Dudley and Walsall Mental Health Partnership NHS Trust

Quality Report

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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

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Overall summary

Bushey Fields Hospital

Core service provided: Three acute admission wards; Two older people's wards; One Health Based Place of Safety

Male/female/mixed: male/female/mixed

Capacity: 99

Dorothy Pattison Hospital

Core service provided: Two acute admission wards; One Longstay/forensic/Secure services ward; One Health Based Place of Safety

Male/female/mixed: male/female/mixed

Capacity: 52

Bloxwich Hospital

Core service provided: Two older people's wards

Male/female/mixed: mixed

Capacity: 40

The trust has three main hospital sites: Bushey Fields Hospital in Dudley, Dorothy Pattison Hospital in Walsall and Bloxwich Hospital in Walsall. There are 191 beds; of which five are extra care area beds for people who require intensive nursing because their mental health problems have caused them to become agitated. The overall level of bed occupancy is lower than the national average (81% compared to the England average of 85%).

The trust also has staff based in about 28 locations across the two boroughs who provide care to people who live in their own homes.

The trust provides core mental health services and additional services such as Substance Misuse and Military Veterans services.

At the time of the inspection, the Board was leading work to change the way in which the trust's services are organised. These changes had unsettled some staff; some staff that we talked to reported feeling unsupported by the trust and did not feel confident that if they raised concerns that they would be listened to and treated fairly. During the course of the inspection, we received some whistleblowing information from a number of staff across different disciplines and locations. Some staff reported to us that they felt 'fearful and frightened of the culture within the organisation' and were reluctant to raise concerns in fear of reprisal. Some staff reported this as 'bullying'. However other staff reported that they felt very engaged.

The Non-Executive Directors (NED's) were able to describe to us the information flows and how they challenged what they did not understand. The NED's had a very robust understanding of all of the issues that the trust was facing and how they were to be tackled but always with an eye on quality.We concluded that the non-executive directors were a strong group who understood their role and exercised their duties effectively.

The trust had a robust approach to learning from incidents and ensured this was embedded in practice across all levels.

Although the trust ensured that all staff undertook mandatory training, it did not always meet the need for specific specialist training. For example, those working in older people's services had not been trained in dementia care and we concluded that this had an impact on the quality of care received by people using this service.

The trust worked well with other local stakeholders, such as the local authorities and the clinical commissioning groups and we saw evidence of good multi-disciplinary team working; particularly between adult inpatient and community services.

With a few exceptions, we found that the trust's staff were caring and had a good approach to patient care, and interacted positively and compassionately with people. We also saw examples of the trust's staff providing good physical healthcare.

Clinical staff recorded risk assessments for all patients but were not so good at developing management plans in line with the assessments.

During our inspection we observed that some patients, on wards for both younger and older adults, were being secluded (nursed in isolation from other patients) without the safeguards and checks set out in the Mental Health Act Code of Practice being followed.

Summary of findings

Before our inspection, the trust had identified problems with provision for older people and we agreed that this was the case for both inpatient and community services. Temporary nurses work many shifts on the older people's wards at Bushey Fields hospital due to unfilled staff vacancies. We observed restrictive practices on both Malvern and Holyrood wards and we concluded that patients' dignity and privacy were not always respected on Holyrood ward. The latter was due to a combination of an unsafe ward environment and staff practices. We also concluded that there was no clear vision for the future of community mental health services for older people in Dudley and Walsall.

The quality of mental health care provided to children and adolescents was good but was only available during office hours. Young people with a mental health problem could not access specialist help out of hours and there was no intensive home care provision to support children and young people in a crisis. Children and young people were waiting a long time to receive the right service after initially being referred.

We found that application of the Mental Health Act across the services was good. People were lawfully detained and had their rights read to them at the appropriate times. People's access to independent mental health advocacy (IMHA) varied across the trust as it was not clear that a referral to IMHA had been made when people lacked capacity.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

There were systems in place to identify and investigate incidents within the inpatient and community settings. There was a strong culture of learning from incidents. Action plans were monitored by local governance groups and we saw that learning from incidents resulted in changes to practice. The trust had an identified safeguarding lead and staff spoke highly of the visibility and leadership of this person within the trust. We found concerns about the safety and suitability of premises at some locations. The care environment on Holyrood ward at Bushey Fields Hospital and the health-based places of safety at Bushey Fields Hospital and Dorothy Pattison Hospital did not fully meet the current good practice guidance. There was a trust-wide risk register and Board assurance framework, and the trust had structures in place to ensure that all risks were recorded and categorised. We found that there was a consistent approach across the trust to the use of risk assessments to keep people safe; however, risk management plans were not always made and implemented in line with the risk assessment. Staffing levels were usually maintained at the level set by the trust; however there were times when staffing levels were stretched and people's needs were not always met.

Are services effective?

In the majority of services we inspected, most teams were using evidence-based models of treatment and guidelines from the National Institute for Health and Care Excellence. We saw some examples of good physical healthcare in mental health settings. Staff used nationally recognised guidance, standards and assessment tools to monitor and assess physical health.The trust had implemented the 'Triangle of Care' approach, which promotes good collaborative and partnership working.

Care and treatment in most services was effective. Information about people's needs was effectively handed over between the community teams and inpatient areas.The majority of staff that we spoke with told us they received regular mandatory training. However, there was limited evidence of specialist training and we saw no evidence that staff were trained in dementia care. This had a negative impact on being able to give good quality care or to respond to people with challenging behaviours. Uptake of appraisals is low but the trust had an action plan in place. We found that, where it was necessary to use the Mental Health Act 1983, people were lawfully detained and staff were working within the Code of Practice.

Are services caring?

Most people felt that they were involved in their care and informed about their treatment. We saw that there was good handover of patient information from inpatient teams to community/crisis teams. Most staff were knowledgeable about people's needs.Some people said they had received the support that they needed, while others had less positive experiences. Some of the hospital locations had mixed sex wards. This meant, in the older people's service, people did not always receive the care they required and their privacy and dignity was not always maintained. We saw that 'de-facto' seclusion was being practised within the wards and that staff were not adhering to the Mental Health Act Code of Practice.

Are services responsive to people's needs?

Some people could access services, including inpatient and community teams, at the right time and without delay. In the children and adolescent mental health service, children and young people were waiting a long time to receive the right service after initially being referred. The individual needs of people in the older people's services were not always met due to a lack of specific training for staff. There was no psychiatric intensive care service at the trust and we heard that people who use services have to be transferred to services out of the area. We found that the trust had taken a proactive role in ensuring that complaints and concerns were dealt with effectively.

Summary of findings

Are services well-led?

In 2013, Monitor deferred the trust's application for foundation trust status because it could not find sufficient evidence that the Board had appropriate quality governance arrangements in place. The trust therefore reviewed its governance systems. The non-executive directors were able to describe to us the information flows and how they challenged what they did not understand. We found that these directors were a strong group who understood their role and exercised their duties effectively. At the time of our inspection, a transformation programme was underway; some staff felt engaged fully in this process while others did not. There was no overall vision for the older people's service, which had an impact on the staff working within that service. Systems were in place to enable people using services, staff and others to give feedback; however, these were not always used. Also, in some inpatient wards, meetings did not take place with people who use services. We saw that Mental Health Act (MHA) administrators were appointed to monitor the legality of the paperwork about detention. There was a MHA scrutiny commitee who reported directly to the board. During the inspection, we saw that audits were completed in relation to the MHA but that the audits were basic and did not include an audit against the code of practice requirements.

Summary of findings

What people who use the provider's services say

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

Community Mental Health Patient survey 2013

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

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

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

Listening Events

We held a number of listening events over a two day period prior to the inspection.

We held a public listening event at Walsall Football club. The listening event was not well attended but the exceptional weather conditions may have impacted on this.

There were lots of positive comments about activities in the community and the caring staff that work in the community.

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

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

We also ran three listening events for detained patients and people subject to a Community Treatment Order at the three hospital locations.

At these listening events, people told us that the staff were caring and respectful. They told us they are encouraged to write issues down for MDT meetings and reviews so that they don't forget what they want to discuss. Some people told us they know what their care plan is and that they were involved in their care. People living in the community were very positive about the support given to them following discharge. People said they were helped to find accommodation and work

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

Dudley Mind Focus Group

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

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

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

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

Some people felt that services were responsive to peoples' needs, but there was a lot of negative feedback

Summary of findings

about the responsiveness and effectiveness of crisis services. People said that when they rang the crisis line, they were often advised to go straight to A and E or to make an appointment with their Consultant Psychiatrist the next working day.

Comment cards

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

- Of the 72 comment cards returned, 16% (12) were illegible.
- 81% (59) mentioned the staff in a positive way; for example, comments included 'staff are lovely', 'staff always treat me well', 'staff are good to me'.
- Of the 59 comment cards that spoke of staff positively, 71% (42) also stated that they thought there should be more staff available.
- One card expressed a negative opinion about the service and this person felt that not enough notice was taken of people who use services' opinions and there was not enough to do.

Areas for improvement

Action the provider MUST take to improve

- Ensure that the environment on Holyrood ward at Bushey Fields hospital reflects national guidance to safely meet the care needs of people with dementia.
- Ensure that the quality of care and treatment within older people's services reflects best practice and national guidance, and that practice is monitored and evaluated on a regular basis.
- The use of seclusion must be correctly recorded and its practice monitored against the Code of Practice. The trust must ensure that areas used for seclusion are safe and risks removed, and that the appropriate safeguards put into place.
- Review the results of the staff survey 2013 and consider what actions should be taken in response to staff stating they experienced bullying in the workplace.
- Ensure that the mixed gender units comply fully with the national guidance.

Action the provider SHOULD take to improve

- Develop a clear vision for older people's services and share it with staff, people who use services, relatives and stakeholders.
- Ensure that specialist training is provided to all staff working in specialist areas of the trust.
- Risk management plans should be developed and implemented from individual risk assessments. People should be involved in developing these plans and include 'advance decisions' where appropriate.
- Ensure that the two hospital places of safety reflect the national guidance regarding their environment. This will make sure people using services are protected from the risks of potentially unsafe or unsuitable premises.
- Develop robust induction procedures for all agency/ bank staff, especially when working within community teams.
- Develop and implement audits in relation to the Mental Health Act to check practice against the Code of Practice as well as the legal documentation in use. Also ensure that the Mental Health Act scrutiny committee are informed of the outcomes of these audits and develop action plans where needed.
- Reduce the waiting times for people who use services using the children and adolescent mental health service (CAMHS), following initial assessment to receipt of clinical interventions and treatment.

Action the provider COULD take to improve

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

Summary of findings

Good practice

There was good practice in the leadership of the trust; the non-executive directors and the Chair were particularly strong.

The trust's quality and governance systems were seen as robust and ran through the trust at every level. The leadership of governance and quality was outstanding.

All people who use services had a comprehensive risk assessment in place.

There was good communication between community and acute admission teams.

Learning from incidents and the embedding lessons programme meant that we could see changes in practice in the inpatient areas and community teams, and staff understood why.

Safeguarding processes were embedded across all of the teams in the trust.

Application of the Mental Health Act was good.

Experts by experience were introduced and used at all levels in the trust.

Throughout the inspection, the interactions between people using services and staff were excellent; they treated people as people.

The trusts approach to meeting physical healthcare needs.

Dudley and Walsall Mental Health Partnership NHS Trust

Detailed Findings

Registered locations we looked at:
Bloxwich Hospital; Bushey Fields Hospital; Dorothy Pattison Hospital; Trafalgar House - Trust Headquarters

Our inspection team

Our inspection team was led by:

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

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

The team included CQC Inspectors, Mental Health Act commissioners, a pharmacist inspector and two analysts. We also had a variety of specialist advisors which included consultant psychiatrists, psychologists, senior nurses, student nurses, social workers, senior managers and a GP.

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

Background to Dudley and Walsall Mental Health Partnership NHS Trust

Dudley and Walsall Mental Health Partnership NHS Trust was formed in October 2008.

The trust provides a wide range of integrated mental health services to children, adults and older people across the communities of Dudley and Walsall. They provide care and treatment for over 20,000 people each year and serve a local population of around 580,000 residents. The trust has a budget of £68 million and employs around 1,200 staff. They provide approximately 50 specialist mental health services from around 28 community sites and three acute hospitals:

- Dorothy Pattison Hospital in Walsall
- Bloxwich Hospital in Walsall
- Bushey Fields Hospital in Dudley

Between July and September 2013, the trust bed occupancy was 81% compared to the England average of 85%

Detailed Findings

Dudley and Walsall Mental Health Partnership NHS Trust has been inspected six times since registration. The six inspections covered four locations which are registered for mental health conditions. The most recent inspection of a mental health location took place on 6 August 2012 at the Bloxwich Hospital. This location was found to be compliant with all outcomes inspected.

The locations that have been inspected for mental health services since registration are listed below together with their level of compliance.

Bushey Fields Hospital
This location has been inspected once. The inspection was carried out in June 2011. The location was found to be compliant with all outcomes inspected.

Trust Headquarters
This location has been inspected once. The inspection was carried out in June 2011 and found the location to be compliant against all outcomes inspected.

Dorothy Pattison Hospital
This location has been inspected twice. The first inspection was carried out in May 2011 and the location was found to be non-compliant with a minor concern against Outcome 4 – Care and Welfare of people who use services, and Outcome 7 – Safeguarding people who use services from abuse. The second inspection took place in March 2012 and followed up on the areas of non-compliance. The location was found to now be compliant with these outcomes.

Bloxwich Hospital
This location has been inspected twice. The first inspection was carried out in May 2011, and the location was found to be compliant with all outcomes inspected. The second inspection took place in August 2012 and again, the location was found to be compliant with all outcomes inspected.

Between 2012 and 2013 there have been 9 Mental Health Act monitoring visits carried out to wards, as well as visits to look at assessment and admission and community treatment orders. Commissioners have met with detained patients and carers in private. Reports from these visits have been shared with the trust.

The purpose of this report is to describe our judgement of the leadership of the trust and its ability to deliver safe, effective, caring, responsive and well-led services at each of its locations. Our judgement will refer to key findings at each location. For a more detailed understanding of the findings, please refer to the relevant location report.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. One reason for choosing this trust was because they are a trust that has applied to Monitor to have Foundation Trust status. Our assessment of the quality and safety of their services will inform this process.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Mental Health Act Monitoring
- Acute admission wards
- Health-based places of safety
- Long stay services
- Child and adolescent mental health services
- Services for older people
- Adult community-based services
- Community-based crisis services
- Specialist eating disorder services

Detailed Findings

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

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

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

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

Are services safe?

Summary of findings

There were systems in place to identify and investigate incidents within the inpatient and community settings. There was a strong culture of learning from incidents. Action plans are monitored by local governance groups and we saw that learning from incidents resulted in changes to practice.The trust had an identified safeguarding lead and staff spoke highly of the visibility and leadership of this person within the trust.We found concerns about the safety and suitability of premises at some locations. The care environment on Holyrood ward at Bushey Fields Hospital and the health-based places of safety at Bushey Fields Hospital and Dorothy Pattison Hospital did not meet the current good practice guidance.There was a trust-wide risk register and Board assurance framework, and the trust had structures in place to ensure that all risks were recorded and categorised.We found that there was a consistent approach across the trust to the use of risk assessments to keep people safe; however, risk management plans were not always made and implemented in line with the risk assessment.Staffing levels were usually maintained at the level set by the trust; however there were times when staffing levels were stretched and people's needs were not always met.

Our findings

Learning from incidents to improve standards of safety for people who use services

All trusts are required to submit notifications of incidents to the National Reporting and Learning System. Serious incidents known as 'never events' are events that are classified as so serious they should never happen. The trust had not reported any 'never events' in the 12 months between December 2012 and November 2013. It should be noted that the trust had not reported any 'never events' since April 2011.

Serious incidents are those that require an investigation. The trust had reported 88 serious incidents between December 2012 and November 2013. Of those serious incidents 49 % occurred in 'ward areas'.

The trust had systems in place to learn from incidents. When incidents occurred there were investigations and learning from those incidents, and the trust had a strong commitment to improving practice. Most staff were able to tell us about recent incidents and the lessons that had been learnt. Each clinical team had an embedding lessons folder where minutes from meetings and changes to practice were kept.

There was learning on a trust wide basis. The trust had a robust 'Embedding Lessons' process where lessons learnt from incidents were owned by the relevant Head of Service. They had an 'Embedding Lessons group', led by the Director of Operations and Nursing, who reviewed all serious incident reports before they were signed off. Action plans were drawn up at this group and cascaded by the Heads of Service. Completion of action plans were monitored through the Heads of Service and the Clinical Governance department and were reported through to the trusts Governance and Quality committee.

The trust reported 110 absconding incidents for the period 1 July 2012 to 30 June 2013 with 28 of these being classified and reported as serious incidents. A significant amount of work had been undertaken to the environment and actions implemented to reduce the number of incidents and a decrease of both frequency and level of risk in incidents had occurred. In October 2013 the trust reported five out of seven serious incidents related to absconding.

Every six months the Ministry of Justice publishes a summary of Schedule 5 recommendations (previously rule 43) which had been made by the local coroners with the intention of learning lessons from the cause of death and preventing further deaths. In the latest report (covering 1 October 2012 – 31 March 2013) there were no concerns regarding the trust.

Behaviours, processes and systems reliable, safe and proportionate for people who use services

Safeguarding

Staff uptake of training was identified as poor by the trust in June 2013 and measures were put into place to address this. During the inspection, the majority of staff confirmed that they received regular safeguarding training. Training records confirmed that staff had either attended training in safeguarding adults or that it was planned in the next few months.

Most staff were able to tell us what the local safeguarding policy and procedure was and we observed good

safeguarding practices during the course of the inspection in a community team. The majority of staff were able to tell us the name of the nominated lead for safeguarding within their team and the trust.

The trust had a safeguarding strategic group which met every two months. This group monitored the safeguarding incidents and trends. Safeguarding sits with the quality team. We were informed that the trust purchased a module on the 'Safeguard' system which was linked to safeguarding; this meant that all safeguarding alerts were automatically sent to the local authorities.

External stakeholders told us that the trust had a good safeguarding lead and they had dealt with all of the safeguarding cases that had been raised in a positive and open manner.

We noted that the trust's safeguarding database had become fully operational from September 2013 and that this worked effectively in conjunction with the incident reporting system. During 2012/13 there were a total of 253 adult safeguarding alerts raised via the trust's safeguarding database (monthly average 21). 55% of these had resulted in some action to safeguard people who used the service.

The trust was a partner of the local safeguarding board and had signed up to the MARAC (Multi Agency Risk Assessment Conference) and DART (Domestic Abuse Response Team) process and procedures. The trust had an identified safeguarding lead and staff spoke highly of the visibility and leadership of this person within the trust. We saw evidence that the trust attended both local authorities safeguarding boards and that exception reports go to the trust Board.

Safe environment

Due to the number of reported absconds from the trust in 2013, the trust implemented some significant environmental changes. This included the introduction of airlocks at most of the hospital locations or locked wards. There was information available to informal patients as to how they could leave the ward environment in most locations. Most people who used services reported that they felt safe on the wards of the hospitals.

We found concerns about the safety and suitability of premises at some locations.

The Health Based Place of Safety or 136 suites at both Dorothy Pattison hospital and Bushey Fields hospital did not meet the good practice guidance for the environment, despite significant environmental work being carried out by the trust.

We also identified concerns about the care environment for older people at Bushey Fields hospital. We found Holyrood ward was a locked environment. Each of the bedroom corridors was electronically locked and was only accessible by staff with a 'swipe card'. There was a way to exit each corridor by means of a push release button, however these were not clearly identified. This had been implemented to reduce unwitnessed incidents in bedroom corridors. There was no indication that the environment had been adapted to support people, who had dementia, to be independent. We did not see call bells in patient rooms. There were occasions when people using the service would be in their room alone within a locked corridor, resulting in them being unable to alert staff to their needs.

During the visit we saw that one individual was secluded, however staff did not recognise this as such. The incident we saw resulted in the person injuring themselves, as the environment was not appropriate for this use.

Some of the hospital locations had mixed sex wards and did not fully comply with the Department Of Health guidance. This meant that the safety of people who use services within these locations may be compromised.

Understand and manage risk to the person using services and others with whom they may live

Risk management

The trust had a trust wide risk register and board assurance framework. It had structures in place to ensure that all risks were recorded and categorised. The trust also collected a range of performance information which was collated to produce trust wide information. The trust was aware that they had a data quality issue regarding this information and this had been raised on the trust wide risk register. The information fed into the trusts Quality and Governance committee to the Board.

Each ward and team owned their risks and recorded them on a risk log. Risks were raised through a risk assessment report to the ward or team manager. When a risk was accepted it was then categorised green, amber or red and reviewed on a monthly basis within the directorate and reported to the Board. All of the risk logs were held

electronically and risks were escalated to different tiers within the trust depending on how they had been categorised. This process provided clear ownership and mitigating action plans.

The trust could identify where a cluster of risks had been raised and these would be forwarded to the Risk and Quality Improvement group. The trusts clinical governance team worked closely with the quality team and improvement plans would be developed on wards or teams where risks had been identified.

There was a lone working policy and procedure in place. We were told that the lone working policy was not always being adhered to, potentially placing them at risk

We were told that agency staff did not receive formal induction in the community so would not understand the trusts procedures. Again this could result in agency staff being placed at risk or not meeting the needs of people who use the service.

Managing risk to the person

We found that there was a consistent approach across the trust regarding the use of risk assessments to keep people safe.

All the patient records we examined showed that an individual risk assessment had been completed.

However in some patient records we reviewed, specifically in the older people's service, it was not always evident that risk management plans had been formulated and implemented in line with the risk assessment. This meant that people who use services were at risk of receiving inconsistent interventions to manage their risks.

Within the Children and Adolescent Mental Health services (CAMHS), we found that although risk assessments were carried out quickly, waiting times for treatment were long. This resulted in deterioration in the mental health of some children and young people.

The trust had a Suicide Prevention Strategy dated 2013 in place that identified that further to their own audit, the trust would continue to audit ligature points on the inpatient areas. Inspectors noted some potential ligature points on Langdale ward during our inspection.

Medicines management

We found that the medicine management team were involved in all aspects of a person's individual medicine requirements across each of the three locations within the trust. The Chief Pharmacist told us that safe medicine management was one of the quality priorities for the trust.

We were shown a Medicine Management Policy dated July 2013, which described medicine procedures for all staff working in the trust, including agency and bank staff, permanent and temporary staff, who were involved in the use of medicines as part of their day to day practice. Nursing staff also told us that if they had any medicine queries they had access to pharmacist advice including an out of hour's pharmacy service. We found an effective and well led medicine management team which were moving forwards to further ensure the safe management of medicines across the trust.

Arrangements were in place to ensure that medicine incidents were documented and investigated. We looked at how the service responded to internal concerns about the prescribing and handling of medicines. We found that there was an open culture of reporting medicine errors in order to change practices and learn from lessons. One documented medicine error had led to the medicine management team checking all people's medicines on admission to ensure that medicines prescribed were safe and correct. The learning from these incidents helped to improve medicines safety and therefore patient safety.

Staffing levels and quality of staffing enables safe practice

We saw that the trust had a committed and caring staff group. We witnessed some positive interactions by staff and observed that they had good patient relationships that demonstrated respect and dignity at all times.

Staffing levels were usually maintained at the level set by the trust, however there were times when staffing levels were stretched and people's needs were not always met.

The trust had identified a risk with junior doctor availability at night on the on-call system. An action plan had been developed and put into place to ensure that junior doctor cover is adequate and doctors were working within the European Time Working Directive.

Are services safe?

We saw that at times the trust relied on agency and bank staff to cover the shortfall in staffing levels, but staff on the wards told us that wherever possible there was continuity in the staff that were used. This was also the case in the community services we visited.

Are Services Effective?

(for example, treatment is effective)

Summary of findings

In the majority of services we inspected, most teams were using evidence-based models of treatment and guidelines from the National Institute for Health and Care Excellence.

We saw some examples of good physical healthcare in mental health settings. Staff used nationally recognised guidance, standards and assessment tools to monitor and assess physical health.

The trust had implemented the 'Triangle of Care' approach, which promotes good collaborative and partnership working.

Care and treatment in most services was effective. Information about people's needs was effectively handed over between the community teams and inpatient areas.

The majority of staff that we spoke with told us they received regular mandatory training. However, there was limited evidence of specialist training and we saw no evidence that staff were trained in dementia care. This had a negative impact on being able to give good quality care or to respond to people with challenging behaviours.

Uptake of appraisals is low but the trust had an action plan in place.

We found that, where it was necessary to use the Mental Health Act 1983, people were lawfully detained and staff were working within the Code of Practice.

Our findings

Monitoring and Managing Quality of Care

The majority of the wards at the trust had been accredited by the Royal College of Psychiatrists. This accreditation is called the Accreditation for Inpatient Mental Health Services (AIMS). AIMS is a standards based programme designed to improve the quality of care in inpatient mental health wards. The process involves a review of quality. This meant that the trust sought opportunities to have the quality of their service reviewed by others.

The trust had a clinical audit and effectiveness committee and we were told that this group monitored the embedding lessons actions and any other clinical guidance that was applicable to the trust, for example National Institute of Health and Care Excellence (NICE) guidance. We were told that the trust audited against this guidance and re-audited on a regular basis and the information was made available at all levels from the wards/teams to the trust Board. Where needed Quality Improvement Areas were identified and plans developed engaging frontline staff.

In the majority of services we inspected, most teams were using evidence based models of treatment and NICE guidelines were used as part of their policies and protocols. In the substance misuse service we could see that care and treatment plans were being monitored by the National Drug Treatment Management Services in line with national guidance.

Use of and training in NICE guidelines was varied across the trust. We saw that medical staff were following guidance as well as some of the Allied Health Professionals (AHP's), for example occupational therapists. Nursing staff did not receive training or updates on NICE guidelines. In addition we were told that clinical guidance, protocols and procedures were available on the trust intranet site. Not all staff had access to the intranet which meant some staff groups were unable to, or were unaware, of how to apply national guidance to improve clinical care and treatment.

Staff used nationally recognised guidance, standards and assessment tools to monitor and assess physical health.

The trust had engaged six 'Experts by Experience' (EbyE) who regularly visited all the inpatient areas and took back to the trust Board all the positive and negative findings. We were told that the work of the EbyE extended to the community teams who had begun to develop the role alongside the Community Recovery Services. The EbyE were involved at all levels within the organisation and they had been involved in the development of and implementation of the Healthcare Assistant training module. The EbyE shared good practice issues and helped the teams monitor the quality of care by being active and visible on the wards. They reported their findings up to trust Board level who then agreed the development of action plans where improvement was needed

Focus groups were held with all disciplines of staff at all grades. Clinical staff told us that they were able to raise

Are Services Effective?

(for example, treatment is effective)

issues and discuss clinical concerns within their peer groups. There were some concerns raised that the trust relied on a medical approach to the care and treatment of people who use services and did not consider alternative psychological approaches.

The trust had implemented the 'Triangle of Care' approach. This approach was developed by carers and staff to improve carer engagement in acute inpatient and home treatment services. It recommends better partnership working between service users and their carers, and organisations. The trust is one of only 22 mental health trusts that has signed up for the scheme.

Demonstrative collaborative multi–disciplinary working across all services

We saw examples of good multi-disciplinary working and team collaborative working. For example there were effective handovers of people's needs between the community teams and inpatient areas.

We saw that there were multi-disciplinary team meetings on a weekly basis in the inpatient areas and that pre-discharge meetings took place that involved other professionals and teams.

We saw that the trust worked collaboratively and in partnership with a number of other providers within their specialist community services.

The trust had arrangements to ensure that physical health issues were properly assessed and treated. The trust had a range of policies to ensure that physical health issues were considered. The trust had physical health leads within each location to champion the importance of ensuring people's physical health needs were considered.

Suitably qualified and competent staff

The majority of staff that we spoke with told us they received regular mandatory training.

The training matrix for the trust identifies limited specialist training within the trust in relation to the services provided by the trust.

Most staff we spoke to had received training during the course of the year. However in some areas we found staff had not been appropriately trained to offer care to specific user groups. For example we saw evidence that not all staff were trained in dementia care. This had a negative impact on being able to give good quality care or respond to behaviours that challenge.

Some staff told us that they had opportunities to attend reflective practice sessions whilst other staff received regular clinical supervision and support. In some areas of the trust, healthcare workers were not routinely offered clinical supervision.

We were told that the trust had introduced a Health Care Assistant (HCA) development programme lasting five days. It covers all aspects of Mental Health. The first cohort had gone through, with nine more planned to take place. Positive feedback had been received from HCAs regarding the programme.

We were told that a training needs analysis was completed yearly as part of appraisals. Appraisal data reflected that there had only been a 72% uptake at the time of the inspection. The trust was working to meet the target of 85% by the end of March 2014.

Adhere with the Mental Health Act and have regard to the Code of Practice

We visited all of the wards at each location where detained patients were being treated. We saw that there were a very small number of people who were (or who had recently been) detained under the Mental Health Act 1983 on each ward.

In the majority of care records reviewed, relating to the detention, care and treatment of detained patients, the principles of the Act had been followed and adhered to.

We saw that attempts were made to inform people of their rights on admission but, where patients lacked capacity to understand their rights, staff were not always as proactive as they could be to help patients to understand their rights for example by referring people to specialist advocates.

Are services caring?

Summary of findings

Most people felt that they were involved in their care and informed about their treatment.

We saw that there was good handover of patient information from inpatient teams to community/crisis teams. Most staff were knowledgeable about people's needs.

Some people said they had received the support that they needed, while others had less positive experiences.

Some of the hospital locations had mixed sex wards. This meant, in the older people's service, people did not always receive the care they required and their privacy and dignity was not always maintained.

We saw that 'de-facto' seclusion was being practiced within the wards and that staff were not adhering to the Mental Health Act Code of Practice.

Our findings

Choice in decisions and participation in reviews

Most people spoken with felt that they were involved in their care and informed about their treatment.

Within the majority of the acute inpatient areas and community settings, people were fully involved in the planning and review of their care, where they were able to do so. Sometimes people were too unwell but staff would try to engage them in these processes as soon as they were well enough to actively participate.

In the older people's service there was a variation in relation to choices and participation. At Bloxwich Hospital, it was evident that patients were actively involved in decisions about their care and treatment where they had capacity to do so. We also observed two people's reviews where we saw them discuss their care and treatment with the multi-disciplinary team.

At Bushey Fields hospital we saw that people were not always involved in discussions about their care and treatment or other aspects of being cared for in a ward environment.

In the older people's community services including day hospitals, we saw that people were consulted. For example people were involved in discussions about their treatment and could make choices about which activities they attended.

In the substance misuse team, we saw that people were also given opportunities to make choices about treatment and participate in reviews of their care.

Across the adult community teams, all the people we spoke to had been actively involved in discussions about their care and made choices in relation to this.

Effective communication with staff

We found good examples of teams working and communicating effectively to ensure that people received good care.

We saw that there was good handover of patient information from inpatient teams to community/crisis teams. Most staff we spoke with were knowledgeable about the needs of the people.

We observed staff in all of the hospital locations helping patients to understand information in a way that reflected the patients' specific level of understanding. For example in some of the older people's services staff used gestures and actions to help patients understand.

There were opportunities for patients in most inpatient settings to participate in meetings about the running of the wards.

People receive the support they need

The Community Mental Health Patient Experience Survey 2013 was conducted to find out about the experiences of people who received care and treatment. Those who were eligible for the survey were receiving specialist care or treatment for a mental health condition, aged 18 and above, and had been seen by the trust between 1 July 2012 and 30 September 2012.

Analysis of data showed that the trust was performing 'about the same' as other trusts in all nine areas. There was one area where the trusts performance had decreased and the result was worse than the previous year. This related to patients having had a review of their care in the last 12 months. During the inspection, when we asked people about this, most people using services said they had been involved in a review of their care.

Are services caring?

Before the inspection, we attended a focus group with people who used the community services. The experiences varied across the group, with some people stating they had received the support that they needed whilst others had less positive experiences.

During the inspection we saw good interaction between staff and patients. Staff were visible on the wards and offered support to the patients when they needed it.

We saw that patients physical health needs were assessed and monitored.

In the Eating Disorder service, we saw the results of a recent survey that 17 people had completed. This identified that people felt supported by the team, treated with respect and listened to.

Privacy and dignity

The trust was subject to Patient Environment Action Team (PEAT) assessments. These self-assessments are undertaken by teams of NHS and private/independent health care providers and for the first time included at least 50% members of the public (known as patient assessors). They focus on the environment in which care was provided, as well as supporting non-clinical services such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity was supported.

The trust scores for the 2012 assessment did not identify any areas of risk.

In the majority of the community services we visited, people told us they felt they were treated with dignity and respect.

Some of the hospital locations had mixed sex wards. During the inspection we saw that in some wards the male and female toilet and bathrooms were located next to one another. In another ward, males had to walk through a female area to get to the ward communal areas.

On one of the older people's wards, we observed during an unannounced evening visit, that all patients had a commode in their bedrooms. Staff told us they were there to offer choice, but acknowledged that the need for a commode was never assessed.

It was not clear that people's level of independence was taken into account and that people's dignity was considered.

In most of the wards, the patients' bedroom doors had a vistamatic observation panel. This meant that patients could operate the integral blind when they wanted some privacy, but staff could operate the blind externally, when for example carrying out observations at night.

Use of seclusion

The trust told us before the inspection that they did not practice seclusion within the organisation and therefore had no policy or procedures for this type of intervention.

We did find evidence that seclusion was being practiced within the acute and older people's services. This meant that staff were not adhering to the MHA Code of Practice regarding seclusion and therefore patients may not be being kept safe at all times.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Some people could access services, including inpatient and community teams, at the right time and without delay.

In the children and adolescent mental health service, children and young people were waiting a long time to receive the right service after initially being referred.

The individual needs of people in the older people's services were not always met due to a lack of specific training for staff.

There was no psychiatric intensive care service at the trust and we heard that people who use services have to be transferred to services out of the area.

We found that the trust had taken a proactive role in ensuring that complaints and concerns were dealt with effectively.

Our findings

Individual needs met, services meeting the needs of the local community

Analysis of data from our intelligence monitoring identified that there was an elevated risk around delayed transfers of care where the delay is attributable to social care.

During the course of our inspection we found that some people did experience delays in discharge from the hospital.

This was specifically noted on the rehabilitation ward where staff confirmed that discharge could be an issue due to funding constraints within the local authorities.

We found that most people in acute care got a responsive service and benefitted from good links between the community teams and inpatient services.

Each inpatient ward had an Equality and Diversity champion (staff and service user if possible).

We were told that translation and interpretation services were available through an external service provider. The trust are looking at current gaps for British sign language providers as want to offer a 24/7 service. Interpreters have mental health training to ensure they are familiar with issues before meeting people who use services.

The individual needs of people in the older people's services were not always met due to a lack of specific training for staff to meet those needs.

In the Eating Disorders service, there were no waiting lists for the service but this contrasted sharply with the experience in the CAMHS service.

In the CAMHS service we found children and young people were waiting a long time after initial assessment to receive their first appointment for treatment and additional waits if they required specialist appointments. There was concern about access to services for people in a crisis or out of hours.

There was no psychiatric intensive care service at the trust and we heard that people who use services have to be transferred to services out of area.

In the community services, the majority of people did not feel they had been asked to give their views on the services they received.

We were told that the Equality and Diversity team work closely with the local community in Dudley and Walsall. We were informed they hold workshops within the local communities and deliver training to promote mental health issues in Black and Minority Ethnic (BME) communities in local area. They encourage referral into the trust from those who might not usually access services.

Provider acts on and learns from concerns and complaints

Our analysis of intelligence monitoring identified that there were 63 written complaints submitted to the trust in 2012/13, of which 41 (65%) were upheld.

46% of complaints received in 2012/13 related to 'all aspects of clinical treatment'.

The trust had a complaints policy and procedure in place.

We found that the trust had taken a proactive role in ensuring that complaints and concerns were dealt with effectively. We were told by one EbyE that the difference in the trust handling of complaints had changed significantly in the last two years.

Are services responsive to people's needs?

(for example, to feedback?)

We were told that the trust had developed a 'service experience desk' (SED) that was a single point of contact for all people with complaints, concerns and compliments. Patients are given information about SED on arrival and at regular points during their inpatient stay and the information was also seen on the wards.

Staff informed us that complaints were much more patient focused; services listened to what the people who use services/service user was saying.

We were told that there was a better resolution of complaints at an early stage. The SED team ensured complaints were analysed and there was feedback given at all levels in the trust regarding emerging themes. We were informed of recent changes to practice as a result of complaints which included:

- responsiveness around care planning – enabling outpatients to develop plans of care for future in patient treatment and ongoing monitoring in the community.
- developing customer care training in response to concerns about staff attitude.
- implementing the 'triangle of care' in response to carers concerns about their involvement in their relatives care.

The SED team shared the good practice stories in a quarterly magazine that was received by all staff in the trust and through the team brief.

People who use services on the wards and in the community told us that they knew how to raise a complaint and were confident it would be dealt with.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

In 2013, Monitor deferred the trust's application for foundation trust status because it could not find sufficient evidence that the Board had appropriate quality governance arrangements in place. The trust therefore reviewed its governance systems.

The non-executive directors were able to describe to us the information flows and how they challenged what they did not understand. We found that these directors were a strong group who understood their role and exercised their duties effectively.

At the time of our inspection, a transformation programme was underway; some staff felt engaged fully in this process while others did not.

There was no overall vision for the older people's service, which had an impact on the staff working within that service.

Systems were in place to enable people using services, staff and others to give feedback; however, these were not always used. Also, in some inpatient wards, meetings did not take place with people who use services.

We saw that Mental Health Act (MHA) administrators were appointed to monitor the legality of the paperwork about detention.

There was a MHA scrutiny committee who reported directly to the Board.

During the inspection, we saw that audits were completed in relation to the MHA but that the audits were basic and did not include an audit against the code of practice requirements.

Our findings

Governance framework is coherent, complete, clear, well understood and functioning

In April 2013 Monitor deferred the application for Foundation Trust (FT) status due to insufficient evidence of the Board having appropriate quality governance arrangements in place. The trust responded to this by reviewing their governance systems. They revised the committees, developed new ones where required and there were some revisions to existing ones.

The trust had a Board Assurance and Escalation framework dated July 2012 that described the trust quality governance structure, performance indicators and systems by which the board received its assurance.

The trust had a Quality and Governance committee which was held monthly. The committee had a programme of work and received all the minutes of the respective service line groups. All of the committees, including the Audit committee reviewed quality aspects as part of their Terms of Reference. We were informed that there was cross membership between committees.

The Non-Executive Directors (NED's) were able to describe to us the information flows and how they challenged what they did not understand. They informed us that there had been extensive work on developing quality dashboards and information could be reviewed at service line level. They stated that the information flows both up and down from the Board were good.

The NED's had a very robust understanding of all of the issues that the trust was facing and how they were to be tackled but always with an eye on quality.

The trust had in place a Quality Improvement Strategy, the implementation of which was supported by a Quality Matters Framework and annual Quality Improvement Plan.

The quality governance structures underpinning the assurance framework were clear. There was also clarity regarding how the clinical governance team and the quality team worked together to promote continuous quality improvement within the trust.

Each service line attended a monthly quality group chaired by Heads of Service. An example of this would be the acute service line meeting which would include all the ward managers and clinical director.

We saw that there were leadership systems in place and minutes of the meetings were made available to all staff. All professions and grades were welcome to attend and governance was a regular agenda item. The minutes showed that service performance, serious untoward incidents and complaints were discussed regularly.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Staffs' understanding of the governance framework was consistent across the trust. Staff were able to tell us how the governance arrangements worked and how they impacted on the provision of care. A few staff said they didn't feel involved in service improvement.

We were told that regular audits across all areas of clinical care took place. We could not see evidence that in all cases the results of audits were analysed and shared in a timely manner.

Engagement with staff and supporting staff with change and challenges

At the time of the inspection, a transformation programme was underway. This had impacted or would impact all staff across the organisation.

Some staff felt involved in the whole process, they felt listened to and felt that they had been consulted with on the changes. Other staff told us that they had not been engaged with; they felt unsupported and unsure of the future direction of the service in which they worked.

In the older people's service staff told us that they were aware of some of the changes in commissioning that was improving care, but there was still no overall vision for the delivery of older people's service.

Most of the staff we spoke to reported that the leadership from their direct line managers was very positive. They informed us that there were regular visits to all areas from the non - executive directors.

During the inspection, we ran a number of focus groups across different disciplines and grades of staff. During those groups, some staff told us that they felt they had not been involved or engaged in the changes to the services that were taking place. Some described how they felt as 'change exhaustion'. Others felt that they had been very involved and engaged.

Staff told us that key messages were communicated via the trust team brief and regular email communications. Staff also told us about the 'Ask Gary' initiative. This was set up to allow staff to communicate directly with the Chief Executive.

The Chair, Chief Executive and the NED's told us that they are regularly out at the various locations and community teams. Board meetings were held at different locations to involve and engage staff and promote their visibility and this was corroborated by staff during the inspection.

Whistleblowing

Prior to the inspection, CQC received some information from a whistleblower who identified that they were concerned about the changes to the trust in relation to clinical service provision and the way in which staff were treated by the senior management team. We also received information from a group of staff who had previously worked at the trust who were concerned about the 'culture of the trust'.

During the course of the inspection, we received some whistleblowing information from a number of staff across different disciplines and locations. Staff reported to us that they felt 'fearful and frightened of the culture within the organisation' and were reluctant to raise concerns in fear of reprisal.

We informed the Chair of the trust, the Non-Executive Directors and the Chief Executive. The information we received related to the culture of the trust and the senior management team. We found that the Non-Executive Directors and Chair responded robustly to the information and they informed us they would start to address the issues raised immediately. We will be following this up with the trust.

Effective leadership

The NED's had a very robust understanding of all of the issues that the trust was facing and how they were to be tackled but told us that they did this 'always with an eye on quality'.

The trust had developed robust communication strategies to ensure that staff at all levels were aware of the vision and values of the organisation and to keep people informed.

The NHS Staff Survey 2012 identified that the trust was in the top 20% of mental health trusts for eleven indicators, including staff feeling satisfied with the quality of work and patient care they are able to deliver and agreeing that their role made a difference to people who use services. During our inspection, the results of the 2013 survey were made public, but not in time for us to analyse them.

In the 2012 survey there was an indicator of risk that related to the percentage of staff appraised in the last 12 months. 76% of trust staff said that they were appraised, compared to 87% nationally. However the trust had improved since

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

the 2011 survey. During our inspection, we were told by staff that appraisals were not always carried out but the NEDS and the trust Board were taking action to address this issue.

Using our intelligence monitoring we identified that the data up to August 2013 showed the trust sickness absence rates had been similar to the national average for mental health trusts.

A General Medical Council (GMC) national training survey indicator showed a 'risk' around the quality of trainees' induction. There was no evidence of risk in the questions relating to workload, clinical supervision and educational supervision from the GMC National Training Survey (March to May 2013). We were informed that the trust has introduced an induction for medical staff. This lasts for three days and includes locum cover for pan site induction.

Engagement with people who use services

Systems were in place to enable people using the service, staff and others to give feedback. This included mechanisms such as the Service Experience Desk (SED), patient reviews and surveys.

The trust produced a complaints report for a 12 month period from February 2013 to January 2014.This report gave feedback on the numbers and types of complaints at service line level. We saw notices at all the trust locations informing people who use services how they could raise concerns or complaints and how to access advocacy services.

The trust provided services to patients for whom English was not their first language. The trust said that interpreter services were available if they were needed. This was also corroborated by staff. We saw very few leaflets or information that was readily available in alternative languages.

In the older people's services we found no evidence that feedback from people who use services was sought to assess and monitor quality. There were no patient meetings held.

In the community services, the majority of people did not feel they had been asked to give their views on the services they received.

Functioning governance framework for MHA duties

We saw that Mental Health Act administrators were appointed to monitor the legality of the detention paperwork, as well as ensure that mental health review tribunals and hospital managers' meetings took place in the appropriate timeframes.

The MHA scrutiny committee identified that as a trust they felt they scrutinised the application of the act robustly. They reviewed information at location and individual level and worked closely with the local authorities. They had good multi-agency working with ambulance services and police in terms of the section 136 suites.

The scrutiny committee reported directly to the Board . The committee were in the process of reviewing their Terms of Reference. The committee felt they had good assurance. They received statistics and information needed to be assured and what that meant. They captured equality data to monitor trends. There was a fair reflection of Black, Minority and Ethnic (BME) groups in services and recognition of the differences in the two local authority areas. Approved Mental Health Professionals had access to interpreting services. We saw minutes of the committees meetings and noted that the group reviewed themes from the reports of CQC Mental Health Act monitoring visits.

Audits were completed in relation to detention papers, rights, consent to treatment, section 17 leave and care planning. The audits were basic and did not include an audit against the code of practice requirements.

As a result of audits, we were told the trust was targeting Mental Capacity Act/Mental Health Act training particularly for inpatient nurses. They recognised that all staff should have a degree of training on MCA. We were informed that it was not just about training but embedding practice.

The trust provided us with action plans for both MCA and MHA for each ward, with completion dates. The plans were RAG rated and there were a number of red and amber actions outstanding.

It was identified during the inspection, that de-facto seclusion was taking place across the wards. We asked the scrutiny committee if this was an area that they should review along with the extra care areas. The committee responded positively and stated that this was an area that they should review and would do so in light of our findings. They told us that the extra care area and Rapid

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Tranquilisation were monitored via other governance groups. This meant that there was a risk that themes may be missed if there was not full oversight of Mental Health Act and Code of Practice issues in this committee.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17(1) (a) **17.**—(1) The registered person must, so far as reasonably practicable, make suitable arrangements to ensure— (a) the dignity, privacy and independence of service users; How the regulation was not being met: We found that people's privacy and dignity was not respected because the separate toilets for male and female patients were not easily identifiable. We saw male patients using female toilets and vice versa and staff did not intervene. We saw male patients using toilets and not closing the doors, these toilets were in the communal areas of the ward and could be directly viewed. We saw that each bedroom had a commode placed in there at night. Staff told us told that the need for commodes was never assessed. This meant that the person's previous level of function was not always acknowledged and respected and their previous routines and independence were not always promoted. We found that people's privacy and dignity was not respected because men had to walk through the female bedroom, toilet and bathroom areas to access the communal areas of the ward.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9(1)(b)(i), 9(1)(b)(ii) and 9(1)(b)(iii)The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of –b) the planning and delivery of care and, where appropriate, treatment in such a way as to –i)

This section is primarily information for the provider

Compliance actions

meet the service users individual needs,ii) ensure the welfare and safety of the service useriii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatmentThis regulation was not being met as patients were not always cared for in an environment that assured their safety and welfare.Individual patient preferences and needs were not always met because the staff did not have the knowledge and skills to meet these needs.We saw that seclusion was practiced without following the guidance from the Mental Health Act 1983 Code of Practice.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10(1)(b) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to – b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. This regulation was not being met because an effective system was not in place to manage patient's identified risks. An effective system was not in place to enable patients to summon assistance in the event of an emergency. This risk had not been adequately managed on Holyrood ward. There was no effective system in place to ensure that staff could summon assistance in the event of an emergency where they or others were at risk of harm. Patients could not be assured that risks were managed in accordance with the least restrictive principle.