Dudley and Walsall Mental Health Partnership NHS Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units.	Dorothy Pattison Hospital Alumwell Close Walsall WS2 9XH Bushey Fields Hospital Russells Hall Dudley DY1 2LZ	 RYK10 RYK34
Mental health crisis services and health-based places of safety.	Dorothy Pattison Hospital Alumwell Close Walsall WS2 9XH Bushey Fields Hospital Russells Hall Dudley DY1 2LZ	 RYK10 RYK34
Specialist community mental health services for children and young people.	THQ - Trafalgar House 47-49 King St Dudley DY2 8PS	RYK33
Wards for older people with mental health problems.	Bloxwich Hospital Reeves Street Walsall	RYK01 RYK34

Summary of findings

	WS3 2JJ Bushey Fields Hospital Russells Hall Dudley DY1 2LZ	
Community-based mental health services for older people.	THQ - Trafalgar House 47-49 King St Dudley DY2 8PS	RYK33

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

Summary of findings

Ratings

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

Overall rating for services at this Provider	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

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

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

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

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Overall summary

Following the inspection in November 2016, we have changed the overall rating for Dudley and Walsall Mental Health Partnership NHS Trust from requires improvement to good because:

- The trust had made improvements to the documentation of long-term segregation and the management of blanket restrictions on the adult acute wards. The trust had revised all blanket restrictions and new protocols were now in place. Long-term segregation occurs when a patient is not allowed to mix freely with other patients on the ward on a long-term basis due to reduce the risk they pose to others. Blanket restrictions are rules or restrictions placed on all patients within a ward with no individual assessment considered.
- Since our inspection in February 2016, the trust had reduced the specialist community services for children and young people's waiting lists. We found that although waiting lists existed, teams had made significant reductions.
- The staff throughout the trust displayed a dedicated and caring attitude towards people who used the services. We saw several examples of staff being respectful and inclusive. Feedback from patients, carers and families also reflected this.
- The core services we inspected were responsive to the needs of the people who used them. The trust demonstrated listening and learning from complaints. Patients we spoke with knew how to raise concerns and complaints, and said staff gave them feedback.
- We also carried out a 'well led' review and found the leadership across the trust at a senior management level had continued to develop a new positive culture of leadership. We found in most of the services we visited that staff morale was good and staff reported managers supporting them to carry out their roles effectively.

However:

- Although some teams had made improvements regarding care plans and risk assessments, we found that the consistency and quality of documentation across the services we inspected had not improved significantly. We found examples of missing, incomplete, out-of-date risk assessments and care plans that were not recovery orientated.
- In some teams, the management of medicines and emergency equipment was not always safe. We found that staff did not always regularly check and seal emergency equipment using a tamper proof seal.
- In the older people's community services, not all of the recommendations made in previous inspection reports had been put in place. We found that managers had not provided an introduction to physical health education to unqualified staff, or personal safety training to all staff in teams. They had not updated their lone working policy before planned extended working hours in the Walsall team.
- Although the trust had made a degree of improvement with regard to the monitoring of mandatory training, we found some teams' compliance remained below the trust target. The adult acute wards Mental Health Act training remained below trust target and staff did not fully follow the principles of the Mental Capacity Act.
- Although staffing had generally improved in areas where this had previously been a concern, occupational therapists and psychologists remained concerned that they lacked the capacity to effectively function in their roles and in multidisciplinary teams.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Good

We rated Dudley and Walsall Mental Health Partnership NHS Trust as **Good** for safe because:

- The trust had effective systems for reporting and learning from incidents that involved an embedding lessons group of senior staff who considered the outcomes of investigations
- The trust's safeguarding process was robust and involved a good level of staff training. Trust policies were all in place and in date relating to safeguarding and raising concerns.

However:

- We found inconsistencies in how staff used the report format for root cause analysis investigations following serious incidents. On one occasion, a report into the death of a service user included no learning or further actions.
- During the last inspection in February 2016, we found not all risk assessments contained detailed and consistent information about historical and present risks of patients. During this inspection, risk assessments continued to be variable in the quality and consistency of documenting patient risk across services.
- The trust had not revised their business continuity policy and business continuity plan since the last inspection in February 2016. Therefore, these documents still lacked information relating to the trust's contingency plans in the instance of fire or water damage rendering all records stored unusable.
- We found several areas of concern in the organisations medicines management. During our inspection, we looked at emergency equipment and found that the grab bags on Kinver and Clent were inconsistent in content, left unsealed contrary to trust policy and some medicines were out-of-date.

Are services effective?

Requires improvement

We rated Dudley and Walsall Mental Health Partnership NHS Trust as **requires improvement** for effective because:

- The majority of care plans that we looked at were not person-centred, did not contain patients' views, and did not demonstrate consistent monitoring of patient ongoing physical health. We also found some evidence of care plans being cut and pasted from other patients' care plans.

Summary of findings

- At our previous inspection in February 2016, the trust multiagency operational policy on the use of the place of safety. During this inspection, we found that the policy had a revised 136 suite monitoring form. The policy did not reflect changes in the way in which services should care for patients detained under section 136 as this policy is a West Midlands Police policy for which serves all trust services in the West Midlands.
- Multidisciplinary team meetings were not consistently attended by all disciplines involved in patients care. Occupational therapists and psychologists did not always attend due to their limited capacity, which also meant that they struggled to become fully integrated into the multidisciplinary team and influence the predominantly medical model of care. Pharmacists did not take part in multidisciplinary meetings due to the limited staff resources.
- Patients who used the health-based place of safety were not routinely made aware of their rights under the Mental Health Act and were not informed of their right to an advocate if being assessed under the act.

However:

- Staff had the appropriate skills, experience and qualifications to support the care and treatment of patients.

Are services caring?

Good

We rated Dudley and Walsall Mental Health Partnership NHS Trust as **good** for caring because:

- Staff spoke and conducted themselves in a way that was respectful, kind, caring and compassionate.
- Staff demonstrated a professional attitude and provided practical and emotional support responding quickly to patients and providing reassurance.
- Staff knew how to communicate effectively with patients and took their time to explain things to them
- All patients we spoke with during inspection were complimentary about the support they received from the staff and felt staff provided them with the right support all the time. They told us that staff were polite and kind and treated them with respect and dignity

However:

Summary of findings

- Sixty eight percent of respondents in the patient Friends and Family Test between April 2016 and June 2016 were either 'likely' or 'extremely likely' to recommend the trust as a place to receive care. This was in comparison with 79% for April 2015 to June 2015.

Are services responsive to people's needs?

Good

We rated Dudley and Walsall Mental Health Partnership NHS Trust as **good** for responsive because:

- The number of out of area placements in the trust in the twelve months prior to inspection was zero.
- Staff in the crisis teams were proactive and flexible with patients who were harder to engage. Patients could attend the team base, or be seen at home, dependant on their choice. When patients missed their appointment or were not at home, staff would re-allocate the visit to later in the day and would attempt to make contact over the telephone.
- Patients told us that the quality of food was good and meal times were flexible. According to the patient-led assessment of the caring environment (PLACE) data provided by the trust in relation to food, Ambleside ward scored 100%; this was around 12% higher than the national average of 88%.
- Information for patients was not accessible at all locations and not always in easy read format where applicable
- The trust received 422 compliments between 1 November 2015 and 31 October 2016. This was an increase of 110 compliments compared to the year before our previous inspection.

Are services well-led?

Good

We rated Dudley and Walsall Mental Health Partnership NHS Trust as **Good** for well-led because:

- There was evidence from the inspection of services that a 'healthy' culture existed within the organisation. The majority of staff we spoke with said there was a positive culture of team working and mutual support and felt able to raise concerns and issues.
- The trust demonstrated a degree of progress in its governance and monitoring of staff supervision, appraisal and mandatory training since the previous inspection in February 2016.
- Feedback from external partners of the trust was positive.

Summary of findings

Our inspection team

Our inspection team was led by:

Team Leader: James Mullins, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

Inspection Manager: Kathryn Mason, Inspection Manager, Care Quality Commission

The team of 26 people included:

- 14 CQC inspectors
- one CQC assistant inspector
- one expert by experience who had personal experience of using, or caring for someone who uses, the type of services we were inspecting
- four nurses from a wide range of professional backgrounds
- an inspection planner
- one pharmacist special adviser
- four people with governance experience.

Why we carried out this inspection

We undertook this inspection to find out whether Dudley and Walsall Mental Health Partnership NHS Trust had made improvements to its services since our last comprehensive inspection on 1-5 February 2016 when we rated the trust as **requires improvement** overall.

When we inspected the trust in February 2016 we rated:

- The acute wards for adults of working age and psychiatric intensive care units as requires improvement overall. We rated this core service as requires improvement for safe, requires improvement for effective, good for caring, good for responsive and good for well-led.
- The wards for older people with mental health problems as good overall. We rated this core service as good for safe, effective, caring, responsive and well led.
- The community-based mental health services for adults of working age as good overall. We rated this core service as good for safe, effective, caring, responsive and well led.
- The mental health crisis services and health-based places of safety as requires improvement overall. We rated this core service as requires improvement for safe, requires improvement for effective, good for caring, good for responsive and good for well-led.
- The specialist community mental health services for children and young people as good overall. We rated this core service as requires improvement for safe and good for effective, caring, responsive and well led.
- The community-based mental health services for older people as good overall. We rated this core service as good for safe, effective, caring, responsive and well led.

In February 2016 we issued the trust with seven requirement notices that affected the acute wards for adults of working age and psychiatric intensive care units, the mental health crisis services and health-based places of safety and the trust's specialist community mental health services for children and young people. These related to the following regulations under the Health and Social Care Act (Regulated Activities):

- Regulation 12 Safe care and treatment
- Regulation 15: Premises and equipment
- Regulation 17: Good governance
- Regulation 18: Staffing

Our follow-up inspection took place six months after the publication of the comprehensive inspection report (in May 2016). We have re-rated the acute wards for adults of working age and psychiatric intensive care units and mental health crisis services and health-based places of safety. We have also re-rated the safe domains of the trust's specialist community mental health services for children and young people, wards for older people with mental health problems and the community-based mental health services for older people core services as part of this follow-up inspection (November 2016).

Summary of findings

How we carried out this inspection

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

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

During the unannounced inspection from 14 to 16 November 2016 the inspection team:

- visited 15 wards, teams and clinics
- spoke with 54 patients and 12 relatives and carers who were using the service
- spoke with 155 staff members including managers
- attended and observed 11 handover meetings and multidisciplinary meetings
- joined care professionals for 12 home visits and clinic appointments
- interviewed 17 senior managers, executives and board members
- looked at 126 treatment records of patients
- carried out a specific check of the medication management across a sample of wards and teams and looked at 51 medication charts
- looked at a range of policies, procedures and other documents relating to the running of the service.

After the unannounced inspection from 14 to 16 November 2016 the inspection team:

- attended six focus groups attended by 23 staff
- asked a range of other organisations for information including the Trust Development Authority, NHS England and clinical commissioning groups, Healthwatch, Health Education England, and the Royal College of Psychiatrists, other professional bodies, user and carer groups; we met with five representatives from these groups after the inspection
- requested and analysed information from the trust to clarify what was found during the inspection
- requested information from the trust and reviewed the information we received.
- received information from patients, carers and other groups through our website.

The team inspecting the mental health services at the trust inspected the following core services:

- acute ward and the psychiatric intensive care unit
- mental health crisis services and health-based places of safety
- specialist community mental health services for children and young people.

From whistle-blowing information shared with the CQC during the inspection, we made a decision to also carry out unannounced visits to the community-based mental health services for older people and the wards for older people with mental health problems in the 10 days following the comprehensive inspection.

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and balanced when sharing their experiences and perceptions of the quality of care and treatment at the trust.

Information about the provider

Dudley and Walsall Mental Health Partnership NHS Trust (DWMHPT) employed approximately 1,115 staff. Its application for foundation trust status was on hold at the time of the inspection to allow the organisation to focus on providing a period of stability.

The trust's main inpatient sites registered with the Care Quality Commission (CQC) were Bloxwich Hospital, Walsall; Dorothy Pattison Hospital, Walsall; and Bushey Fields Hospital, Dudley.

The trust served a population of around 560,000 people; 305,000 in Dudley and 255,000 in Walsall.

The services we inspected included those jointly commissioned by Walsall Clinical Commissioning Group and Dudley Clinical Commissioning Group.

Mental Health Act reviewers have visited the trust on five occasions since the previous inspection in February 2016.

Summary of findings

What people who use the provider's services say

Patients and carers we spoke with during our unannounced visit were very positive about the staff and the care and treatment they provided. Patients were complimentary about the friendliness, availability and helpfulness of staff. Most patients we spoke with were very complimentary about the food. Carers told us that whenever they visited the ward for older people, often without prior notice, they found high standards of staffing in both numbers and quality, and high standards of cleanliness, with patients well cared for.

The parents and young people we spoke to during inspection were all very complimentary about the service they had received. They said that they felt involved in their care and knew whom to contact in an emergency. They said that the staff always responded to phone calls in a timely manner and the young person said they felt listened to. Parents and young people shared with us at the time of inspection the challenge of car parking at the Dudley base being difficult and at times causing a degree of distress prior to appointments.

Family and carers we spoke to in a focus group told us that they regularly attend the hospitals depot medication clinic, which is a good resource. They were aware of medications prescribed and possible side effects. They felt informed and support.

Family and carers shared concerns regarding issues at the time of discharge from inpatient services. They shared instances of delays in receiving medication following discharge up to four days or being given a week's supply of medication instead of the agreed two weeks. Others described leaving without care plans and receiving community psychiatric nurse (CPN) visits every two days but not any details, which meant they had to stay at home and wait.

There was a general concern shared about a lack of communication with family and carers informing people of care and plans and also of the trust's complaints and advocacy services. This was also shared through focus groups we held with local Healthwatch groups. Advocacy services we spoke with during inspection described care as medically focused and often patients struggled to fully understand multidisciplinary review meeting discussions as terminology used was complicated and medical in nature and at time not fully explained.

Recognition was given to changes in some environments managing mixed genders on inpatient wards better however others still felt there was a lack of space in the wards for visiting and having private conversation without having to leave the ward often to the designated smoking area regardless whether patients and family smoked or not.

Good practice

- The trusts chief executive had nominated the specialist community mental health services for children and young people for a national NHS award for their work around transformation.
- The trusts chief executive had also nominated the specialist community mental health services for children and young people for the 'Frontline Team of the Year' award for the trust's annual Recognising Success Awards.
- Wards for older people with mental health problems had staff undertaking risk-based observations ensured these were beneficial, rather than intrusive, for patients. They did this by engaging patients in positive interactions and activities, based on a good understanding of their needs and wishes.
- CCGs recognised the trust's strategy review on falls as an area of good practice. The work undertaken was proactive and innovative. Trust management had also shared this with acute trusts in the area as a means to share good practice.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that emergency equipment and medicines are checked consistently and managed in line with the recommendations of the Resuscitation Council.
- The provider must ensure that risk assessments are present, up-to-date and regularly reviewed for all patients. The risk assessments must be detailed enough to capture all risks and have clearly state how staff should manage the risks identified.
- The provider must ensure that all staff receive and are up to date with mandatory and essential training.
- The provider must ensure that staff always follow the trust's rapid tranquillisation policy by carrying out physical health observations and completing the monitoring forms after the administration of rapid tranquillisation.
- The provider must ensure that staff carry out ongoing physical health monitoring for all patients in line with the trust's policy and national guidance.
- The provider must ensure that care plans are up-to-date and are detailed, holistic, person-centred and recovery-focused.
- The provider must ensure that staff follow good practice in relation to the Mental Capacity Act.
- The provider must ensure their multi-agency operational policy for place of safety is updated and in line with the Mental Health Act Code of Practice, 2015.
- The provider must ensure that effective processes are in place to monitor the quality of recorded information for all patients assessed in the health-based places of safety. Information about rights being given to patients and when they commenced on section 136 of the Mental Health Act were not being consistently recorded. This was not in line with the code of practice. The police can use section 136 of the Mental Health Act to take you to a place of safety when you are in a public place. They can do this if they think you have a mental illness and are in need of care.
- The provider must ensure all care plans are personalised to the patient's individual needs and staff and patients work collaboratively to produce them.
- The provider must ensure that staff complete and update risk assessments and risk management plans for all patients.

Action the provider SHOULD take to improve

- The provider should ensure they maintain and check all equipment used by patients in accordance with agreed schedules on wards for older people with mental health problems.
- The provider should ensure training done by staff is captured promptly by the trust in order to accurately identify any training needs.
- The provider should ensure that the fire extinguishers are inspected on time.
- The provider trust should ensure that positive behaviour support plans are in place for patients with behaviours that challenge.
- The provider should ensure that all handovers are detailed and fully discuss individual patients' risks. All staff coming on shift should attend handovers.
- The provider should ensure that all patients receive copies of their care plans.
- The provider should ensure that patient activities are planned for weekends as well.
- The provider should ensure that information is made available in an easy-read format to meet the needs of patients with severe cognitive impairment.
- The provider should ensure more detailed risk management plans are developed following risk assessment.
- The provider should ensure patients receive crisis plans in addition to their care plan.
- The provider should have consideration for patient's privacy and dignity by ensuring patients are able to lock the toilet door in the health –based place of safety at Dorothy Pattison hospital.

Summary of findings

- The provider should ensure that people who use crisis services have access to psychology-based therapies.
- The provider should ensure that the staff are aware of the operational protocol to support the introduction of the cardio metabolic risk assessment.
- The provider should ensure that staff undertake personal safety training tailored to the potential risks of the service's patient group.
- The provider should ensure that fit and proper person requirements for directors are up to date, regularly reviewed and any gaps acted upon.

Dudley and Walsall Mental Health Partnership NHS Trust

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider. During this inspection, we examined the Mental Health Act in the mental health acute wards for adults of working age and psychiatric intensive care units and the mental health crisis services and health-based places of safety services.

Most staff had received training in Mental Health Act (MHA) however training records in the crisis and health based place of safety services indicated that 57% of staff had received training in Mental Health Act (MHA) . Staff explained to patients their rights on admission and routinely after admission. The wards displayed information on the rights of detained patients where it was easily accessible. However, in the crisis services we found recording of whether a patient had received their rights was missing in ten cases.

The trust had a current Mental Health Act policy and staff told us that they were aware of this. Staff we spoke to showed a good understanding of the MHA and the Code of Practice. However, the multi-agency operational policy on the use of the place of safety remained out-of-date and did not reflect the guidance in the revised Mental Health Act Code of Practice introduced in April 2015; therefore, staff using the place of safety were misinformed.

The majority of MHA record keeping and scrutiny was appropriate. Detention records were up-to-date, stored appropriately and compliant with the MHA and the Code of Practice. The MHA administrator offered support to the wards to ensure that staff followed proper MHA procedures in relation to renewals, consent to treatment and appeals against detention. Consent to treatment and capacity forms were completed and attached to the medication charts of detained patients. However, similar to the findings of our inspection in February 2016, of the crisis and health based place of safety services we found inconsistency in recording the beginning or ending of the person's detention under section 136 of the Mental Health Act, and the majority of the forms were incomplete or missing. There was also no evidence of an effective audit system in place.

Independent mental health advocacy (IMHA) services were readily available to support patients. Staff knew how to contact the Mental Health Act team for advice when needed. This meant that staff could get support and legal advice on the use of the MHA when needed.

Mental Capacity Act and Deprivation of Liberty Safeguards

During this inspection, we examined the Mental Capacity Act and the Deprivation of Liberty Safeguards in the mental health acute wards for adults of working age and psychiatric intensive care units and the mental health crisis services and health-based places of safety services.

The trust had a current policy on Mental Capacity Act (MCA) including deprivation of liberty safeguards (DoLS) that staff were aware of and could refer to at any time. Staff we spoke with showed a good understanding of the Mental Capacity

Detailed findings

Act and we saw documented in care notes whether a patient had capacity or not. Most staff employed by the trust had received training in the Mental Capacity Act. The trust required staff to update this training every three years.

Staff assessed and recorded patients' capacity to consent to treatment with the exception of patients referred to the crisis team who should have the capacity to agree to the assessment and transfer of care. However, staff in the adult acute wards did not do this on a decision-specific basis. There was a standard form used to assess capacity, which did not record information in detail on how they sought capacity to consent or refuse treatment, or consistently record their reasons for decisions made.

In the acute and crisis services when patients lacked the capacity, the multidisciplinary team made decisions in the patient's best interest, recognising the importance of their wishes, feelings, culture and history. Staff involved relatives and the independent mental capacity advocate (IMCA), where appropriate.

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

At the time of our inspection, the acute wards had one patient who was subject to Deprivation of Liberty Safeguards (DoLS), and awaited a decision on another application.

Good

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean care environments

- All the locations we visited during the inspection were clean and maintained to a high standard. We saw evidence of regular cleaning schedules in place. Patients on the acute inpatient wards told us that the level of cleanliness and maintenance was good which was supported by the patient–led assessment of the caring environment (PLACE) findings. Visiting relatives to the older people's wards also told us they always found wards clean and well maintained whenever they visited. PLACE assessments will see local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job.
- The trust-wide ligature risk policy was in date. A **ligature** is anything that a patient could use for the purpose of hanging or strangulation. Management had undertaken an annual ligature risk assessment in January 2016 and again in October 2016 and November 2016 in all inpatient areas and the ligature policy detailed how staff should escalate significant risks. Individual ward ligature risks assessments detailed actions required and completed to ensure monitoring and mitigation. The older people's wards effectively balanced ligature risk and the need for a dementia-friendly environment on two of the wards.
- Environmental risk assessments were also in place including regular legionella checks following past reports of higher than average levels of legionella in trust premises. We saw evidence of regular checks and maintenance of equipment used across services we inspected. However, we found that the fire extinguishers on Langdale, Ambleside and Kinver wards had passed the dates for inspection in July and October 2016.
- We found that the layout of the wards inspected generally allowed clear lines of sight for staff to observe patients. Where this was not the case, staff observed patients and the trust had identified and recorded the risk on local risk registers and in some appropriate instances, mirrors were on order to reduce this risk.
- All clinic rooms we visited appeared clean and most were fit for purpose. Staff checked equipment regularly to ensure it was in good working order so that equipment was safe for use in an emergency. However, we found inconsistencies in staff checks of emergency equipment and medicines on Ambleside, Clent and Kinver wards. We found staff on Kinver and Clent wards kept emergency medicines for a severe allergic reaction in a locked medicine stock cupboard. This meant that these medicines were not readily available in an emergency as recommended by the resuscitation council. We also found inconsistencies in the contents of emergency bags across acute wards and some equipment was out-of-date. All wards had resuscitation grab bags, however, those on Clent and Kinver wards were not in line with the trust policy and the resuscitation council recommends the use of a tamper-evident seal to ensure the contents of the bag remain secure and available.
- The trust did not have any seclusion rooms in its inpatient services and reported no incidents of seclusion in the six-month period from May 2016 to October 2016. Seclusion is the supervised confinement and isolation of a person away from other patients, in an area from which the person is prevented from leaving (Mental Health Act CoP 2015).
- On the majority of wards, there were clear arrangements for ensuring that there was single-sex accommodation in line with guidance from the Department of Health and the MHA Code of Practice. There were no incidents of mixed sex breaches occurring from 1 November 2015 to 31 October 2016. On our previous visit on Linden and

Cedars wards, the female and male bathrooms were next to each other. This had changed during this inspection with male and female bedrooms in separate corridors and female-only lounges now available.

- All services we visited during inspection had information on how to follow infection control principles displayed in all key areas. Staff followed infection control principles including handwashing. Services carried out environmental audits concerning infection control precautions (hand hygiene), security of sharps and cleanliness of equipment.
- There was access to appropriate alarms and nurse call systems in the majority of services we inspected. Where alarms were not fitted in rooms, all staff had access to personal alarms. We noted during our inspection that a discontinued alarm in the disabled toilets on Holyrood was still in place. CQC staff raised this and the trust commenced action at the time of inspection.

Safe staffing

- At the time of our inspection, we concluded that the staffing levels and skills mix across the wards and teams inspected was generally sufficient to provide safe care. Acute ward managers established staffing levels in line with the national institute for health and care excellence (NICE) guideline SG1: Safe staffing for nursing in adult inpatient wards in acute hospitals, taking into account the bed occupancy and the level of illness of patients. Staff and patients on the adult acute wards told us staffing levels were rarely below the required numbers. Patients told us that staff rarely cancelled leave or activities. Patients told us that they felt safe.
- In October 2016, there were 962 whole time equivalent (WTE) substantive clinical staff working at the trust and there had been 125 leavers in this period. Staff turnover was reported as 13%.
- Across the trust, there were 183 whole time equivalent vacancies, excluding seconded staff. This was equal to a 16% vacancy rate. The staff sickness rate for all permanent staff across the year before our inspection was 4.8%. This was consistent with the year before our previous inspection in February 2016.
- Bank and agency staff filled 250 WTE inpatient positions between August and October 2016 to cover sickness, absence or vacancies. There were 0.9 WTE posts not filled in the same period.
- Medical cover was generally acceptable across the services we inspected at this time. However, community mental health services for children and young people did not have a specialist child and adolescent mental health services (CAMHS) doctor out of hours. Outside normal working hours, the trust-wide on-call medical doctor provided cover.
- The trust audited its management of medical revalidation through both internal and external processes, in line with the national implementation procedures. Medical revalidation is the renewal process by which doctors in the UK demonstrate to the General Medical Council (GMC) on a regular basis that they remain up to date and fit to practise. Fifty-nine out of the trust's 67 doctors had completed revalidation on the date of inspection. This compared with 38 of the trust's 66 doctors (60%) at the previous inspection in February 2016, with three doctors being deferred for the period between April 2016 and October 2016.
- Eleven of the 12 mandatory training areas were above the trust's target of 70% staff completion at the time of inspection. Moving and handling was the only course below this level, with 56% compliance. Compliance rates included health and safety at 82% staff completion, infection control (Level 1) at 75% and equality, safeguarding adults level one 78% and level two 76%. We noted that the board had recently agreed for the trust to increase its target for mandatory training to 90% as from 1 April 2016 to align with other healthcare organisations. 'Prevent' training, part of the government's counter terrorism strategy, was a one-off training course within the trust. It had 76% completion compared with 37% at the time our previous inspection in February 2016.

Assessing and managing risk to patients and staff

- The trust's safeguarding process was robust and involved a good level of staff training. Trust policies were all in place and in date relating to safeguarding and raising concerns, (whistleblowing procedures). The trust had a safeguarding team that oversaw and governed all safeguarding alerts and referrals. Between 1 November 2015 and 31 October 2016, there were six safeguarding alerts. Between November 2014 and October 2015, the trust made 271 child referrals and 238 adult referrals. The trust's safeguarding team had established close working arrangements with other agencies including CCGs and local authorities where required. There was

evidence of internal scrutiny and triangulation of trends across safeguarding and incidents within the organisation. As of 31 October 2016, 78% of staff had completed adults' safeguarding level 1 training; 75% level 2; 96% level 3; and 13% level 4. For children's safeguarding level one, 82% of staff had completed the training; for level two it was 78%; level 3, 99%; and level 4 13%. Children's and adults' level 1 and 2 training is mandatory and completed every three years, while levels 3 and 4 are not mandatory but are refreshed every year. We audited five safeguarding records of which all were robust and contained patient details and views, next of kin details and views, information pertaining to capacity and consent, details of the investigation and the outcomes. Records showed there were other agencies involved and included detailed minutes of any related meetings.

- During the last inspection in February 2016, we found not all risk assessments contained detailed and consistent information about historical and present risks of patients. We saw that the trust had reviewed the risk assessment tool and introduced a new risk assessment tool. On this inspection, we reviewed 198 care records for patients that included risk assessment documentation and found continued variability of quality and consistency of documentation of patient risk across services.
- There were no incidents of seclusion across the trust from 1 November 2015 to 31 October 2016.
- From November 2015 to October 2016, there were six incidents of long-term segregation. During our previous inspection, we found inaccuracies in record keeping in some instances of long-term segregation on the adult acute wards and that record keeping was not always in line with trust policies. During this inspection, we reviewed one patient's long-term segregation records and found they were in line with MHA Code of Practice.
- The trust's restrictive practice reduction programme for physical restraint, rapid tranquillisation and seclusion was in line with best practice/guidance and up to date. When we last inspected the trust in February 2016, there were blanket restrictions used on all the acute wards and we found inconsistent practice across wards. On this inspection, we found that the trust had made improvements concerning blanket restrictions having reviewed all related existing policies in line with their restrictive intervention work plan to ensure they included consistent least restrictive principles. The trust had also introduced individual risk management of patients to address and monitor individual risks and least restrictive practice. Nursing staff told us they feel practice has improved due to these changes.
- During the inspection in February 2016, we found that staff on adult wards sometimes prevented informal patients from leaving the ward when they wanted to. On this inspection, we found there were signs on the doors informing informal patients they could leave at their will and there had been improvement in the practice for reviewing patients who wished to leave.
- Trust figures for restraint for November 2015 to October 2016 showed 405 incidents of restraint. This use of restraint involved 237 separate patients. Of the 405 incidents of restraint, staff used prone restraint 48 times. The highest reporting ward for restraint was Linden Ward with 81 restraints in this period. These reflected the fact that the service had a culture of high reporting, and the majority of these restraints involved minimal contact, where staff gently escorted patients away from potential conflict. During our inspection of Linden ward, we observed staff gently de-escalating potential incidents of conflict by good observation and intervention and engagement.
- The trust's team of pharmacists visited wards regularly to check medication stock, monitor the safe management of medicines and carry out audits however did not attend multidisciplinary meetings due to the limited staff resources. During our visit, we saw evidence of pharmacy technicians having left written advice on a standard pharmacy advice note attached to the front of a patient's prescription chart. This ensured that ward staff would see important advice. The pharmacy department also provided a monthly newsletter for clinical staff that promoted safe and effective use of medicines. The trust pharmacy team had developed a bespoke side effect monitoring tool for anti-psychotics, which staff used on the wards. During our re-inspection, we found several areas of concern in the organisation medicines management. During our visit we looked at emergency equipment and found that the grab bags on Kinver and Clent were inconsistent in content, left unsealed contrary to trust policy and some medicines were out-of-date, audit records of these bags evidenced this. Emergency drugs for these wards were stored in locked cupboards inside of locked clinic rooms. This meant that these medicines for emergency

use were not readily available in an emergency as recommended by the Resuscitation Council. We found variable standards of medicines management practice (transport, storage, dispensing, and medicines reconciliation) in the services we inspected. Concerns from previous inspections regarding the crisis team transportation of medication and recording of controlled drugs had been fully addressed. Medicines were in date and prescription charts were clear and well documented for all crisis services visited. Staff checked fridges and room temperatures daily. The trust provided the Choice and Medication online resource on its website, which patients or staff had access to obtain easy-to-read information on medication and conditions. This promoted patient involvement and choice with their medication. However, we did not find evidence of patients using this.

- There had been thirty recorded incidents of rapid tranquilisation administered on the wards in the year from November 2015 to October 2016. Staff recorded each of these incidents and the governance team and the clinical lead reviewed them all. The pharmacy team reviewed all uses of these medicines. However, during this inspection we found on the adult acute wards staff did not always follow the trust's policy when they administered rapid tranquillisation by not completing physical health observations and routinely completing clinical monitoring forms.
- The trust had a lone working policy in place for staff. Staff we spoke with were aware of local lone working practices and how to best support colleagues and maintain safety. However, the trust had not updated this policy to reflect changes in working practices already introduced or planned.

Track record on safety

- The trust discovered increased levels of legionella spores in the water systems of Dorothy Pattison Hospital during 2015 and had to evacuate patients on the wards because of the purification process. During this inspection, the trust reported that there was no longer legionella in the water and that the trust now had processes in place to monitor this.
- The STEIS (Strategic Executive Information System) which captured all serious incidents data for the trust recorded 36 incidents between 1 October 2015 and 31 October 2016. Ten of the 36 incidents related to patients absconding or their unauthorised absence; one involved a slip, trip or fall; and four involved the admission of a patient under the age of 18 to an adult ward; one was an infection control incident; 13 were apparent, actual or suspected self-inflicted harm, meeting serious incident criteria; two were the failure to obtain an appropriate bed for a child; and four were deaths. Of the four deaths, one was at Bushey Fields Hospital, and three were not on trust premises.
- The acute wards for adults of working age reported the highest number of incidents with 23 (59% of all reported incidents). Apparent/actual/suspected self-inflicted harm meeting serious incident criteria was the most common type reported with 17 (43.5% of all incidents reported).

Reporting incidents and learning from when things go wrong

- The trust had effective systems for reporting and learning from incidents that involved an embedding lessons group of senior staff who consider the outcomes of investigations. The trust and ward managers shared lessons learnt from incidents with staff through a range of methods including handovers, emails, supervision, reflective practice sessions and postings on the intranet. Managers offered staff debriefs and support after serious incidents.
- Staff we spoke to during inspection reported they were aware of how to complete incident forms and their responsibilities in relation to reporting incidents. They were able to explain the process they used to report incidents through the trust reporting systems.
- During our inspection, we audited six completed serious incident investigation files; three of these were concise reports and three were full reports. The organisation had investigated in line with national guidance of undertaking a full root cause analysis (RCA) investigation when unexpected deaths and or suicides occur within services. The trust's serious untoward incident policy reflected this. From our audit, we found that report formats did enable links to the trust's incident reporting systems or the identification of individual patients through documentation of an NHS number. One report used patient initials and identified the hospital ward and dates of admission, which raised a confidentiality issue surrounding the report. All reports used a risk rating of incidents considering severity of risk and likelihood of reoccurrence; however, there was no key to evidence criteria to the reader. We noted during

our inspection that the format was lacking a safeguarding section. We saw good evidence of duty of candour and communication with patients and their relatives but a lack of relative and staff support documented. Most investigation reports documented lessons learnt which were shared in the trust's embedding learning meeting and actions monitored by the patient safety team. However, despite the seriousness of one of these reports investigating a death, there were no lessons learnt and no recommendations made.

Duty of Candour

- The trust continued to demonstrate good structures and process in place to inform staff and monitor duty of candour within the organisation since the previous inspection in February 2016.
- The trust had provided all senior leads, managers and band 6 nurses with awareness briefings in the duty of candour. The trust did not offer formal duty of candour training as a centrally monitored training course; however, the trust held education sessions for staff and produced a number of resources. These included duty of candour leaflets and the trust's intranet page for duty of candour for support and information, there was a designated duty of candour policy and a trust compliance and safety team to support and monitor duty of candour.
- Staff we spoke with during inspection were aware of the duty of candour and gave us examples of openness and honesty with patients when there were mistakes made.
- At the time of the previous inspection in February 2016, the trust had plans to introduce a new strategy to involve families in serious incident processes. When we reviewed serious incident investigations during our inspection, we could see the trust contacted patients' families. However, staff did not always record the support they offered to families.

Anticipation and planning of risk

- There was an updated business continuity plan at the time of the inspection. The business continuity policy was under review and was ratified in February 2017.
- The trust's major incident and business continuity plan was comprehensive detailing incident response procedures as well as providing action cards and forms for staff use during an incident. This document also included; the business continuity management policy, the business impact assessment, the business disruption risk assessment, emergency preparedness and business continuity training schedule and the information and communications technology (ICT) disaster recovery (DR) plan.

Requires improvement

Are services effective?

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

Summary of findings

Our findings

Assessment of needs and planning of care

- The trust was in the process of redesigning the care planning process. At the time of inspection, care planning and record keeping were not effective throughout the trust services we visited. Care records showed that staff completed care-planning processes in a timely manner following patients' admission that included a physical examination, which ensured that other members of the team had relevant and up to date information. However, the majority of care plans we looked at were not person-centred, did not contain patients' views, and did not demonstrate consistent monitoring of patient's ongoing physical health. We also found some evidence of care plans being cut and pasted from other patients' care plans.
- The wards managed care records appropriately using both paper and electronic systems. Records were organised, stored safely and staff could access patients' records when needed. Managers of the acute wards for adults of working age and psychiatric intensive care units informed us that the trust planned to move to a new system of electronic records in the near future.
- Police completed a joint assessment form with the approved mental health practitioner (AMHP) for all patients assessed in the health-based places of safety. We looked at 15 forms, of which six were fully completed, and nine were incomplete or missing. There was no requirement to complete any other clinical notes in these services.

Best practice in treatment and care

- The trust had a policy on prescribing medicines that was in line with the national institute for health and care excellence (NICE) guidelines such as medicines adherence (clinical guidance 76) and psychosis and schizophrenia: preventions and management of in adults (clinical guidance 178). However, on the acute wards for adults of working age and psychiatric intensive care units we found that 10 patients were on more than one antipsychotic medicine and four patients had total doses of antipsychotic medicine above British National Formulary (BNF) levels.
- The teams we looked had evidenced consideration of patients' physical health needs within care plans. Teams worked closely to ensure appropriate tests and results were obtained where necessary. However, there were no care plans for additional physical health monitoring and any potential side effects. There was no evidence of any regular physical health checks and staff did not consistently complete weekly side effects monitoring scale forms.
- Staff used a variety of outcome measures in practice including the health of the nation outcome scales (HoNOS), the national early warning score (NEWS) and the model of human occupation screening tool (MoHOST) to monitor patients' progress and recovery. We saw evidence of this within the care records we looked at.
- Staff carried out a range of clinical audits to monitor the effectiveness of the service provided. These included clinical records, medicines charts, infection control and prevention, health and safety, patient activities, Mental Capacity Act, Mental Health Act and environmental audits. Managers discussed results with staff in supervisions and team meetings. The wards used the findings to identify and address changes needed to the quality of the service provided.

Skilled staff to deliver care

- The majority of services we visited had access to a full range of mental health professionals and workers including psychologists, psychiatrists, and pharmacists, nurses, nursing assistants, activity coordinators and occupational therapists.

Requires improvement

Are services effective?

- Staff had the appropriate skills, experience and qualifications to support the care and treatment of patients. The trust provided staff with training relevant to their role.
- The trust had a policy in order to support managers with dealing with poor performance. Managers addressed issues of staff performance in a timely manner in management supervision and received support from the human resources team for any disciplinary issues.
- New staff received appropriate trust and ward inductions. The trust gave bank staff formal inductions and nurses gave them ward inductions if they were new to that ward. Agency staff received induction at ward level. The trust also had a preceptorship programme for newly qualified staff. Staff gave positive feedback about the preceptorship programme although one staff member felt they did not receive enough support. The trust encouraged unqualified staff to complete the care certificate.
- When we last inspected the trust in February 2016, we found that staff did not receive clinical supervision and appraisal in line with the trust's policy. On this inspection, we found that the trust had implemented a system to help ensure staff received supervision appropriate to their roles, and in line with trust policy standards. The trust had made improvements and records reviewed showed that the ward managers provided regular and good quality supervision to staff. As at October 2016, the trust had an appraisal rate of 79% for permanent non-medical staff and 92% for medical staff.
- Managers provided staff with an annual personal development plan (PDP). Data received from the trust showed that all staff working for the mental health crisis and health-based places of safety teams had received a PDP in the year prior to our inspection. In the acute and psychiatric intensive care services, Ambleside and Kinver wards reported the highest rate with 88%, followed by Clent ward with 76%, Wrekin ward with 72% and Langdale ward with 67%.

Multidisciplinary and inter-agency team work

- Services that we visited had daily multidisciplinary team meetings. These meetings involved different professionals within the team and sometimes included professionals from other teams and family members. Occupational therapists and psychologists did not always attend due to their limited capacity also meant that they struggled to become fully integrated into the multidisciplinary team and influence the predominantly medical model of care.
- Pharmacists did not take part in multidisciplinary meetings due to the limited staff resources. However, they were available to discuss medication treatment during their daily ward visits.
- The trust had good working relationships between the core services. They shared information about patients likely to move between services and discussed patients due for discharge. This helped ensure that staff understood patients' needs and offered the right support. During the inspection, we observed good handover systems in place to ensure staff communicated between each shift.
- The teams had strong links with relevant external organisations to ensure patients received the support needed to meet their needs. They worked closely with GPs, hospitals, police, local community facilities, the local authority, housing associations, the benefit office and health commissioners. A local strategy group had been set up in order to monitor and ensure collaborative working between agencies in relation to the 136 suites for which crisis team members regularly attended.

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

- Staff in the services we visited during inspection showed good understanding of the Mental Health Act and the code of practice. Mental Health Act (MHA) training had a completion rate of 55% from 1 November 2015 to 31 October 2016. This was a reduction from February 2016 when 69% of staff had completed the training. The Mental Health Act training was not mandatory, however, it was essential for clinical staff and they received updates every three years. In the crisis and health-based places of safety services, 56% of eligible staff were up to date with this training and 57% of eligible staff in the acute wards and psychiatric intensive care units had MHA training. However, staff told us the MHA training did not include specialist training in the use of section 136 of the MHA.
- Where appropriate, consent to treatment and capacity forms were completed and attached to the medication

charts of detained patients. Staff in the health-based places of safety were aware they did not have the authority to administer medication to anyone detained under section 136 of the act.

- On the acute and psychiatric intensive care units, staff explained to patients their rights on admission and routinely after admission. Staff monitored this regularly. Patients on these wards confirmed that staff had explained their mental health act rights to them. However, in the crisis and health-based places of safety services we found inconsistencies in the recording of people receiving their rights. Staff had recorded that one person had received their rights in verbal and written form, four people received only verbal rights and ten people had not received their rights at all.
- Staff knew how to contact the MHA administrator in the trust for advice when needed. The MHA administrator offered support to the wards to ensure that staff followed proper MHA procedures in relation to renewals, consent to treatment and appeals against detention. They gave legal advice on the implementation of the MHA and its code of practice to ward staff.
- The MHA administrator carried out regular audits to check that staff were applying the MHA correctly. There was evidence of action plans and improvements made because of audits. However, although there had been audits of the use of section 136, there were no effective audits or processes in place to monitor the quality of recorded information. During this inspection, we found that staff had not been completing all sections of the 136 paperwork.
- The wards displayed information on the rights of detained patients where it was easily accessible. The independent mental health advocacy (IMHA) services were readily available to support patients. Most of the staff were aware of how to access and support patients to engage with the advocate. People detained in the place of safety under section 136 were not eligible for services from an independent mental health advocate as defined in the Mental Health Code of Practice. However, patients could request an advocate if they were to be assessed under the Mental Health Act process. Staff we spoke with were not aware of how to access written information about patients' rights whilst under section 136 and we saw no evidence that this had been offered, apart from one occasion.
- At the time of our previous inspection in February 2016, the trust was not following the Mental Health Act Code of Practice in the place of safety by not consistently and accurately documenting patient's detention. During this inspection, we found varied but limited improvements. The trust had updated their joint paperwork to a good standard and the updated paperwork was available for staff to use from October 2016. However, we found staff were not always recording when people had been detained under section 136 in line with the Mental Health Act Code of Practice. This meant we could not determine if staff followed guidelines set out by the Royal College of Psychiatrists and the Code of Practice. Paperwork reviewed at the 136 suite at the time of this inspection showed the majority of forms seen were incomplete or missing. Although there had been audits of the use of section 136, there were no effective audits or processes in place to monitor the quality of recorded information. Staff did not always record when people had been detained under section 136 in line with the Mental Health Act Code of Practice. This meant we could not determine if staff followed guidelines set out by the Royal College of Psychiatrists and the Code of Practice.
- When visiting the crisis team and health based places of safety there were 15 new forms across both sites for us to review. We found that there was inconsistency in recording of people receiving their rights. Staff had recorded that one person had received their rights in verbal and written form, four people received only verbal rights and ten people had not received their rights at all.
- When visiting the acute wards for adults of working age and the psychiatric intensive care units we found that overall, the MHA record keeping and scrutiny was appropriate. We reviewed the detention records of 15 patients. They were up to date, stored appropriately and compliant with the MHA and the Code of Practice.
- At our previous inspection in February 2016, the trust multiagency operational policy on the use of the place of safety. During this inspection, we found that the policy had a revised 136 suite monitoring form. The policy did not reflect changes in the way in which services should care for patients detained under section 136 as this policy is a West Midlands Police policy for which serves all trust services in the West Midlands.

Good practice in applying the Mental Capacity Act

Requires improvement

Are services effective?

- At the time of our inspection, 79% of staff employed by the trust received training in the Mental Capacity Act. The trust required staff to update this training every three years and it was essential for all clinical staff. In the crisis services, training records indicated that 91% of staff had received training in the Mental Capacity Act. In the acute services, training records showed that 76% of staff had received training in Mental Capacity Act (MCA).
- The trust had a policy on the Mental Capacity Act, including DoLS, which staff were aware of and could refer to on the trust intranet. Staff could discuss any MCA matters with medical staff and the trust lead.
- Part of the inclusion criteria for referral to the crisis team was that staff deemed patients to have capacity. During medical reviews, staff always assessed capacity as a standard part of the process. Staff supported patients to make decisions independently before they assumed to lack the mental capacity to make those decisions.
- The MCA is not applicable to children under the age of 16. Staff used the Gillick competence, which balances children's rights with the responsibility to keep children safe from harm, for those under 16. All staff we spoke to demonstrated knowledge of Gillick competence.
- On the acute and psychiatric intensive care wards, staff assessed and recorded patients' capacity to consent to treatment. However, staff did not do this on a decision-specific basis. Staff did not record information in detail on how they sought capacity to consent or refuse treatment. Staff did not consistently record their reasons for decisions made about patients' capacity.
- When patients lacked capacity, the multidisciplinary team made decisions in the patient's best interest, recognising the importance of their wishes, feelings, culture and history. Staff involved relatives and the independent mental capacity advocate (IMCA) where appropriate.
- Staff made deprivation of liberty safeguards (DoLS) applications when required. Seventy-six DoLS applications made between November 2015 and October 2016. Of the 76 applications made, 74 met the approval threshold.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

- Throughout the inspection, we observed a range of interactions between staff and patients. Staff spoke and conducted themselves in a way that was respectful, kind, caring and compassionate. Staff demonstrated a professional attitude and provided practical and emotional support responding quickly to patients and providing reassurance. Staff knew how to communicate effectively with patients and took their time to explain things to them.
- In the 2016 Patient-led assessments of the care environment (PLACE), the trust scored 86.2% for privacy, dignity and wellbeing across all services. This was slight decrease from 88.6% in the 2015 survey. Langdale acute ward had the highest score with 95.3%, followed by Kinver and Wrekin wards with 91.1%, Clent ward with 87.5% and Ambleside ward with 81.7%. Langdale, Kinver and Wrekin wards scored higher than the national average of 89.7%
- Sixty eight percent of respondents in the patient Friends and Family Test data between April 2016 and June 2016 were either 'likely' or 'extremely likely' to recommend the trust as a place to receive care. This was in comparison with 79% for April 2015 to June 2015. Seventy-nine per cent of respondents in the staff Friends and Family Test data between April 2016 and June 2016 were either 'likely' or 'extremely likely' to recommend the trust as a place to work, compared with 86% for April 2015 and June 2015.
- All patients we spoke with during inspection were complimentary about the support they received from the staff and felt staff provided them with the right support all the time. They told us that staff were polite and kind and treated them with respect and dignity. They felt staff were knowledgeable and took time to understand their individual needs.
- During our inspection of older people's inpatient wards, we undertook Short Observation Framework for Inspection (SOFI) assessment on Linden and Cedars wards. These study the interactions of patients who may not be able to articulate concerns easily. Results of these showed overwhelmingly positive interactions taking place, with staff reacting promptly to requests, and supporting and enhancing patient safety and well-being.

The involvement of people in the care they receive

- Since the previous inspection in February 2016, the trust had continued to involve patients in several ways. These included a service experience desk created to encourage patients to be involved in service development through compliments and complaints, a community development worker to work with hard to reach groups of patients, experts by experience (people who had experienced services) involved in improvement forums, community and careers groups and non-executive directors involved in forums.
- Trust services had completed a range of audits and surveys to hear patient and carers views. These included a survey of patient views on treatment groups offered, carers support groups and an audit of the carer engagement strategy within the organisation and community services care plans. All audits including the findings of patient and carer views, highlighted good practice and made recommendation to continue to improve areas of practice.
- The trust had a number of patient representative groups. In Dudley, there was SAMH, POHWER and VoiceAbility; In Walsall, there was Age UK Walsall, VoiceAbility and Walsall SUE who all provided Independent Mental Health Act advocacy (IMHA) and Independent Mental Capacity Act (IMCA) advocacy services.
- All wards we visited had ample information about the ward environment, facilities and services. All patients admitted received a welcome pack and a tour of the ward. There were posters signposting patients and carers towards services such as advocacy. Staff also held community meetings where patients could raise any issues of concern.

Good

Are services caring?

- Patients told us they were actively involved in multidisciplinary clinical reviews and staff took time to speak to them about care plans and treatments. However, only some of the patients we spoke to had received copies of their care plans. Patients told us that they attended their clinical reviews and were able to express their views.
- Staff involved carers and relatives in care planning and clinical reviews with the patient's consent. Staff also invited families and carers to meetings and encouraged to visit inpatient wards. Some adult acute wards had a carers' lead worker who met regularly with families and carers offering emotional support, advice about care and treatment and information about other useful organisations.
- The trust promoted the use of the 'triangle of care', which ensured carers involvement and prompted staff to discuss carers issues and assessments. Carers in the crisis services reflected this; carers were positive about the service, and had felt involved and listened to by staff.
- Adult acute wards completed regular surveys to gain patient and carer views to influence changes to services. These wards also had an expert by experience who attended the ward to speak with patients regularly. Staff in the crisis and health based place of safety services conducted similar surveys. Patients received user satisfaction questionnaires when they exited the service, which the trust audited. We reviewed the data collated from eight surveys in the Dudley team, which showed patients were 100% satisfied with their care and treatment.

Good

Are services responsive to people's needs?

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

Summary of findings

Our findings

Service planning

- Trust services were planned to meet the needs of the local population of the towns of Dudley & Walsall. The trust delivered services within a health economy that contained the diversity, degree of deprivation and health inequalities across a heavily urban area.
- Previously in February 2016, the commissioners we spoke to had positive feedback of involvement in service planning to meet the needs of people in Dudley and Walsall and shared the example of CAMHS Tier 3 plus service that the trust had developed. However, when speaking to Healthwatch during this inspection they raised a concern that the deaf community did not feel that the trust tailored services for them; an example shared was the lack of access to interpreters for deaf patients.

Access and discharge

- The crisis teams were accessible 24 hours every day. Crisis team staff assessed each referral within 24 to 48 hours, dependant on the urgency. Staff were flexible as to where they saw patients. However, the trust did not monitor the time taken from initial assessment to the onset of treatment, although the teams would start treatment following assessment.
- Records within the places of safety were incomplete meaning that we could not determine the length of stay for all patients. Of the 15 records we saw, we found that staff only assessed four patients within the four-hour period and two took five hours. These findings were not in line with the Royal College of Psychiatrists standards that assessment under section 136 should be within four hours, or as near as possible.
- When we last inspected the trust in February 2016, we found that crisis staff did not always return calls to patients in a timely manner and, on occasions, not at all. The trust had made a number of changes to improve this including the completion of a crisis call log. A target was set that staff responded to all calls within one hour. Staff were required to complete an incident form, when calls were not returned within one hour. Audit results for the month of August 2016 showed that both teams combined had received 580 calls. The average response time for the Dudley team was seven minutes and Walsall was 25 minutes.
- Average bed occupancy in the trust in the last 12 months from November 2015 to October 2016 was 92% compared to 82% at our previous inspection. Ambleside ward had the highest rate with 107%.
- The number of out of area placements in the trust in the twelve months prior to inspection was zero.
- Managers and staff we spoke to on adult acute wards stated they had good access to PICU beds in neighbouring trust's, and could transfer a patient on the same day where it had been arranged with the commissioners.
- Some patients and staff we spoke to said that patients did not always have access to a bed on the same ward on return from leave. The managers told us that this only happened for clinical reasons where staff identified a bed elsewhere in other wards for a patient on leave to ensure that the needs of a new patient were safely met. The trust did not monitor this and were not able to provide figures of frequency.
- The trust's inpatient facilities had 30 delayed discharges in the 12 months from November 2015 to October 2016. September and October 2016 had the most delayed discharges with eight and seven respectively. The majority of delayed transfers of care related to older peoples services with 27 delayed discharges in total.
- There were 130 readmissions within 28 days of discharge between November 2015 and October 2016. Clent ward had the most readmissions with 35 for this period with Kinver the next highest with 29. Linden had the lowest number of readmissions with one during the period between November 2015 and October 2016. Trust data showed there were 48 readmissions within five days of discharge and 1 readmission on the same day of discharge.
- Staff in the crisis teams were proactive and flexible with patients who were harder to engage. Patients could

attend the team base, or be seen at home, dependant on their choice. When patients missed their appointment or were not at home, staff would re-allocate the visit to later in the day and would attempt to make contact over the telephone.

The facilities promote recovery, comfort, dignity and confidentiality

- Both the adult acute wards, crisis teams and health-based places of safety we visited during this inspection had the quantity and range of rooms and equipment needed to support treatment and care. All the wards had appropriate activity and therapy rooms that supported care and treatment of patients and designated quiet room where patients could go and relax if they needed time on their own. There were also rooms where patients could meet visitors in private. Crisis team bases had access to comfortable, sound proofed interview rooms to see patients. The health-based places of safety at both Bushey fields and Dorothy Pattison hospitals had en-suite toilets and washing facilities.
- Patients on acute wards had the opportunity to personalise their bedrooms, access to their personal mobile phones and had key coded safes in their bedrooms for storing valuable items.
- Patients told us that the quality of food was good and meal times were flexible. According to the patient-led assessment of the caring environment (PLACE) data provided by the trust in relation to food, Ambleside ward scored 100%. This was around 12% higher than the national average of 88%. The trust did not give figures for the other wards.
- During our previous inspection in February 2016, we found that the majority of activity on adult acute wards took place on weekdays. However, there were activity co-ordinators who worked flexibly over the weekends to provide activities for inpatients. During this inspection, we found that each ward had a dedicated activity worker who worked across shifts. However, patients on all wards told us activities did not take place at weekends although they had access to the activity rooms.
- All services we inspected provided accessible information for patients and relatives. Crisis teams provided accessible information to all new patients about their service, including information about maintaining confidentiality and advice on how to provide feedback. The Walsall team had developed a comprehensive information pack, which also consisted of leaflets on safeguarding, carers support, care programme approach and useful telephone numbers on local and national services. We did not see any information within the places of safety regarding patient's rights. Staff we spoke with were not familiar with, or had not seen patient's rights information leaflets, which should be given to all patients, brought to the place of safety on a section 136 or 135.
- All of the acute wards offered patients useful information on treatment guidelines, advance decisions, religious needs, medical conditions, medicines, safeguarding, advocacy, patients' rights and how to make complaints. However, none of the information was in an easy-read format to meet the needs of patients with severe cognitive ability.

Meeting the needs of all people who use the service

- The trust had made reasonable adjustments to enable people requiring disabled access to access services. Of the services we inspected the adult inpatient wards had appropriate adjustments for patients who required disabled access, for example, the wards had adapted toilet facilities and bathrooms. Access to the place of safety was step free and had sufficient space to manoeuvre a wheelchair in the assessment areas. However, the toilet at Dorothy Pattison hospital was not easily accessible for wheelchair users. When crisis team staff saw patients at their base, it was within one of their dedicated outpatient rooms, which were accessible to disabled people.
- Adult acute wards had some information leaflets available in different languages and staff requested leaflets in other languages when needed. However, none of the information was in an easy-read format to meet the needs of patients with severe cognitive ability. Interpreting services were available when required and staff knew how to access these.
- The trust provided a choice of food that enabled staff to meet the dietary requirements of people with physical health needs and the preferences of religious and ethnic groups.
- Patients had access to appropriate spiritual support and chaplaincy services in designated multi-faith rooms or

through staff support to attend faith centres in the local community. Spiritual information and contact details for representatives from different faiths was available to all patients.

Listening to and learning from concerns and complaints

- The trust's service experience lead described proactive actions undertaken to receive feedback from complainants following completion of complaint investigations and had provided training for all investigating staff on a quarterly basis on the process required.
- We completed an audit of ten complaint investigations during our inspection and found all investigations were detailed and well recorded. The trust acknowledged all complaints within three working days detailing whom to contact for support and the process of investigation the trust would follow. All investigations had action plans recorded centrally to flag overdue actions. We saw evidence of clear communication updating the complainant of changes in expected timescales.
- The trust had an embedding lessons team who forwarded feedback from complaints and investigations by email to all staff, which managers would also discuss in team meetings for reflection, learning and any action related to the findings. Staff we spoke with during inspection told us some of the changes made to practice because of learning from complaints.
- The trust received 148 complaints relating to services over the 12-month period from 1 November 2015 to 31 October 2016. This is in comparison to the 92 complaints received in the year before our previous inspection. Of the 148 complaints received, 10 complaints were fully upheld, 58 partially upheld, seven complaints were referred to the ombudsman, with one complaint partially upheld by the ombudsman. The trust received 422 compliments between 1 November 2015 and 31 October 2016. This is an increase of 110 compliments compared to the year before our previous inspection.
- The trust demonstrated listening and learning from complaints. Patients we spoke with knew how to raise concerns and complaints, and said staff gave them feedback. We saw 'You said, we did' posters displayed within patient accessible areas, which referred to patient feedback, complaints and actions that the trust had taken to make improvements. Wards displayed information on how to make a complaint and staff gave patients this information on admission.
- Staff were aware of the formal complaints process and knew how to handle complaints, support patients, and their families when needed. We looked at some of the complaints raised by patients on the wards and saw that staff tried to resolve patients' concerns informally at the earliest opportunity. Staff logged all formal and informal complaints raised and forwarded them to the service experience desk, as appropriate.
- Staff we spoke to across all services were knowledgeable and confident when discussing the complaints procedure. All staff were aware of the trust's policy. We saw evidence on the adult acute wards that staff tried to resolve patients' concerns informally at the earliest opportunity and logged all formal and informal complaints raised and forwarded them to the service experience desk, as appropriate.

Good

Are services well-led?

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

Summary of findings

Our findings

Vision, values and strategy

- The trust's vision"to be Better Together – delivering flexible, high quality, evidence-based services to enable people to achieve recovery" remained the same since the previous inspection in February 2016. Quality and safety remained the organisations top priorities. Staff we spoke with during this inspection were aware and proud of the trust's values of caring, integrity, quality and collaborative. All wards displayed the vision and values for staff, patients and visitors.
- The objectives of the acute wards reflected the organisation's values and objectives. For example, the acute wards aimed to help patients understand the nature of their mental health difficulties by providing information and education. Staff offered person-centred care to help promote recovery. In addition, managers in crisis team discussed the values within team meetings and reflected on how they could use them more effectively. We also saw the values reflected within staff personal development plans and discussed within supervision.
- All staff we spoke to were familiar with the chief executive and the chair of the organisation and told us senior managers were visible in services. Staff were also able to attend the chief executive team brief and could email him through a page on the trust intranet.

Good governance

- During the inspection, the trust CEO made us aware of the suspension from duty of two senior leaders within the organisation. It was clear that the trust had robustly followed HR procedures in carrying out and communicating the suspension both internally and externally.
- The CCGs we spoke with shared that the trust had strengthened the governance around reporting which had improved issues relating to ownership and transparency. It was felt that staff now had a safe place to voice their concerns.
- The representatives of external agencies we spoke with including CCGs, Healthwatch and local authorities felt that Dudley and Walsall was a very well engaged trust; that it was patient centred and strove to give a good service. These external agencies described seeing a change in culture towards a more integrated, outward-looking organisation since the trust had a new chief executive officer, and they hoped a recently appointed chair would further strengthen this change in culture. The timeliness of sharing outcomes with primary care partners was felt to need some further work. The trust acknowledged that the current electronic system did not meet their needs and often staff relied on faxes and letters that could cause delay. The trust accepted that any new electronic system would need to work with partner organisations as much as possible to prevent patients being overlooked. CCGs and the local authority shared some concerns around communication. The trust's reporting of workforce issues including vacancies and the accuracy of performance data relating to workforce was an example given. There had been delays by the trust to share its developing workforce plans before internal committee approval. These caused a delay in CCGs understanding what the trust was putting in place to reduce workforce risks. CCGs we spoke with recognised the energy and resources the trust had invested in to the suicide prevention strategy and work with public health to agree a local partnership arrangement.
- The trust demonstrated a degree of progress in its governance and monitoring of staff supervision, appraisal and mandatory training since the previous inspection in February 2016. However, the average training rate for the adult acute services was 65%. This meant that staff did not receive all the training required for their roles.
- The trust had upskilled managers in excel and involved ward clerks from an administration perspective to

create a more comprehensive dashboard for mandatory training. This included weekly updates to all managers based on a RAG (red, amber and green) rated system to identify hotspots of outstanding areas of training. However, the system for centralised monitoring of training and supervision for the organisation did not always reflect local figures of completion in real time. The trust had also developed innovations such as e-learning parties as a way of supporting staff to complete training online and providing incentives for individual staff who gained mandatory compliance within set timeframes. The review of training monitoring processes had also strengthened the process for application of specialist training which included the completion of all mandatory training for all staff.

- The trust's information management and technology department ran monthly reports on care plan and risk assessment documents that senior operational managers reviewed regularly to monitor concordance to agreed standards. In addition to this, all team managers and clinical leads had access to the clinical dashboard that showed this information locally.
- The trust had reviewed the appraisal policy and related documentation since the previous inspection in February 2016, provided staff with training and developed a clinical supervision database for staff to request supervision from experienced staff within the organisation. Managers recorded all supervision on paper documents, however; managers recorded and monitored dates of supervision electronically. The trust has planned to undertake process mapping of appraisals to seek further improvements including those individuals who change roles within the organisation.
- During the Feb 2016 inspection, therapy staff told us of previous reductions in workforce and increased generic working, with a lack of professional support and specialist training. Staff at this time felt recent changes flattened the management structure and resulted in a lack of professional voice in senior management and leadership forums pivotal to contributing to the trust's service planning and practices. During this current inspection, allied health professional staff told us that they are now in discussions with the CEO about exploring professional governance structures and visiting similar mental health NHS trust's to benchmark. However, feel there remains a basic shortage of occupational therapists and increased generic working continues to limit the specialist input to patients' recovery journeys. Staff we spoke with during focus groups felt that psychology and allied health professionals remained stretched, with wide remits and competing demands on their time.
- There was evidence of local and clinical audits taking place with staff involvement to monitor the effectiveness of services. However, these were not effective as action plans were not implemented nor monitored to ensure improvements were made. During the inspection in February 2016, we found that there were no effective audits or processes in place to monitor the quality of the recorded information in the places of safety. This remained the case on re inspection in November 2016.
- The trust had a robust governance structure that supported the learning from incidents, complaints at all levels within the organisation and service user feedback. However, there were areas in need of improvement in the formats used for investigations in to serious incidents. The CCGs recognised that new structures and processes within the trust's governance team had focused on a whole-systems approach that had improved the quality of root cause analysis (RCA) investigations of incidents in Dudley. Walsall area investigations of serious incidences had also started to see improvement in robustness and quality.
- Since the trust's, last inspection in February 2016 the trust had reviewed long-term segregation policy and the deprivation of liberty safeguards policy. The trust had also introduced individual risk management of patients to address and monitor individual risks to bring all restrictive practices including restraint and segregation, in line with the MHA Code of Practice.
- On review of the trust's quality and safety committee minutes we found a good framework of information, a process of assurance including deep dives and spotlights, triangulation of information received through patient stories, service units and audits. This committee was working towards gaining further assurances of culture and staff speaking up.
- The trust's compliance and improvement in the area of MHA and MCA practice was variable across the services we re-inspected. Training in both these areas of practice remained varied, having seen a reduction in staff compliance with MHA training since the last inspection in February 2016. It was also noted by staff we spoke with that no specific MHA training for 136-suite practice

was provided. The multiagency operational policy for the place of safety remained out-of-date on re-inspection and despite new record documents in the 136 suite there remained inconsistencies and limited improvement in the completion of these. MHA record keeping and scrutiny on the adult acute wards visited were compliant with the MHA code of practice however we found MCA assessments were not decision specific as required by the code of practice.

- The audit of safeguarding records under taken during inspection demonstrated effective and close working arrangements with local agencies including commissioners, local authorities regarding safe guarding concerns and activity.
- The services we re-inspected had performance and risk motoring systems in place. Managers discussed performance at monthly governance meetings and made changes where necessary to improve the quality of the service. Managers displayed key performance indicators dashboard on ward notice boards for staff and patients to see. Managers were able to submit items to the trust risk register. Staff we spoke to told us that items previously submitted were appropriately considered, addressed and removed.
- There had been progress made against the information governance related recommendations from the last inspection in February 2016. However, not all best practice was in place at the time of inspection. There was assurance of plans to have the governance changes in place by the end of the 2016 and the new IT system in place by the end of 2017/18.
- At the time of inspection, the trust was planning for a proposed enhanced out-of-hours service for older people's community services. The trust had originally planned to start the enhanced service in October 2016, but due to staff concerns about capacity, and the ability of planned staffing to meet the new duty arrangements managers recognised that they could not cover the outstanding gaps without a negative effect on the existing service. Trust management then agreed to postpone plans further until January 2017 to enable sufficient time to recruit and address identified staffing shortfalls.

Fit and proper persons test

- Healthcare providers are required to ensure that all directors were fit and proper persons for their senior roles within healthcare organisations. The CQC requires trust's to check that all senior staff met the stated requirements on appointment and had set up procedures and policies to give continuous assurance that senior managers remained fit for the role throughout their employment.
- The trust had an appropriate Fit and Proper Person policy, which the trust reviewed in November 2015. It outlined a robust process for recruitment, appointment and continually evidencing the fitness of Directors in trust employment. The trust had undertaken recent internal auditing of fit and proper person requirements by use of an audit tool. There was no action plan to address shortfalls in evidence at the time of inspection in November 2016. However, on revisiting the fit and proper person files in February 2017 the trust company secretary informed inspectors of an ongoing action plan to address identified shortfalls.
- In February 2016, we audited board members personnel files during our inspection and found gaps in records viewed which was of a degree that resulted in this area being a regulatory breach requiring improvement. During our inspection in November 2016 we reviewed six board members personnel files and found that some gaps in recording remained. Four of the six files evidenced valid Disclosure and Barring Service (DBS) checks. However, on revisiting the providers FPP files in February 2017 the provider was able to evidence applications for renewal and update. One of the six files audited in November 2016 required professional body checks relevant to role but did not hold current evidence of such at the time of recruitment. On revisiting this in February 2017 this had been rectified. Since we carried out a re-audit on the files clear progress had been made and we are assured of an ongoing action plan to address any shortfalls is in place.

Leadership and culture

- There was evidence from re inspection of services that a 'healthy' culture existed within the organisation. The majority of staff we spoke with said there was a positive culture of team working and mutual support and felt able to raise concerns and issues. Staff described a past negative leadership culture prior to the current CEO and felt that some improvements had been made, yet there was still room for a greater degree of positive change around transparency, consistency in management and leadership, consultation and collective responsibility.

Good

Are services well-led?

- Staff morale and job satisfaction was good in the services were visited. Although some multidisciplinary staff groups described feeling over stretched and not benefiting from an appropriate and full professional structure and voice within the organisation.
- Staff we spoke to in teams and wards felt able to raise concerns to their immediate managers. However, staff had mixed views about their willingness to raise concerns within the organisation due to fear of repercussions in some areas.
- Staff sickness absence rates for the services we re-inspected were higher than the trust average of 4.8%. The acute wards sickness was 5% and the crisis teams in Dudley 6% and Walsall 8%.
- Equality and diversity training was mandatory and staff are required to complete it every three years. For the year 01 November 2015 to 31 October 2016, the average yearly compliance rate for training was 82%. The trust also offered additional training in areas such as cultural competency training, deaf awareness, lesbian, gay, bisexual, and transgender (LGBT) awareness and migration awareness.
- Staff on the front line of services felt involved in local practice changes and developments. However, we found that the trust did not always communicate effectively with staff areas of organisational change involving dialogue with commissioners and did not always involve the relevant professional groups in planning. The trust's most recent plans to extend the scope of older peoples community services was poorly project managed, had limited involvement of front line staff and was inconsistently communicated with staff groups during the journey of development. We found that the trust had not heard staff concerns regarding safety of the proposed changes and some concerns remained unanswered up to a week prior to the commencement date and the time of our inspection.
- All staff we spoke to were positive about the CEO and felt that time would support the change in culture that had begun. Staff groups felt the trust heard their views at a senior level and trust management were giving professional concerns consideration. Although not all resolved, clear action had begun to explore possible improvements.

Engagement with the public and with people who use services

- During our re-inspection of services, patients told us they were actively involved in multidisciplinary clinical reviews and care plans. Most however not all patients told us they had received copies of their care plans.
- The trust promoted the use of the 'triangle of care', which ensured carers and relatives involvement in care planning and clinical reviews with the patient's consent. Both the adult acute wards and the crisis teams completed regular surveys to gain patient and carer views to influence changes to services.

Quality improvement, innovation and sustainability

- The trust participated in national quality improvement programmes and was accredited by: Electroconvulsive Therapy Accreditation Service (Bushey Field clinic and Dorothy Pattison clinic are both accredited as excellent until January 2017); Accreditation for Inpatient Mental Health Services (Cedars, Linden and Malvern wards received excellent accreditation) and Memory Services National Accreditation Programme (Memory service Walsall, accredited until January 2018).
- Langdale and Ambleside wards had submitted their applications for the Royal College of Psychiatrists accreditation for inpatient mental health services (AIMS) in September 2016 and awaited the outcome. Kinver and Clent wards were in the process of completing their assessments. The adult inpatient service was also taking part in the prescribing observatory for mental health (POMH-UK) quality improvement programme for rapid tranquillisation.
- There was participation in national audits including the second national audit of schizophrenia 2014, the national audit of psychological therapies 2013 and the prescribing for people with personality disorder national audit 2015. The trust were also part of a Commissioning for Quality and Innovation (CQUIN) payment framework in relation to physical health care for people with serious mental illness and they had completed communication with GPs as part of this CQUIN. The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how staff delivered care and to achieve transparency and overall improvement in healthcare.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 Person-centred care How the regulation was not being met: The provider must ensure all care plans are personalised to the patient's individual needs, have clear goals, are recovery centred and staff and patients work collaboratively to produce them. This is a breach of Regulation 9 (3) (a,b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11 Need for consent How the regulation was not being met: Staff did not assess patients' capacity to consent to treatment on a decision-specific basis. Staff used a

This section is primarily information for the provider

Requirement notices

standard form to assess capacity and did not specify the issue. Staff did not record in detail on how they sought capacity to consent or refuse treatment, and the reasons for capacity decisions they made.

This was a breach of regulation 11(1)(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe care and treatment How the regulation was not being met: The wards did not manage emergency equipment and medicines in line with the Resuscitation Council guidelines. On Kinver and Clent wards, staff kept emergency medicines for severe allergic reactions in locked medicine stock cupboards. Ambleside ward clinic room had no warning signs to show it held oxygen cylinders. There were inconsistencies in checking of emergency equipment and medicines on Ambleside, Clent and Kinver wards. The resuscitation grab bags on both wards Kinver and Clent were unsealed. This was a breach of regulation12(2)(e) · Staff did not manage medicines properly and safely. One patient received a depot injection with a prescription that had no start date. On Clent ward, the room temperature was not recorded correctly. On Clent

This section is primarily information for the provider

Requirement notices

ward, there were differences in stock levels recorded in different books in the same period. On Kinver ward, staff had not recorded the date of opening for medicines that determined the expiry date.

This was a breach of regulation12(2)(g)

· Two patients did not have risk assessments and eight risk assessments were not up-to-date. Sixteen risk assessments did not contain enough detail to fully capture patients' risks or and how staff should manage any risks identified.

· Staff did not follow the trust's policy on rapid tranquillisation. Staff did not carry out physical health observations and routinely complete the clinical monitoring forms.

· Staff did not consistently monitor patients' physical health. Staff did not always follow the policy and guidelines to monitor physical health of patients on high dose antipsychotic treatment. Two type two diabetes patients on Ambleside ward did not have their blood glucose levels monitored in line with their care plans.

This was a breach of regulation12(2)(a) and 12(2)(b)

· There had been a failure to act on internal audits about a lack of risk assessments and management plans in a significant number of care records.

This left patients vulnerable to risks that staff could have identified and put in place management plans for.

This was a breach of regulation12(1) and 12(2)(a,b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

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Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good Governance How the regulation was not being met: · The provider must ensure effective processes are in place to monitor the quality of recorded information for all patients assessed in the health-based places of safety. · Information about rights being given to patients and when they commenced on section 136 was not being consistently recorded. This is a breach of Regulation 17 (2) (a,c) Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 Staffing How the regulation was not being met: · The average compliance rate for mandatory and essential training for the core service was low at 65%. There were rates of less than 75% achieved in training for: o Clinical risk assessment, 19% o Domestic violence and abuse, 33% o Fire safety, 73% o Infection control, 72%

This section is primarily information for the provider

Requirement notices

- Medicines management awareness, 22%
- Mental Health Act, 57%
- Prevent WRAP, 65%
- Rapid tranquillisation, 47%
- Resuscitation level 2 with AED, 64%
- Resuscitation level 3, 32%
- Violence and aggression, 63%.

This was a breach of regulation18(2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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