical health needs were discussed as well as their mental health. The level of ongoing support that people required was discussed with them.

In care plans we were able to see how referrals to other organisations had been completed with the person to address a variety of social, financial and physical health needs.

There were staff vacancies in the CRHT team at the time of our inspection visit. The service manager told us that agency/bank staff were not widely or regularly used in the community mental health services, but more recently this had been the case as a temporary measure. Although we did not see any impact on people using the service, there was a risk that without induction that agency staff were lone-working without being familiar with the trust's procedures around this.

Are community-based crisis services caring?

Community-based crisis services – Bushey Fields Hospital

Staff told us that people had a review of their care. People could have daily visits from the home treatment team, regular telephone calls or less frequent contact. The frequency with the teams very much depended on people's care needs and the level of risk. Each contact with the person was recorded on paper documents and the electronic system to ensure the passing of information was effective. We saw records that indicated where concerns had been identified, when nurses were out on visits, a review with the doctors was immediately carried out.

The crisis team work closely with the home treatment teams and GPs to help people remain in their own homes. Contact with other professionals, such as doctors, social workers and care coordinators were recorded in the care notes. This meant that information was readily available and accessible for staff to enable them to meet the needs of people.

Community-based crisis team out-of-hours service

Staff told us that people had a review of their care. People could have daily visits from the home treatment team, regular telephone calls or less frequent contact. The frequency with the teams very much depended on people's care needs and the level of risk. Each contact with the person was recorded on paper documents and the electronic system to ensure the passing of information was effective. We saw records that indicated where concerns had been identified, when nurses were out on visits, a review with the doctors was immediately carried out.

The crisis team work closely with the home treatment teams and GPs to help people remain in their own homes. Contact with other professionals, such as doctors, social workers and care coordinators were recorded in the care notes. This meant that information was readily available and accessible for staff to enable them to meet the needs of people.

Crisis Resolution Home Treatment Team (CRHT)

Everyone we spoke with told us they had been involved in the care planning process and had been given copies of their care plans. We saw some care plans that were clear, goal oriented and included the views of the person.

We attended four visits to people in their homes with members of the CRHT team. We saw that people were regarded with respect and open discussions were held.

We saw reviews of care to be comprehensive with staff engaging positively with the person and their families to establish their goals and views.

People knew where to contact staff if they needed urgent support. People were positive about their experiences of receiving community mental health services. People received support the needed at varying frequencies dependent on the stage of their recovery.

Our observations of staff interactions with people showed us they were respectful and gave people time to speak and share their views. There were open discussions and people

were able to ask questions. Staff had regard for people's capacity to understand information and checked out with people that they had understood the information given to them.

We found care plans to be overly clinical in their language. A copy was provided to the individual, however reference in care plans to red, amber and green were unhelpful to people. We raised this on the inspection and the manager told us that the team also raised the issue of clinical language in care plans.

People's privacy and dignity were respected and staff used appropriate language when talking to people as well as allowing family members to be included in assessments where appropriate to ensure that people felt comfortable.

Are community-based crisis services responsive to people's needs?
(for example, to feedback?)

Community-based crisis services – Bushey Fields Hospital

The crisis team is based at two locations, one in Dudley at Sandringham ward at Bushey Fields Hospital and the other one in Walsall at the Dorothy Pattison Hospital. There is only one member of staff on duty from 9pm to 8am at each location.

The duty on-call doctor, manager and senior nurse would be contacted where swift decisions were needed. In urgent and emergency situations the plan of care would be discussed and a decision made. The circumstances of the referral and the risk to the person would determine the course of action.

Where the referral was extremely urgent and immediate action was needed to ensure the safety of the person the emergency services would be contacted. On occasions the person would be directed to the local accident and emergency department at the local hospital.

Mobile phones were provided to all members of the crisis team so that they could be contacted when a referral to the service was made. This meant that when a call was received a message could be swiftly passed on to the staff to return the call of the person.

The provider's website includes information on the service and the action people can do in a crisis: 'If you have an urgent issue that can't wait, or you become unwell outside of normal working hours, support is available for you'. It provided other organisations contact details such as the Samaritans as well as the phone numbers for the local crisis teams.

We saw a record that documented a call from a person who was in crisis and who reported self-harm ideation. We saw that the call was answered and responded to within one minute and swift action was taken to reduce the risk.

Every person who accessed the crisis service had a plan of care for the level of risk presented, current medication, their state of mind and mood and for liaising with other services. The care plan was reviewed at any time in response to the changing care and support needs of the person.

We saw that the provider had employed both male and female staff and from different ethnic backgrounds. This ensured that staff were able to support people with their gender, cultural and personal preferences.

Information on the service was not provided in alternative languages to help people whose first language was not English. Very few leaflets, information and guidance were readily available in other languages apart from English. There was no reference on the leaflets we saw that they could be available in other formats or languages. Staff told us that they were able to access the translator services available when and if this was needed.

Personal information recorded in the care plans gave details of the person's marital status but made no reference about their personal relationships and partnerships. There was no evidence of lesbian, gay, bisexual or transgender information being available which meant that people were not supported to disclose their personal relationship preferences if they wanted to.

Information on the referral and continuing care and support needs were recorded both electronically and on paper. Information was recorded on a white board within the crisis team office as a visual and quick way of communicating current support needs provided to people. A handover of information was verbally given to staff at each change of shifts. There was also a handover system in place between the early access team and the crisis team for any people who needed support out of hours. This meant that a consistent and reliable service was provided.

Community-based crisis services

Community-based crisis team out-of-hours service

The crisis team is based at two locations, one in Dudley at Sandringham ward at Bushey Fields Hospital and the other one in Walsall at the Dorothy Pattison Hospital. There is only one member of staff on duty from 9pm to 8am at each location.

The duty on-call doctor, manager and senior nurse would be contacted where swift decisions were needed. In urgent and emergency situations the plan of care would be discussed and a decision made. The circumstances of the referral and the risk to the person would determine the course of action.

Where the referral was extremely urgent and immediate action was needed to ensure the safety of the person the emergency services would be contacted. On occasions the person would be directed to the local accident and emergency department at the local hospital.

Mobile phones were provided to all members of the crisis team so that they could be contacted when a referral to the service was made. This meant that when a call was received a message could be swiftly passed on to the staff to return the call of the person.

The provider's website includes information on the service and the action people can do in a crisis: 'If you have an urgent issue that can't wait, or you become unwell outside of normal working hours, support is available for you'. It provided other organisations contact details such as the Samaritans as well as the phone numbers for the local crisis teams.

We saw a record that documented a call from a person who was in crisis and who reported self-harm ideation. We saw that the call was answered and responded to within one minute and swift action was taken to reduce the risk.

Every person who accessed the crisis service had a plan of care for the level of risk presented, current medication, their state of mind and mood and for liaising with other services. The care plan was reviewed at any time in response to the changing care and support needs of the person.

Information on the service was not provided in alternative languages to help people whose first language was not English. Very few leaflets, information and guidance were readily available in other languages apart from English.

There was no reference on the leaflets we saw that they could be available in other formats or languages. Staff told us that they were able to access the translator services available when and if this was needed.

Personal information recorded in the care plans gave details of the person's marital status but made no reference about their personal relationships and partnerships. There was no evidence of lesbian, gay, bisexual or transgender information being available. This meant that people were not supported to disclose their personal relationship preferences if they wanted to.

Information on the referral and continuing care and support needs were recorded both electronically and on paper. Information was recorded on a white board within the crisis team office as a visual and quick way of communicating current support needs provided to people. A handover of information was verbally given to staff at each change of shifts. There was also a handover system in place between the early access team and the crisis team for any people who needed support out of hours. This meant that a consistent and reliable service was provided because systems were in place for the effective sharing of information.

Crisis Resolution Home Treatment Team (CRHT)

The majority of the people we spoke with could not recall being formally asked to share their views of the service they experienced. Managers we spoke with told us that they were aware of events held that involved engaging people across the trust but that they were not directly seeking feedback about their own team's performance from patients. This meant that feedback at a local level was not being sought to inform service planning specific to the local community. There were inconsistencies amongst the teams we visited with regard to gaining people's views in a systematic and regulated manner.

Out of office hours support was provided to people through a crisis resolution team. Each person we spoke with knew how to contact this team.

A clear complaints system was in place. Managers we spoke with were clear about their role and that of their staff in managing issues arising at the earliest opportunity before a formal complaint was made. We saw information displayed

in areas accessed by people that provided information on how to make a complaint. Staff we spoke with said they would always encourage people to complain and supported them in this process where appropriate.

This meant that the provider had an effective system in place to respond to complaints. A system for feedback to the relevant parties for learning or to bring about changes in practice, were shared at the conclusion of any investigation.

We found that inpatient services used a paper based recording system and did not input into the electronic care planning and recording system used by the community mental health services. This meant that if a person was discharged from an inpatient ward and then accessed the liaison service staff would not direct access to the most up to date information about the person's needs and risks.

One staff member gave us an example where a person had been discharged without any care programme approach paperwork. This meant community staff did not have sufficient information on the person. However, staff that we spoke with told us that communication between community and inpatient staff was good.

Are community-based crisis services well-led?

Community-based crisis services – Bushey Fields Hospital

Staff told us that they felt well supported by their managers and peers. Regular team meetings were held with minutes of the meetings completed.

As part of the inspection a focus group was held with a mixed group of staff from community services which included the staff working in the crisis team. Some staff from the community reported that neither they nor people who used the service had been sufficiently engaged in the transformation process of the service. They did not feel that they had been sufficiently involved or consulted on the changes to the service. Some staff told us that they felt there was a bullying tone to some emails sent to them and that meeting targets was at the expense of providing a quality service. Staff from the crisis team reported that they had experienced an improvement since the recent changes to the service and felt well supported.

Staff at the office during this inspection were positive regarding the out of hours service and reported they were 'working well as a team'.

Community-based crisis team out-of-hours service

Staff told us that they felt well supported by their managers and peers. Regular team meetings were held with minutes of the meetings completed.

As part of the inspection a focus group was held with a mixed group of staff from community services which included the staff working in the crisis team. Some staff from the community reported that neither they nor people who used the service had been sufficiently engaged in the transformation process of the service. They did not feel that they had been sufficiently involved or consulted on the changes to the service. Some staff told us that they felt there was a bullying tone to some emails sent to them and that meeting targets was at the expense of providing a quality service. Staff from the crisis team reported that they had experienced an improvement since the recent changes to the service and felt well supported.

Staff at the office during this inspection were positive regarding the out of hours service and reported they were 'working well as a team'.

Crisis Resolution Home Treatment Team (CRHT)

Most of the staff we spoke with told us they felt well supported by their managers. They all spoke positively about their role and demonstrated their dedication to providing quality patient care. They told us that senior managers and the board members had engaged them, provided information and consulted with them in a variety of formats. Staff reported to us that morale in teams was high.

Senior managers told us that a wide range of professionals from across all disciplines attended a meeting known as the Quality and Governance meeting. These meetings incorporated discussion around current trust policies and identified work groups to review or write new policies. This meant that the engagement in policy development was encouraged from all levels within the organisation.

We were told that regular random audit of the quality of Care Programme Approach (CPA) documentation was undertaken by managers.

In addition to these themed auditing within the trust was undertaken periodically throughout the year.

Community-based crisis services

Staff told us they felt coherent as a team and that all members were valued and respected regardless of discipline or level of seniority. We were able to observe teams working in collaboration and saw many examples of positive working relationships. Transfer of care between teams and shared care within teams was overall effectively managed. This enabled smooth transition between teams for the patient as part of their ongoing recovery. Staff we met with were clear about the lines of accountability and who to escalate any concerns to.

Staff reported good communications with regular handover/information sharing meetings being held. At team level we found that staff reported there was good morale and that staff were supportive of each other. The staff we spoke with were passionate about their role and were patient focused.

Staff reported that waiting lists were effectively managed. Higher levels of caseload numbers were escalated to board level for a risk management discussion to take place and action plan development. Managers described how all people on the waiting list had been provided with an initial assessment of their needs.

Specialist eating disorder services

Information about the service

The Eating Disorder Service offers community based assessment and support for people suffering with an eating disorder and their carers. The service is small and is provided by just two clinical nurse specialists; one based at Canalside in Bloxwich and the other at The Elms Health Centre in Dudley.

In addition to supporting people, the service also provides consultation and advice to a range of health and social care professionals.

Summary of findings

Overall we found that people experienced responsive care that promoted their physical and psychological recovery. People's needs were fully assessed and any physical risks they faced were closely monitored. Staff worked well with other agencies to ensure that people received additional support when necessary. Staff told us they enjoyed their job and received good supervision of their work. They reported that senior managers were easy to engage with and took their concerns seriously. However, we found that the quality of the service was not routinely monitored or assessed to determine its overall effectiveness.

Specialist eating disorder services

Are specialist eating disorders services safe?

We found that safeguarding and incident reporting systems were robust and ensured people were safe. Staff received regular training in how to protect both adults and children, which was updated every three years. The trust's policies and procedures were easily available on the intranet site and staff told us they could also report concerns outside the trust, to the local authority's multi-agency safeguarding team if needed. They were aware of the trust's whistle blowing policy and told us they felt confident to use it if necessary.

Staff reported that they had confidence in the trust's incident reporting system, which was easy to use. All reported incidents were assessed and if serious, were then allocated to a service manager for full investigation. Lessons learned from any serious incidents were shared via team meetings or the trust's intranet, making them easily available to staff.

We looked at a small sample of care notes and saw that assessments had been completed of people's physical, psychological and social needs. This included an assessment of any risk of suicide, self- harm or substance misuse people faced. The level of risk to people's physical health was monitored closely and reviewed by the clinical nurse specialist during each appointment.

People were only discharged from service once their target weight had been reached, and maintained for some time, to ensure their safety.

Are specialist eating disorders services effective?
(for example, treatment is effective)

Staff carried manageable caseloads of about 18 to 20 people, allowing them to get to know people well and monitor their needs closely. We found that staff had a high level of specialist training for their role and were skilled in assessing and treating people suffering from eating disorders. Staff were able to offer a range of interventions depending on the type of eating disorder people experienced including dietary counselling, cognitive behaviour therapy and interpersonal psychotherapy. In addition to this, one of the clinical nurse specialists had developed her own six step treatment programme which she used frequently with people experiencing anorexia nervosa. This programme helped people focus on their eating behaviour and attitudes, and their negative thought patterns around food and body image. It provided a range of practical exercises and tools to help people understand their illness and manage it more effectively.

People received a wide range of information from staff to help them understand their eating disorder and its effects on both their physical and psychological health. They were also provided with information about national support groups, web sites and self-help books.

The clinical nurse specialist told us that most people received treatment for a period of eight to ten months which was in lines with NICE (National Institute for Clinical Excellence) guidelines for eating disorders treatment.

Staff were supported by the trust to keep their skills and knowledge up to date, and regularly attended national conferences about eating disorders, as well as specialist training. For example, one of the nurse specialists told us she was about to attend a two day course on cognitive behaviour therapy and body dysmorphia. Staff also attended a quarterly regional eating disorders group where they could share information and good practice, and discuss any complex cases with other professionals in the field.

We viewed a small sample of people's care records which were held on the trust's computer system. These records were detailed and clearly documented the advice and treatment given to people at each appointment, making it accessible to other health professionals involved in their care. We saw that people's weight and body mass index had been monitored closely, and that their feelings about their treatment had also been recorded.

Overall, people we spoke with felt their treatment had been effective and had helped them gain and maintain their weight. One person reported, "I've been seeing X (nurse specialist) for about 12 months, the change has been unbelievable. She set me a target weight of 50kg and I'm just a few kilos off that now". We reviewed care records for six people and noted that in four cases people had gained weight. However, we found that the quality of the

Specialist eating disorder services

treatment provided to people was not consistently measured or assessed to determine its effectiveness. Staff were unable to demonstrate to us how the treatment they provided to people was effective.

Are specialist eating disorders services caring?

We conducted telephone interviews with five people who used the service and received many positive comments from them about the quality and empathetic attitude of staff. People told us that staff had a good understanding of eating disorders and felt their treatment had been effective. One reported, "X talks and listens to me, she understands my illness better than most people". Another person told us, "You can tell 'X' (nurse specialist) really cares, you're never just a number".

We viewed the results of a recent survey which had been completed by 17 people who had received support from the eating disorder service. The results were very positive, with people strongly agreeing that staff treated them with respect; that they had felt listened to and they were provided with relevant information to manage their eating disorder. Interactions we observed between staff and people who used the service were good, and we saw that the clinical nurse specialist worked collaboratively with people to help them manage their illness.

Although under review at the time of our visit, a monthly regional support group had been set up to provide additional information, help and support for people affected by eating disorders and their carers.

Are specialist eating disorders services responsive to people's needs? (for example, to feedback?)

There were no waiting lists for the service and people told us they had been seen quickly by the clinical nurse specialist once they had been referred to the service. People valued the flexibility of the service offered and the fact they could choose to receive support either at home or at the community clinic. They told us the nurse specialist was easy to contact by phone and always responded to their calls quickly.

We found that staff responded quickly when people's physical or psychological needs changed and referred them for additional support when necessary. For example, during our visit the nurse specialist organised a GP appointment that afternoon for one person who had raised health concerns during their morning appointment. One person told us, "X (nurse specialist) helps me get referred easily at my worst times".

We found there was good collaboration with a number of relevant agencies to ensure people's needs were met. The clinical nurse specialist regularly attended people's care plan reviews and continued to support them when they were admitted for inpatient care, even if this was out of the local area. There were established links with children and adolescent mental health teams so that young people continued to receive support with their eating disorder when they transitioned to adult services. Although there was no longer any formal arrangement in place for dietetic support to people, the clinical nurse specialist reported she had informal links with a dietician for more specialist advice if needed. The clinical nurse specialist ensured that additional support for people was organised from other healthcare professionals if she was unable to visit them regularly due to training or annual leave.

Regular training and advice on eating disorders was provided by the clinical nurse specialist to junior doctors, primary care workers and community mental health teams to improve their knowledge and skills when supporting people with eating disorders. Work books about bulimia and anorexia nervosa had been developed by staff specifically for use by these professionals in their work.

People were also asked if they wanted to receive copies of letters sent about them to health and social care professionals so they were aware of any communication about them. However people did not receive a copy of their initial assessment, or sign it to show that it was an accurate representation of their needs.

People we spoke with confirmed they had been given information about how to raise concerns or complaints and most felt confident their concerns would be taken seriously by staff.

Specialist eating disorder services

Are specialist eating disorders services well-led?

Staff felt that senior managers had a good understanding of the service they offered and were responsive to their concerns. One staff member was pleased that a particular risk she had identified had been taken seriously by the trust's medical director and put on the service's risk register as a result. Senior managers regularly visited the service and the trust's head of governance and the head of estates had recently visited the Walsall service.

We found that staff received good clinical supervision of their work, which was provided by specialist eating disorders professionals outside of the trust. However, although providing a trust wide service, the clinical nurse specialists were managed within different primary health care teams, and received support from different line managers. One of the clinical nurse specialists reported that the service lacked cohesion, describing it as "a bit disjointed' as a result.

People were asked about their views of the service via satisfaction surveys which asked them to rate the quality of the staff that supported them. However they were not specifically asked about the effectives of the treatment they had received and we found no evidence that people had been involved in the design and delivery of the eating disorders service. Staff were unable to demonstrate how the effectiveness of the service was monitored, or describe performance indicators or outcome measures by which its success was measured.

Other specialist services

Information about the service

We inspected a dedicated military veteran service, a recovery intervention service and a substance misuse service. We did not review the latter service at the Dudley location, since the trust would not be providing it from 1 April 2014. The trust provided these as part of their community recovery mental health services.

The dedicated military veterans' service provided the support and links with other local agencies to ensure veterans receive the help they need to achieve recovery. The trust had appointed a dedicated mental health nurse as the military veterans' lead for the trust. They also acted as the regional nurse lead for the West Midlands military veterans' service.

The recovery intervention service had recently been reconfigured by the trust and provided an opportunity for people with chronic and long standing mental health conditions to attend skills-based psychologically informed groups.

The substance misuse service was made up of the shared care team (drugs), structured drug team, community alcohol team and the family team.

We visited and reviewed the treatment being provided in two community locations. We examined nine treatment plans and spoke with senior clinicians and other staff over the course of a two-day inspection.

We interviewed two people who used these services with their prior agreement. We also used information provided by the trust and information that we requested, which included some trust policies and other information.

Summary of findings

The provision of these services was safe. The trust had good systems in place to review incidents and near misses. This included a formal debrief for staff and discussion during clinical, managerial and group supervisions for frontline staff. We saw that people's treatment records clearly identified current concerns and assessed risks. These had been reviewed based on an evaluation of each specific treatment episode. Comprehensive risk assessments were seen and these included assessments of the person's physical health and their risks to themselves or others where applicable. We saw evidence of the active involvement of the person in assessing risks for themselves – for example, associating with certain groups of people. The trust was actively recruiting to staff vacancies.

The effectiveness of these services was good. For example, we saw that the trust's substance misuse care and treatment plans were being monitored and supported by the National Drug Treatment Management Services (NDTMS). We noted that the service monitored their care outcomes via the 'treatment outcomes and program performance system'. This was a specific outcome measure used to monitor treatment effectiveness. We identified good examples of collaborative working with stakeholders and other partners. Staff told us that they had received their mandatory training and we saw good examples of additional skills-based training for specific team members.

The services provided were caring. This was confirmed by our observations and discussions with frontline staff during our inspection. Additional evidence to support this was individual treatment records, feedback received from people and the trust's and external agencies' quality monitoring systems. We saw good examples of individualised and person-centred care being provided. We saw that staff were engaged at a local level. They felt that they were doing the best they could for people. They told us that they felt that people got a 'good service'.

The service's ability to respond to people's needs was good. We saw a number of posters around the locations we visited welcoming the views of people and referring

Other specialist services

them to the trust's service experience desk. Staff at one location explained how they worked closer with independent advocacy services to try and support people. We saw examples of where the military veterans champion had supported people to access support from war veterans' charities where this was required. Staff informed us that local actions were taken to address any informal complaints in a prompt manner. For example, if a person wanted to change their therapist or key worker this would be discussed within the team. However, the trust should be aware that the results of the recent patient survey were being collated and were not available for inspection.

Local leadership was proactive and we saw good examples of service leadership that led to effective service delivery. We saw some good examples of the executive team visiting local delivery teams and the positive involvement of non-executive directors where applicable. However, the trust should be aware that some staff expressed concerns about the service transformation process and about 'change exhaustion'. Other concerns were identified about the tender process which had led to the loss of the substance misuse service from one part of the trust to an independent provider.

Are other specialist services safe?

How well does the provider learn from incidents and improve standards of safety for people who use services?

Staff reported a positive and inclusive culture within their particular team. For example, they told us that individual concerns were discussed at their team meetings. They confirmed that they were encouraged to report incidents and 'near misses'. People told us that they felt safe in the service and told us that they were comfortable in raising their concerns with staff.

The trust's serious incident data showed us that three serious incidents had occurred in these specific services between April 2013 and February 2014. These were related to serious harming behaviour. Staff told us that the lessons learnt from these incidents had been discussed within their specific team and disseminated through the trust.

Staff confirmed that the trust had an on-line reporting system to report and record incidents and near misses. We saw that staff had easy access to this system via 'password' protected computers.

Systems were in place to review incidents and near misses. This included a formal debrief for staff and discussion during clinical, managerial and group supervisions for frontline staff. Staff confirmed that they had received risk assessment training and felt well supported by their line manager following any safety incidents.

Wider trust learning was evidenced through the 'Wednesday Wire' and the monthly 'team brief'. These included updates and 'key messages' for staff.

We saw that people's treatment records clearly identified current concerns and assessed risks. These had been reviewed based on an evaluation of each specific treatment episode.

The evidence seen demonstrated to us that the service learnt from any incidents that had happened and we saw that trust wide learning had been recorded and disseminated.

Other specialist services

Are behaviours, processes and systems reliable, safe and proportionate for people who use services?

We noted that the trust's safeguarding database had become fully operational from September 2013 and staff reported that this worked effectively in conjunction with the incident reporting system.

The trust had an identified safeguarding lead and staff spoke highly of the visibility and leadership of this person within the trust.

Staff were aware of the trust's safeguarding and other polices. They told us that they knew how to raise any safeguarding concerns. This was demonstrated by those individual treatment records seen. These showed us that identified safeguarding concerns had been reported appropriately and pro-actively by staff.

Staff told us that they were aware of the trust's whistleblowing policy and confirmed that they knew about the trust's 'Ask Gary' initiative. This had been introduced by the trust's chief executive to enable staff to raise issues directly with him. Staff acknowledged that he had responded promptly whenever individual concerns were raised.

Some staff told us that they had raised concerns through their line manager. For example, in relation to their individual workload and that they felt satisfied with the response received.

The evidence seen showed us that behaviours, processes and systems were reliable, safe and proportionate for people who used this service.

How do services understand and manage risk to the person using services and others with whom they may live with?

The treatment records seen showed us that individual safeguarding and other clinical risks had been assessed on initial referral to the service. These had been reviewed based on an evaluation of each care episode and any associated presenting risk to the person or others. This showed us that frontline staff were pro-active in managing identified risks and had taken a 'person centred' approach towards risk management.

For example, we saw that the trust had a suicide prevention strategy. Staff reported joint and effective working arrangements with local voluntary sector providers, the relevant local authorities and West Midlands Police as part of this strategy.

Staff knew about the trust's lone worker policy and confirmed that they had developed additional safeguards within the team to address any identified risks with specific individuals. A duty officer, individual location identifier and 'phone in' system had been established to try and ensure individual staff safety.

Comprehensive risk assessments were seen and these included assessments of the person's physical health and their risks to self or others. Evidence was seen of the active involvement of the person in assessing risks for themselves. For example associating with certain groups of people.

We saw that each assessed risk had a relevant care plan drawn up with the person concerned in order to try to minimise risks for the people who used this service. This showed us that the services reviewed, understood and managed the risk to people who used this service.

How does the provider ensure that staffing levels and quality of staffing enables safe practice?

Staff told us that they had received training to prepare them for their role and felt well supported by their line manager. Each member of staff spoken with told us that they received clinical, managerial and group supervisions from their line manager as required.

We saw that one team was carrying vacancies and that another team had three people who were leaving shortly. In relation to one team, 'succession planning' had taken place with respect to the shared care co-ordinator' post. This showed us that the service was proactively addressing a key staff role to maintain leadership for the team.

The military veterans' team was a single resource but confirmed that they received support from other teams within the service and from their direct line manager. Their specific role in relation to 'sign posting' people to appropriate treatment or other support mechanisms meant that most people did not require ongoing long term support.

Other specialist services

Senior staff informed us that where agency staff were used this was usually the same people. These staff had received induction to the team and were supported by permanent team members.

People told us that recruitment took place in line with the trust's human resources policy and procedures. This was confirmed by frontline staff who told us that they knew that active recruitment was taking place to address the identified vacancies within their specific team.

Staff confirmed that systems were in place to monitor staff sickness and that they had access to occupational health support. Individual staff stress levels were monitored through clinical supervision and regular staff meetings. Staff told us that they felt well supported by their line manager.

The evidence seen showed us that the trust was taking action to address the identified shortfalls in staffing levels within these services.

Are other specialist services effective?
(for example, treatment is effective)

Can the provider demonstrate that nationally/ internationally recognised clinical guidelines and standards, other recognised guidance and standards and current recognised best practice are used to deliver care and treatment that meets the needs of people who use services and delivers positive outcomes?

From the evidence inspected and discussions with managers and frontline staff, we saw the trust was able to demonstrate that people who used this service received care and treatment in line with the current best practice guidance. For example, we saw that the trust's substance misuse care and treatment plans were being monitored and supported by the National Drug Treatment Management Services (NDTMS). We noted that the service monitored their care outcomes via the 'treatment outcomes and program performance system'. (TOPPS). This was a specific outcome measure used to monitor treatment effectiveness.

The military veterans' service acted as a supportive and educative resource to trust staff. For example we saw examples of effective liaison between this service and the trust's acute admission wards. Examples were seen of training opportunities being provided for ward based staff around specific military veteran concerns.

The newly reconfigured Recovery Intervention Services (RIS) provided an opportunity for people with chronic and long standing mental health conditions to attend skills-based psychologically informed groups. This service also ensured that people received specialist mental health interventions not available within primary care. We noted good links between RIS staff and care coordinators.

Can the provider demonstrate collaborative multi-disciplinary working across all services and in partnership with other providers, support networks and organisations?

We saw that the trust worked collaboratively and in partnership with a number of other providers within this service. Staff were knowledgeable about their key roles and responsibilities.

We received a clear description of how the military veterans' team worked closely with the trust and third sector providers to promote the mental health and other needs of military veterans.

Those care plans seen were noted to be comprehensive and included the input of other providers who were supporting the person who used the service. Evidence was seen that people had signed their own care plans and that these copies had been scanned into the person's computerised records for completeness.

We saw that substance misuse care and treatment was recorded onto the trust's 'HALO' record system. This was different to the trust's main care documentation system. Staff told us that they had implemented a 'work round' system to address this. This meant that case worker who accompanied the person to trust or other appointments recorded the required information into the 'Oasis' system. The trust should consider whether there is a risk that some information may be missed or incorrectly recorded as a result of this 'work around' solution.

The 'shared care' team confirmed that they had negotiated access to the computerised records system used by the local General Practitioners. This meant that the shared care team had access to the required records for the practice that they were working with.

Other specialist services

The records seen were computerised and access to these records were 'pass word' protected. Staff confirmed that they had the required level of access to enable them to review and contribute to individual treatment records.

Staff spoken with reported that they had established good working relationships with other providers. For example, in relation with charitable providers in the area of criminal justice and military veterans' charities.

Those treatment records seen showed us that people had accessed other services as required. For example the military veterans' team acted as a resource and a 'sign posting' indicator to health and welfare services for that specific group of people.

The shared care team were able to give us examples of how they reached out to 'difficult to reach' groups. For example, the homeless by working with charities in that sector, use of flexible meeting venues and collaborative working with 'walk in centres'.

How is the quality of care measured and managed in a manner to deliver the best outcomes for people?

Evidence was seen that the trust's substance misuse care and treatment plans were being monitored and supported by senior staff and by external agencies specialising in drug treatment services.

Effective clinical audits and other reporting mechanisms to the trust board were in place. Feedback systems were in place for example, we noted that individual evaluation took place following attendance at therapeutic groups.

Referrals to and from the military veterans' service were monitored and we saw that these had increased exponentially. For example 378 military veterans had been seen by the trust between March 2012 and end September 2013. There had been an increase of 33% in the number of referrals to this service between April 2012 and March 2013.

This meant that a specific group of the population was receiving an enhanced service from the trust as part of the 'military covenant'. This stated that 'no one from the armed forces and ex-service veterans will be disadvantaged as result of their service or any issues that arise from it in the state or the community'.

We saw that some systems, including audits and monitoring by external bodies, were in place to measure quality. However, the results of the recent patient survey were being collated by the trust and were not therefore available for inspection.

Do people who use services receive treatment and care from suitably qualified and competent staff, supported in their role and service delivery?

Staff spoken with confirmed that they had received adequate training and support to prepare them for their role. This was supported by the findings of the 2012 staff survey which showed us that 86% of staff had received job-relevant training, learning or development in the last 12 months. Staff told us that they received support from other members of their team. They gave us an example of a 'duty officer' system and team meetings as opportunities for receiving appropriate support.

Staff gave us examples of trust wide training undertaken. For example, mandatory safeguarding, customer care and equality and diversity training had been received by them.

Other service specific examples given included 'assessing physical health' for those staff involved in alcohol detoxification work with people and the 'cognitive behavioural therapist' course. Specific staff updates on tuberculosis, honour based violence and a needle exchange presentation had been provided. We were informed that some of these training sessions were provided and attended by partners for example West Midlands Police and third sector providers.

Ensuring that staff training was embedded into individual practice was assessed through a variety of methods. These included case load reviews, staff supervision and monthly team meetings. Staff told us that they could ask for additional support if this was needed.

Staff told us that they felt that they had enough time to provide effective interventions with people. For example with group sessions and in clinical appointments. Short term staff absence was covered from within the team. Staff confirmed that if agency staff were used these staff were consistently the same and had received a team induction and training as required.

Senior staff informed us that caseloads were monitored through clinical leadership and supervision. Individual caseloads varied as a result of ongoing changes in specific needs of people who used the service.

Other specialist services

We were told that when any concerns regarding caseload sizes had been identified, these had been raised and addressed through the trust's risk register. Clinical team leaders confirmed that they had a reduced case load to allow them time for their other duties.

The evidence seen demonstrated to us that people who used these services received treatment and care from suitably qualified and competent staff who were supported in their role and in service delivery.

Are other specialist services caring?

Do people who use services have choice in decisions affecting their care and support and are enabled to participate at each level?

The evidence seen showed us that people who use services had a reasonable choice in decisions affecting their care and support and were encouraged to participate in this.

We noted a wide range of information available for people at each location visited. Whilst this was mostly in the form of literature we were informed that people with literacy problems would be assisted wherever possible by their key worker. We were told that staff had access to literature in other languages and that appointment letters were sent to people in their language of choice. Some staff members were fluent in languages other than English and senior staff confirmed that translation and interpreting services were available if required.

The treatment records seen demonstrated a person centred approach to individual care but that where applicable; some carer involvement was recorded if people who used the service wanted this. We noted that a high level of peer group support was available.

For example through 'Narcotics Anonymous' (NA) and 'Alcoholics Anonymous' (AA) meetings.

Staff reported good links with advocacy services. For example 'Rethink' and 'MIND'. We saw robust examples of joint working arrangements with third sector providers such as 'Combat Stress' and the Royal British Legion who often acted as advocates for the individual concerned.

The records seen showed us that people who used these services had the opportunity to discuss their care, support and any treatment received with their key worker and care co-ordinator where applicable.

This was supported by discussions with one person who spoke highly of the support that they had received from the substance misuse service. For example, ensuring that they had received their prescribed medicines when unable to leave their house.

We spoke with one person who had received support from the military veterans' service. They spoke well of the support that they had received from the service and the individual assistance they had received. However the trust may wish to note that they expressed some frustration with the ability to access specific trust services. These specific issues were currently being addressed with the support of the military veterans' champion.

The records seen showed us that mental capacity issues were assessed and discussed with the person concerned. For example motivation and individual support mechanisms were documented. Evidence was seen of some active peer support groups in place. These were often facilitated by partner organisations for example a local church.

Do people who use services participate, in a review of their needs and preferences when their circumstances change?

We saw some good examples of how people who used these services were involved in discussions around their care and that encouragement and support had been given by staff where appropriate.

The records seen showed us that people were involved in the decisions around their care wherever possible. For example we noted that people often self-referred when they realised that they required assistance. Systems and procedures were in place that enabled people to be assessed in different settings. For example, the local acute hospital or the city centre 'walk in' centre.

We saw that the care given was as responsive as possible. For example meetings were held at different venues and staff confirmed their flexibility around making appointments with people.

The military veterans' team confirmed that joint visits were arranged with other stakeholders to attempt to support those people who required additional or different modes of individual support. For example military charity involvement or access to additional therapy through Combat Stress for example.

Other specialist services

Staff informed us that the choices people made were discussed with them by their key worker and the effects of these on any potential treatment outlined to them.

Do staff develop trusting relationships and communicate effectively so people who use services understand what is happening to them and why?

We saw clear records that demonstrated to us that people were able to ask questions around their care options and that staff always attempted to answer these if possible.

For example, we noted how the Military Veterans' service acted as a sign posting service for people and provided treatment and welfare options wherever possible for them. We noted that veterans received care from the main stream services of the trust and that the involvement of the veterans champion was developed on a 'case by case' basis', with the consent of the veteran and their family.

One person told us that they had yet to receive the promised support from the trust following initial contact with the Military Veterans' service. Subsequently, we were informed that these concerns were now being addressed.

Staff told us that they welcomed any complaints that people may have. Effective systems were in place to address these through the trust's complaint procedures or through an informal mechanism at a local level.

Staff told us that people were kept informed of the progress of any complaint made and that an independent investigator would be appointed by the trust to ensure that the correct procedures were being followed.

Staff told us that people were kept informed of any changes to their care and treatment. Evidence was seen of effective communication between staff and the people they were caring for. For example contact numbers and preferred communication methods were listed in individual care records. Flexibility was in place with regards to assigning key workers to people and in the sign posting of people to particular services.

One person told us that staff were always on time for their appointment and that support and encouragement had been provided in a supportive and non-judgemental manner.

The evidence seen showed us that effective communication took place within and without this service in partnership working with other providers.

Do people who use services receive the support they need?

The records seen showed us that effective joint working took part with a number of other services to promote the safety and wellbeing of people. We saw that close working relations were in place with third sector organisations including charities. Sign posting arrangements were in place with for example specialist support organisations for example the Royal British Legion. This was supported by staff who also informed us that key workers would advocate on behalf of people where this was appropriate.

Both people spoken with in detail told us that they had been well supported by the service involved. For example one person told us, "I would give them 11 out of ten" and, "I have been alcohol free for 217 days."

Some feedback mechanisms were seen for example following individual groups and we saw two examples of where this had been built into the programme. For example the 'system training for emotional predictability and problem solving' (STEPPS) programme included a questionnaire and group evaluation exercise. Staff told us that this feedback would be reviewed and used in reviewing the effectiveness of this programme.

The evidence seen and the direct feedback from people showed us that people were receiving the appropriate levels of support from this service. However, some concerns had been expressed by one person regarding accessing trust services following initial contact with the Military Veterans' service.

Is the privacy and dignity of people who use services respected?

Staff told us that they had received 'equality diversity and human rights' training. They confirmed that the trust had a 'zero tolerance' to any unlawful discriminatory behaviour. They confirmed that any disrespectful or abusive attitudes towards people who use services were not tolerated.

From the interactions that we observed staff were seen to be interacting positively with people. For example, we saw people being welcomed politely to the service and being given clear guidance about their appointment.

People told us that their privacy and dignity were respected. For example, during consultation and meetings. We saw that therapy groups were provided with clear ground rules around privacy and respect for the contribution of others.

Other specialist services

For example the recovery intervention service was able to give us clear examples of how they set up and managed groups within a number of community settings. This promoted individual access to these services and community 'outreach' where this was needed.

We saw that private rooms were available for consultations if required and that these were used for 'one to one' therapy sessions where applicable.

The evidence seen and discussions with people showed us that the privacy and dignity of the people who used this service was being respected.

Are other specialist services responsive to people's needs?

(for example, to feedback?)

How are the individual needs of people who use services met at each stage of their care?

We saw examples of where people had self-referred or were referred by their General practitioner to these services. Other people had been assessed at one of the two local acute NHS hospitals. Some publicity about other locally available services was seen around each service visited.

Example were seen of where people had self-referred or been referred by their families to the Military Veterans' service. Staff confirmed that family support was often crucial in acting as a catalyst for the changes that the veteran may need to make.

Staff reported that the building at Lantern House was not suitable for purpose for example, in relation to accessibility for the disabled. They told us that this was on the trust's risk register. We noted that some rooms at the Poplars did not contain call bells for staff to summon assistance should this be required.

Good examples were seen of where the trust worked in partnership with other providers to respond to people's changing needs. For example we saw that key workers acted as people's advocates with for example the 'benefits agency' and 'job centre plus'.

Examples were seen of where the military veterans champion had supported people to access specialised support where this was required due to changing needs. For example from the Service Personnel and Veterans Agency (SPVA) regarding war pensions and the 'Big White Wall' for on line therapeutic support.

Evidence was seen in some care plans of cultural needs having been assessed and discussed with the individual. Staff told us that they had received 'equality diversity and human rights' training. Staff had access to a translating and interpreting service where this was required. We were told that at least one team member was fluent in more than one language and they were able to act as a resource to the other members of the team.

How well do providers work together when people who use services during periods of transition?

The records seen showed us that people were well supported when and if they underwent a transition from one provider to another. For example we saw that people in the NHS acute hospital wards received a full assessment from the trust's substance misuse hospital liaison nurse before being accepted for treatment by this team.

We saw evidence of close working between the military veterans' service and the substance misuse services. For example the substance misuse assessment form seen made reference to people past military service if applicable. People were also referred onto the military veterans' team if additional support was required. For example, from specialised military charities and other sources of assistance and support.

How does the provider act on and learn from concerns and complaints from people who use services and use this information to improve quality and plan services?

Staff were aware of the trust's complaints policy and confirmed that any complaints are addressed through the trust's complaint procedure as required. Complaints were recorded on the trust's incident system. They confirmed that complaints handling was part of the trust's 'customer care training'. They told us that local actions were taken to address any informal complaints in a prompt manner. For example if a person wanted to change their therapist or key worker this would be discussed within the team.

We saw a number of posters around the locations visited welcoming the views of people and referring them to the trust's service experience desk (SED). Staff at one location

Other specialist services

explained how they worked closer with independent advocacy services to try and support people. Some members of staff told us that they had advocated on behalf of people with housing and other welfare services issues.

Staff told us that people were kept informed of the progress of any complaint made and that an independent investigator would be appointed by the trust to ensure that the correct procedures were being followed.

Evidence of trust wide learning from complaints and incidents was demonstrated through the 'Wednesday Wire' and the monthly 'team brief'. These included updates and 'key messages' for staff.

Are other specialist services well-led?

Is the governance framework coherent, complete, clear, well understood and functioning to support delivery of high quality care? How does the provider make sure that the organisations vision and culture for services is focused on good and effective care?

Evidence was seen of monthly senior managers' meetings. The service was involved in the quarterly clinical governance meetings held with public health and attended by other partners including general practitioners and charitable providers.

Staff told us that they felt well supported by their line manager. Each member of staff spoken with told us that they received clinical, managerial and group supervisions as required. Staff attended monthly team meetings and where appropriate multi-disciplinary team meetings.

Staff told us that they had been involved in the 'better together' and 'Ask Gary' trust initiatives and that they felt that staff morale was generally 'OK'. They told us that they felt well supported by their line managers.

Staff confirmed that members of the executive team visit monthly and that the non-executive directors (NED) took an interest in their service. For example, by visiting and discussing service provision. Monthly meetings were held with the commissioners by the substance misuse service.

The service is currently recruiting a specialised Experts by Experience group. However in the meantime, they are using the trust's generalist mental health Experts by Experience and they played an important role in some group work undertaken by the service.

A trust wide risk register was in place and senior staff informed us that this was generally an effective tool for capturing ongoing concerns.

How are staff concerns dealt with; risks identified ,managed and mitigated in a manner that ensures quality care and promotes innovation and learning; and what assurances are sought and provided?

The 2012 NHS staff survey showed us that the trust were in the top 20% of mental health trusts for eleven indicators, including staff feeling satisfied with the quality of work and patient care they are able to deliver and agreeing that their role makes a difference to patients.

Staff told us that they were aware of the trust's whistleblowing policy and that they felt able to report incidents and raise concerns and that they would be listened to. Service line leaders confirmed that their line manager was supportive and acted upon any concerns raised.

Are there high levels of staff engagement; cooperation and integration; responsibility and accountability; and do HR practices reinforce the vision and values of the organisation?

The trust should be aware that some staff expressed concerns about the service transformation process and about 'change exhaustion'. Other concerns were identified about the tender process which had led to the loss of the substance misuse service from one part of the trust to an independent provider.

We saw that staff were well engaged at a local level. They felt that they were doing the best they could for people. They told us that they felt that people got a 'good service'.

Staff confirmed that they had received 'information governance' training. This was supported by the trust board minutes of November 2013 that reported 95% of staff had received this training.