Birmingham and Solihull Mental Health NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	**Requires Improvement**
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health services for people of Birmingham and Solihull, and to communities in the West Midlands and beyond.

Birmingham and Solihull Mental Health NHS Foundation Trust was established on 1 July 2008. Before becoming a foundation trust, the organisation was created on 1 April 2003 following the merger of the former North and South Birmingham Mental Health NHS Trusts.

The trust provides a range of inpatient, community and specialist mental health services for people from the age of 16 years upwards in Birmingham and for all ages in Solihull. However, the trust provides services to children younger than 16 in forensic child and adolescent mental health services and Solar services. Other community mental health services for children and young people in Birmingham is provided by another NHS trust.

The trust provides services to 73,000 service users, with 700 inpatient beds across over 40 sites. The trust has an annual budget of £366 million and a workforce of around 4,000 staff.

We carried out this unannounced inspection of five of the mental health services provided by this trust as part of our continual checks on the safety and quality of healthcare services. We also inspected the well-led key question for the trust overall because at our last inspection we rated the trust overall as requires improvement.

The services we inspected;

- Acute wards for adults of working age and psychiatric intensive care units
- Mental health crisis services and health-based places of safety
- Rehabilitation services
- Wards for older people with mental health problems

Our findings

- Forensic inpatient or secure wards

Following this inspection, due to concerns we found within the acute wards for adults of working age and psychiatric intensive care units, rehabilitation services and forensic inpatient or secure wards, we issued the trust with a Section 29A Warning Notice requiring the trust to make significant improvements regarding the trust deploying sufficient numbers of staff to work with patients and those staff receive the right training, professional development and have access to supervision and appraisal.

We did not inspect three other services previously rated good because we did not have intelligence which told us about risk in these services. We are monitoring the progress of improvements to these services and will re-inspect them as appropriate.

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated caring and responsive as good, and safe, effective and well led as requires improvement.
- We rated all 5 of the trust's services we inspected as requires improvement. In rating the trust overall, we took into account the current ratings of the 3 services not inspected this time.
- The trust leadership team had not ensured that all requirements from the last inspection had been actioned and embedded across all services. In 3 of the core services we visited the trust was not meeting its' own safer staffing levels with regards to qualified staff. Across all core services we visited we found significantly low compliance rates with staff managerial and clinical supervision. Staff sited staffing levels and work pressures as the main reasons for this. As a result, we issued the trust with a Section 29A Warning Notice requiring significant improvement.
- Whilst the trust had made improvements since the last inspection with regards estates related to fixed ligature concerns, we were concerned that progress was slow, with the trust having known about concerns since 2014 and still not having completed estates work. Additionally, we found that staff on Avon ward were not adhering to ligature risk management plans, and whilst new anti-barricade doors had been installed on Citrine ward we were concerned that several staff could not safely and efficiently operate them.
- Whilst the trust had started to address culture related to bullying, racism and harassment, since our last inspection, staff were still raising concerns that this was taking place. The trust acknowledged there was still work to be done to drive improvement.
- Staff compliance with mandatory training in immediate life support and safeguarding was low in 3 of the 5 core services visited, and staff working in specialist areas did not always have the additional training required to support them.
- There was a lack of activities available for patients on most wards we visited. Activities were not taking place seven days a week and staff and patients cited staff shortages as the reason for this. Patient access to support from occupational therapists and psychologists was low on most wards and not all patients that required them had access to psychological therapies.
- Staff had not managed all risks to patients in services and leaders were not aware of or were not actively managing risks across the trust. Not all patients that needed them had risk assessments in place, and risk management plans did not always detail how identified patient risks were to be managed. There were blanket restrictions on some wards that were not individually risk assessed and staff on some wards were not consistently following trust policy with regards searching patients on return from leave. The trust board assurance framework was under development, with a lack of assurance present, and the overarching pharmacy risk register had not been updated for several years.

Our findings

- Staff did not consistently promote dignity and respect as expected in all services. Patients were secluded in their bedrooms without the appropriate facilities on the acute wards and staff were observed discussing patient care in communal areas, staff had not considered the individual needs of patients with regards clothing on the older people's wards, and patients at Reaside were concerned about the lack of privacy when using bathroom facilities due to the restricted environment.
- We identified two directors who did not have a current Disclosure and Barring Service (DBS) check in place and there was no programme of board visits due to take place to ensure visits to services took place regularly. Some staff told us that leaders rarely visited services with some staff being unaware of who senior leaders were.
- We were concerned that information about quality taken to the board was not sufficient for the board to have total oversight of quality. Many sub-groups fed information and data into the quality, patient experience and safety committee which meant only information by exception was delivered to the board. This process relied on the chair of the committee establishing what was pertinent for the board to hear about and we were concerned that this did not allow the board to have effective oversight and awareness of all quality issues and concerns.
- We were concerned that appropriate governance arrangements were not in place in relation to Mental Health Act administration and compliance. The trust previously ran a separate Mental Health Act legislation committee, but since our last inspection this committee had been dissolved following an internal governance review of all board committees. Information was now fed through the quality, patient experience and safety committee and members of the now sub-committee told us they now had no direct route to board and had escalated their concerns in relation to lack of scrutiny and oversight of legislation created by the new system.

However:

- Since our last inspection the trust had appointed a new chief executive a new trust board had been formed. The trust had developed a clear strategy and vision, and leaders were passionate and shared a clear drive to make positive change.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Whilst we had some concerns about the environments at Reaside, and the Caffra seclusion suite, most ward environments were clean, well-maintained and fit for purpose.
- The trust were developing the presence of the patient voice at board level, and whilst leaders acknowledged there was work to be done in this area, there was a clear strategic aim to get this right.
- Staff managed discharge well; planning this from an early stage and making clear plans with patients. Patients had good access to services and waiting times were in line with trust policy.

How we carried out the inspection

During the inspection, our inspection teams carried out the following activities across the 5 core services visited;

Our findings

- Spoke with 169 members of staff including managers, doctors, nurses, healthcare assistants, psychologists, and occupational therapists.
- Spoke with 111 patients and 15 of their families members or carers
- Reviewed 94 patient care and treatment records
- Reviewed 103 patient medication records
- Reviewed 4 seclusion care records
- Observed 9 community visits
- Observed 16 meetings including shift handovers, multidisciplinary team meetings and ward round
- Observed 2 activities on the wards and 3 patient appointments
- Reviewed a variety of documents, policies and procedures related to the running of the services provided
- During our well-led inspection, we spoke with 33 members of staff within focus groups, and conducted interviews with 36 senior leaders of the organisation and looked at a range of policies, procedures and other governance documents relating to the running of the trust.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

Feedback from patients was generally positive. Across all 5 core services we visited patients told us that staff were kind, supportive, caring and respectful. Most patients told us they felt involved in their care planning, other than patients on the acute wards for adults of working age and psychiatric intensive care units told us they would like more involvement in creating their care plans.

Patients told us they received support with both their mental and physical health but across most services told us there was a list of individualised activities taking place on the wards.

Patients on the acute wards for adults of working age and psychiatric intensive care units, rehabilitation services and forensic inpatient or secure wards told us that leave from the hospital was regularly delayed or cancelled due to lack of staff available to facilitate this. Patients at Reaside raised concerns about the environment including the tannoy system which they told us was loud and disruptive, and the lack of ensuite facilities which they felt impacted on their privacy and dignity.

Family members and carers were able to visit patients and were involved in information sharing where appropriate.

Areas for improvement

Actions the service MUST take to improve:
Trust wide

- The trust must ensure that there is an effective system in place for scheduling and completing board level visits to all clinical services (Regulation 17)

Our findings

- The trust must ensure they continue to address and make improvements to the culture within the trust, including in relation to racism, bullying, harassment and discrimination experienced by staff (Regulation 17)
- The trust must ensure staff grievances are responded to within timescales highlighted within trust policy and procedures (Regulation 17)
- The trust must ensure that information pertaining to quality is received by the board in a manner which provides robust assurance (Regulation 17)
- The trust must ensure there is appropriate scrutiny of Mental Health Act legislation at board level (Regulation 17)
- The trust must ensure the board assurance framework is fit for purpose, is reflective of all organisational risks, and is regularly scrutinised and reviewed at board and sub-committee levels (Regulation 17)
- The trust must ensure that outstanding actions in relation to environmental works to reduce fixed ligature points are completed in line with the trust's action plan (Regulation 17)
- The trust must ensure there are regular opportunities for staff engagement (Regulation 17)
- The trust must ensure complaints are acknowledged as per timelines within trust policy, that reference to the Parliamentary Ombudsman is made where relevant, and that relevant learning from complaints is identified and actioned (Regulation 17)

Acute wards for adults of working age and psychiatric intensive care units

- The trust must ensure that the Caffra suite seclusion room is clean and well maintained (Regulation 15)
- The trust must ensure that any environment used for seclusion is suitable and safe for seclusion purposes (Regulation 12)
- The trust must ensure that all eligible staff are compliant with Immediate Life Support (ILS) training (Regulation 18)
- The trust must ensure that safer staffing levels and skill mix are met as per trust policies and procedures, and that they implement robust plans to address the staffing shortfall (Regulation 18)
- The trust must ensure patients can access meaningful and culturally appropriate activities 7 days a week (Regulation 9)
- The trust must ensure that staff have access to regular team meetings and clinical and managerial supervision as appropriate for their role as per trust policy (Regulation 18)
- The trust must ensure that staff produce risk management plans for all identified patients risks (Regulation 12)
- The trust must ensure that systems and processes to manage and administer medicines are followed (Regulation12)
- The trust must ensure that body maps are completed on admission and following incidents when patients may have received an injury (Regulation 12)
- The trust must ensure that patients are involved in their care planning, and that care plans are personalised and recovery orientated and that interventions are regularly updated and are specific to patient need (Regulation 9)
- The trust must ensure staff are respectful of patient's privacy and dignity when secluded in bedrooms (Regulation 10)
- The trust must ensure that systems and processes enable them to effectively identify, assess and mitigate risks to the health, safety and/or welfare of people who use the service (Regulation 17)
- The trust must ensure that psychology is available for all patients who require it (Regulation 9)

Our findings

Forensic inpatient or secure wards

- The trust must ensure that safer staffing levels and skill mix are met as per trust policies and procedures, and that they implement robust plans to address the staffing shortfall (Regulation 18)
- The trust must ensure that all staff have access to clinical and managerial supervision as appropriate for their role as per trust policy (Regulation 18)
- The trust must ensure that all staff receive and are up to date with Emergency Life Support training and Safeguarding training (Regulation 18)
- The trust must ensure that all staff working on Citrine ward are able to safely and efficiently operate the new anti-barricade doors on the ward (Regulation 12)
- The trust must ensure that premises at Reaside Hospital are well maintained and fit for purpose (Regulation 15)
- The service must ensure that effective systems and processes are in place to monitor training and supervision compliance (Regulation 17)
- The trust must ensure that effective systems and processes are in place to manage identified ligature risks on Avon ward (Regulation 17)

Long stay/rehabilitation mental health wards for working age adults

- The trust must ensure that safer staffing levels and skill mix are met as per trust policies and procedures, and that they implement robust plans to address the staffing shortfall (Regulation 18)
- The trust must ensure that systems and processes are in place to ensure staff understand and abide by the trust policy in relation to searching patients returning from leave (Regulation 17)
- The trust must ensure that staff have access to regular team meetings and clinical and managerial supervision and appraisals as appropriate for their role as per trust policy (Regulation 18)
- The trust must ensure that staff carry out regular and complete audits of the service, that these are accurately recorded and that the service shares insight on any learning from audits effectively (Regulation 17)
- The trust must ensure that systems and processes are established and operate effectively with regards to staffing levels and support in place for staff to ensure they can carry out their roles safely (Regulation 17)
- The trust must ensure that the policy regarding ligature risks and risk management on Endeavour Court is clear that that staff understand how to appropriately mitigate any risks identified (Regulation 17)
- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on the wards at all times, in line with the trust's safer staffing levels (Regulation 18)
- The trust must ensure that staff on all wards are up to date with immediate life support and safeguarding training (Regulation 18)
- The trust must ensure that patients have access to psychology, occupational therapy and psychological therapies on all wards (Regulation 9)
- The trust must ensure that patients have access to a range of activities on a daily basis that meet their individual needs (Regulation 9)
- The trust must ensure that any restrictions on the wards are individually risk assessed (Regulation 9)

Our findings

- The trust must ensure that there are examination couches available for patients so that their physical examinations can be carried out in a safe and dignified manner (Regulation 10)
- The trust must ensure that staff feel able to raise concerns about discrimination, bullying and harassment and that these are acknowledged, managed and responded to appropriately (Regulation 17)

Mental health crisis services and health-based places of safety

- The trust must ensure that people's medicines are safely stored (Regulation 12)
- The trust must ensure that staff have a clear contemporaneous record when visiting people in their own homes of their prescribed medicines so they can safely administer these (Regulation 12)
- The trust must ensure that staff have access to regular clinical and managerial supervision as appropriate for their role as per trust policy (Regulation 18)
- The trust must ensure that systems and processes enable them to effectively identify, assess and mitigate risks to the health, safety and/or welfare of people who use the service (Regulation 17)

Wards for older people with mental health problems

- The trust must ensure that all patients risks are assessed including their falls and malnutrition risks (Regulation 12)
- The trust must ensure that all staff receive training in safeguarding appropriate to their role (Regulation 13)
- The trust must ensure that audit systems are effective in assessing, monitoring and improving the quality and safety of services (Regulation 17)
- The trust must ensure that staff know how to use the supervision recording system so that supervision is accurately recorded (Regulation 17)
- The trust must ensure all staff complete training necessary for their role, including in delirium awareness (Regulation 18)
- The trust must ensure that all doctors receive regular clinical supervision as per trust policy (Regulation 18)
- The trust must ensure that staff adhere to National Institute for Health and Care Excellence Dementia: assessment, management and support for people living with dementia and their carers (Regulation 9)
- The trust must ensure that restrictions on patients are individually risk assessed (Regulation 12)

Action the service SHOULD take to improve:

Trust wide

- The trust should ensure that all directors have current Disclosure and Barring Service checks in place.
- The trust should ensure that it continues to improve the patient voice at all levels of the organisation.

Acute wards for adults of working age and psychiatric intensive care units

- The trust should ensure that maintenance work is completed in a timely manner.
- The trust should ensure that they increase their provision of occupational therapy and individualised activities for patients.
- The trust should ensure that a bed is available for patients when they return from leave.

Our findings

- The trust should ensure lessons learned are acknowledged and cascaded to all staff as appropriate.
- The trust should ensure all incidents are reported as per the provider's policy.
- The trust should ensure they provide detailed discharge plans which include the participation of patients.

Forensic inpatient or secure wards

- The trust should ensure that the clinic room on Coral ward has sufficient space to prepare and manage medicines.
- The trust should ensure that staff are able to respond to emergency alarms in a timely manner.
- The trust should ensure that all patients have an up-to-date risk assessment and risk management plan.
- The trust should ensure that staff complete appropriate physical health monitoring for patients post-rapid tranquilisation.
- The trust should ensure that staff follow policy regarding reviews when patients are secluded.
- The trust should ensure that staff maintain appropriate relationships and boundaries with patients at all times.

Long stay/rehabilitation services for adults of working age

- The trust should ensure that Forward House and Endeavour Court have a clinic room that provides an appropriate environment for staff to work in and for equipment to be stored.
- The trust should ensure that the clinic room on Endeavour Court is not overstocked with medicines.
- The trust should consider environmental works to provide sufficient multidisciplinary and activity space for all the wards.
- The trust should ensure that all patients that need them have access to individual self-medication care plan.
- The trust should ensure that staff are aware of who their mental health act administrators are and when and how to approach them for support.
- The trust should ensure that all mental health act paperwork is stored and archived appropriately and that this is audited regularly.
- The trust should ensure that there is appropriate space for family and carer visits to take place.
- The trust should ensure that all patients have access to spiritual support if they so wish.
- The trust should ensure that any outcomes from investigations of complaints and incidents were communicated with staff and patients where appropriate.

Mental health crisis services and health-based places of safety

- The trust should ensure that the emergency bag checklist in the psychiatric decisions unit is clear and relates to the tags on the bag, so staff know what they are checking.
- The trust should ensure that all staff receive training on how to meet the needs of autistic people.
- The trust should consider adjusting the lighting in the psychiatric decisions unit to ensure people's sensory needs and sleep are not adversely affected.
- The trust should consider the role of an occupational therapist in the home treatment teams.

Our findings

Wards for older people with mental health problems

- The trust should consider camouflaging doors on wards where there are people living with dementia to relieve their distress and promote their wellbeing.
- The trust should ensure that all patients are offered a copy of their care plan.
- The trust should ensure all staff receive an annual appraisal.
- The trust should ensure that eye ointments that have expired are not left in medicine trolleys but are disposed of.

Is this organisation well-led?

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

The Chief Executive led the executive management team which consisted of; the Chief Nursing Officer, the Medical Director, the Director of Strategy, People and Partnerships, the Director of Finance, and the Director of Operations.

The trust had a newly appointed interim board chair and one senior independent director and three non-executive directors, with one vacancy. During our well-led review, we spoke with most of the board members and the interim trust secretary.

The trust board and leadership team consisted of members largely new to their roles. Members were skilled but lacked experience and some knowledge of the roles. Several roles were occupied in the interim whilst permanent appointments were sought, including an interim Head of Safeguarding and interim Chair. The Chief Executive, who had joined the trust within the three years prior to inspection, explained this was a conscious decision in order to develop the team and bring new focus. The newly formed team had a good knowledge of the current priorities and challenges facing the trust, and were taking action to address them, but this was in its' infancy. A board development programme was in place with various workshops available to support new members. The trust board reflected the diversity of the population served by the trust.

The non-executive directors chaired the sub committees of the board including the; quality, patient experience and safety committee, audit committee, people committee, charitable funds committee, and the finance, performance and productivity committee, and the leadership structure provided clear lines of accountability.

The trust board and senior leadership team displayed integrity on an ongoing basis. There were effective systems in place to ensure that board members were fit for the role on appointment and throughout their employment. This included an annual self-declaration, checks on the insolvency register and disqualified directors list, professional body registration checks, proof of qualifications and references. However, we raised concerns about the processes in place for disclosure and barring service checks at the time of inspection as two Directors did not have a current DBS in place. The trust did act to ensure these were completed once they were informed.

Although leaders had conducted visits to services during 2022, there was no programme of board visits in place for the coming year to ensure visits took place regularly. Staff feedback at ward level was mixed, with some staff telling us that senior leaders were visible and approachable, and others telling us that they rarely visited services with some staff being unaware of who senior leaders were.

Our findings

Vision and Strategy

The trust had a clear vision of 'Improving Mental Health Wellbeing' and this was made up of three values; Compassionate, Inclusive and Committed. The value of inclusivity was centred around challenging discrimination and treating people fairly.

Following our last inspection in 2018 we reflected that there was a culture of racism, bullying and discrimination within the trust as described by staff. There was now a clear focus on addressing this culture, with most staff describing an improvement following the appointment of the new Chief Executive. However, some staff still described a negative culture, with senior managers not listening to concerns and inappropriate language and comments going unchallenged because staff did not believe anything would be done even if they reported it. The trust recognised they still needed to continue work in this area, and this was reflected in the five-year strategy which commenced in 2021.

The trust five-year strategy was underpinned by four strategic priorities;

- clinical services,
- quality,
- people
- sustainability.

Each strategic priority was then underpinned by clear strategic aims, for example, some of the aims underpinning the 'people' priority were shaping the future workforce and transforming culture. At the time of inspection, the trust had just completed the first year of the strategy and had evaluated this including challenges going forwards, for example with capacity they had identified workforce challenges as an ongoing concern. Staff had the opportunity to contribute to discussions about the strategy, but it was not clear how patients and carers were actively involved. The trust were aware there was work to do on engaging patients going forwards.

Although the trust had identified areas of concern going forwards it was not always clear how they were going to address these. With regards workforce there were clear plans to conduct oversees recruitment as well as to offer training to those in certain roles to increase and upskill the workforce. Other initiatives from the trust included an investment to increase places in nurse associate and registered nurse training programmes, more flexible shifts to all staff, and flexible working arrangements for staff when commencing work in the trust. However, the numbers projected from these initiatives would still leave a shortfall in staffing numbers overall, and staff at ward level told us, and example rotas demonstrated, that staffing was an ongoing concern with little immediate action.

Following our core service inspections, we issued the trust with a warning notice which highlighted concerns around low staffing levels in the acute and psychiatric intensive care unit service. Additionally, as part of the 'quality' priority were aims relating to fixed and non-fixed ligatures. Whilst work was well underway to rectify estates issues identified in relation to reducing ligature points, we remained concerned that some works were still not complete despite risks in this area being highlighted to the trust as far back as 2014.

There were systems in place to manage and monitor the implementation of the trust's infection prevention and control (IPC) strategy. The trust were taking action to improve the governance around IPC including looking at their recording system and outbreak programme to ensure effective compliance and monitoring.

Culture

Our findings

During inspection we interviewed 169 members of staff across the core services, and spoke with a further 33 during focus groups. Most staff we spoke with during inspection told us they felt respected, supported and valued and felt positive and proud about working with their teams. However, staff including managers in some services, including those working on the acute and psychiatric intensive care unit wards, and forensic wards, told us that they felt morale was low and that this was having an impact on the culture with cliques forming in some teams and staff feeling undervalued and not listened to. Staff largely attributed difficulties to low staffing levels placing excess pressure on teams.

The trust worked with trade unions to support staff although feedback was that relationships with executives needed to develop in some areas due to the number of changes in the executive team and lack of leadership involvement in regular meetings. Feedback from trade union representatives was mixed, with negative experiences of management of bullying and harassment cases with concerns around confidentiality and adherence to policy being raised. The trust board and leadership team were aware that experiences in this area remained mixed and were driving forward initiatives such as their 'enough is enough' campaign with the aim of ensuring everyone has a voice and feels listened to when they raise concerns.

The trust had two freedom to speak up guardians who managed the role. One was a full time Band 7 and one a 0.8 Band 8 role. They explained that they did this in addition to other roles and struggled to get the necessary work done in their contracted hours. The trust had plans to enhance the role by recruiting 8 champions and at the time of inspection onboarding was being finalised in terms of training and support for the additional roles. The trust informed us that they had recruited the 8 champions. The freedom to speak up guardians were a regular part of new staff inductions to ensure the role was understood. The freedom to speak up guardians told us that leaders were approachable but were not always accepting of feedback from them and were occasionally defensive about areas of concern raised.

The guardians provided quarterly reports through the people committee and an annual report to the board, the most recent annual report was provided in July 2022. Within the report it was shared that 140 speaking up concerns had been raised within the last 12 months which was an increase of 96 cases compared to the previous 12-month period. Themes included poor leadership, including lack of action when concerns were raised, inconsistent application of policies and lack of communication, and cultural concerns, including bullying and harassment, staffing challenges and stress. The annual report contained several recommendations for the board to consider, including inviting them to complete training around the speak up process, and considering how to improve oversight, feedback and learning from investigations.

The trust had a grievance and disputes policy and procedure which was in date and due for review in May 2023. The policy identified timescales and responsibilities for responses and outcomes.

The trust had managed six staff grievances December 2021, all of which were reviewed as part of the inspection process. Three had been resolved informally, and three were ongoing at the time of inspection, the longest of which had been ongoing for eleven months. They included concerns about the behaviour of colleagues and managers, management not responding to concerns raised, and discrimination. Not all grievances were responded to in line with trust timescales and it was not always clear as to the reason for this. Additionally, in two cases those making grievances chased the trust for an initial response several times before one was provided.

The trust had four staff networks;

- Disability and neurodiversity network
- Race equality network

Our findings

- LGBTQ+ network
- Women's network

Most networks were established within the trust, apart from the women's network which had recently launched. Staff network leads described a commitment from senior leaders to the groups and to equality, diversity and inclusion, apart from the LGBTQ+ network who felt that the board did not provide them with the same level of support as other networks and did not give their concerns as much acknowledgement. Each network had an executive sponsor but the LGBTQ+ network did not feel the sponsor allocated was passionate about the network or represented them well at board level. The Chief Executive was aware of this and was encouraging relationships between the network and the sponsor. Staff network leads had varying time allocated to the role, for example some network leads told us they did not get any allocated time whilst others had one or two days a week allocated time. It was difficult to ascertain how feedback from staff networks was actioned by leaders for learning and improvement as there was no clear structure for this.

Not all staff had the opportunity to discuss their learning and career development needs through regular supervision and appraisal as per the trust policy. Staff largely attributed this to staffing pressures and not having the time to engage in these activities.

The trust was aware of pressures felt by staff. The trust had a people strategy which focused on shaping the future workforce, transforming culture and staff experience, and modernising people practice. The trust had just reviewed the first year of the strategy and had identified ongoing challenges with recruitment, staff exhaustion and burnout, culture, and workforce development. There were wellbeing offers available to staff and the trust were committed to the ongoing development of these, although it was not always clear from speaking to staff how useful the wellbeing support on offer was to them practically, as many wellbeing concerns arose from staffing issues.

The trust had taken part in the NHS staff survey 2021. The overall response rate to the survey was 55% which was an increase of 11% on the previous year. The trust acknowledged the importance of the survey and its' results and offered staff protected time to complete it. Staff survey results were delivered through the people committee to provide assurance on results and action plans. Data showed a negative trend in several areas compared to the previous year;

- 62% of staff would recommend the trust as a place to work. This was a decrease of 4% on the previous year.
- 30% of staff felt there were enough staff in the trust to do their job properly. This was a decrease of 10% on the previous year.
- 77% of staff felt care of patients / service users was the trust's top priority. This was a decrease of 3% on the previous year.

There was also improvement noted in some areas compared to the previous year including in relation to bullying at work. However, whilst scores in this area had improved, they were still higher than the average benchmark, for example 20% of staff reported experiencing at least one incident of harassment, bullying or abuse at work from other colleagues in 2021 compared to 22% in 2020, but this was still much higher than the average benchmark of 14%.

The trust had a sickness target of 3.9%. Actual sickness rates were noted to be higher than this across all services, for example, across the acute and urgent care services average staff sickness was 8% in September 2022. Sickness rates fluctuated across the previous 12-month period but were consistently higher than the trust target, with the lowest being 6.68% in March 2022. Staff cited work related pressures as the main reason for sickness.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts from April 2015, whereby trusts must report against nine indicative measures of equality in the workforce.

Our findings

The trust last reported on the standards in 2022, when 37% of the trust's workforce was from a Black and minority ethnic background; a slight increase on the previous year. The trust had committed to increasing this figure to 40% by 2028 and were completing quarterly reports to monitor progress. There had been some positive improvements recorded in the data, for example the number of Black and minority ethnic colleagues likely to enter formal disciplinary processes when compared to White colleagues had almost halved on the previous year, although was still higher. Some areas of concern also remained with 16.4% of Black and minority ethnic colleagues reporting discrimination at work from managers of leaders compared to 10.6% of White colleagues, and only 41% of Black and minority ethnic colleagues believing that there were equal opportunities for career progression. This had also decreased from 60% in 2020.

The Workforce Disability Equality Standard (WDES) comprises a set of ten metrics which aim to compare the experiences of Disabled and non-disabled staff. The trust's data for 2022 showed that 5.6% of trust staff reported having a long-term condition or illness. There had been some positive indicators since the last report including colleagues being more likely to be appointed from shortlisting, but there were a number of areas that required ongoing action from the trust. These included colleagues reporting an increase in reporting bullying and harassment, and a decrease in colleagues believing the trust provided equal opportunities for career progression.

The trust had a guardian of safe working hours who was experienced in their role. The guardian reported to the board on a quarterly basis. In December 2022 the report highlighted two significant concerns which had occurred during the last quarter. Twelve exceptions had also been reported, with the theme of exceptions related to higher number of hours spent on-call compared to paid hours per on-call. The guardian could explain the trust plan to address this. Additionally, the guardian described a quality improvement project which was underway to support a culture change in encouraging doctors in raising exceptions generally.

Governance

The trust leadership team had not ensured that all requirements from the last inspection had been actioned and embedded across all services.

The trust had structures, systems and processes in place to support the delivery of its strategy including board committees, sub-board committees, and team meetings. There was a board committee structure in place, with each committee chaired by a Non-Executive Director who reported to the board. The trust had 6 committees that reported directly to the Board of Directors.

We reviewed papers from sub-committees and trust board and whilst the majority detailed a clear flow of information, we were concerned about the effectiveness of the quality, patient experience and safety committee. Many sub-groups fed information and data into this committee which meant only information by exception was delivered to the board. This process relied on the chair of the committee establishing what was pertinent for the board to hear about and we were concerned that this did not allow the board to have effective oversight and awareness of all quality issues and concerns. The committee had also been renamed in recent years to drive focus on patient experience, but it was unclear how much this had changed in practice, as from papers reviewed at the time of the inspection there was no clear inclusion of patient voice or experience in discussions held. Subsequent information from a trust quality, patient experience and safety committee report was seen that highlighted experiences from patients but further work was required. Members of the committee were clear that they wanted to increase the patient voice but there were no clear plans around how to do this, for example, members talked about having a patient experience report, or considering governor presence at committee meetings, but these were not happening at the time of inspection.

Our findings

We were also concerned that appropriate governance arrangements were not in place in relation to Mental Health Act administration and compliance. The trust previously ran a separate Mental Health Act legislation committee, but since our last inspection this committee had been dissolved following an internal governance review of all board committees. Information was now fed through the quality, patient experience and safety committee and members of the now sub-committee told us they now had no direct route to board and had escalated their concerns in relation to lack of scrutiny and oversight of legislation created by the new system.

With regards financial governance, the trust operates as a group model, with a subsidiary company providing a range of facilities management, contract and consultancy services; and hosts an integrator partnership that commissions forensic services for itself and other trusts in the Midlands. As part of Integrated Care Board (ICB) development, the trust expects to be part of two other integration commissioning collaboratives covering place-based services (including services for people with learning difficulties and autism) for children and young people, and services for adults. Governance, including financial governance, is still in development prior to the formal delegation of commissioning from the ICB.

The Trust expects to deliver its' financial plan in 2021-22. However, trust leads told us that the trust would not deliver its cost improvement and efficiency plans recurrently, drawing particularly slippage on benefits from e-rostering implementation; secure patient transport and transformation initiatives. The Trust had taken steps to reformulate the design of initiatives to improve staff engagement.

The Chair of the audit committee was a qualified accountant with significant experience in health and public services. The Director of Finance (DoF) has significant NHS leadership experience and chairs the finance workstream within the ICB with a wide scope of responsibilities, including procurement, contracting, performance information and performance management, and information and communication technology.

In the year 1 October 2021 to 30 September 2022 the trust received 142 formal complaints, of which 123 had been closed. Of these, 3 had been upheld and 59 partially upheld. The trust had a complaints policy which detailed response times to complaints dependent on the level, for example for a single issue relating to one team the expected timescale for a final response was 25 working days and for complex issues requiring a multi-agency approach up to 6 months was allowed for. The trust told us that on average it took 52 working days from registration to resolution of complaints, with a minimum of 2 working days and a maximum of 140. However, from the start of 2022, due to increased levels of complaints received, and in order to meet targets, the trust decided to categorise all complaints at the highest level other than those that were very straightforward. So, although data would suggest the trust was largely meeting its' response targets it was unclear whether this was the case due to the trust's decisions around categorisation. Findings at core service level demonstrated that people knew how to complain and that staff teams identified and took forward relevant learning from complaints outcomes. We reviewed 5 complaints during the well-led element of this inspection; 2 were not acknowledged within 3 working days as per the trust policy and 2 did not include reference to the Parliamentary Ombudsman and how complainants could escalate concerns if dissatisfied with the outcome, and 2 did not evidence any learning or actions as a result of the complaint.

Management of risk, issues and performance

The trust had a board assurance framework (BAF) in place which was developed in response to the new Trust strategy and was set against its' four strategic priorities. The BAF identified risks to the organisation and was agreed by the board in early 2021 at the start of the new strategy and was last received in committees in February 2022. At the time of inspection, the BAF was undergoing review and risk scores were still being determined, with risks cascaded to committees for oversight. The framework appeared underdeveloped and it was unclear how evidence presented would

provide clear assurances to committees and the board, for example the assurance offered to mitigate the risk of the non-delivery of the financial plan was said to be reporting to the finance committee and board and we were concerned this would lead to the board being reassured rather than assured. An external auditor found that further work was needed to establish controls in 2 areas of risk; delivery of lead provider services and focus on the digital agenda. Following the inspection the trust submitted information that the BAF was further developed during 2022 and a refreshed version was approved by the board in October 2022 and received by committees by 19 October 2022. We remain unclear on the assurances to our concerns.

The trust continued to have estates challenges. The trust had an estate's and facilities strategy which detailed risks related to estates and how these were managed. We raised concerns about the safety of the wards with the trust, including ward environments in relation to fixed ligature points, as far back as 2014. Following an inspection in 2020, due to lack of sufficient improvement, we notified the trust of a decision under Section 31 of the Health and Social Care Act 2008, to impose conditions on their registration as we believed patients may be exposed to the risk of harm. We asked the trust to submit monthly updates with regards improvements made in relation to ligature risks. The trust submitted plans to replace all bedroom and ensuite doors in inpatient areas, but at the time of the current inspection these works were still not fully complete. The trust acknowledged that the replacement of all doors had taken a significant amount of time to complete and sighted acuity, escorting of contractors and the COVID-19 pandemic as reasons for this. We were concerned about the timeliness of works and additionally were concerned that despite the known risks associated with ligatures whilst works were still ongoing, this risk was not represented in the trust BAF.

Since our last inspection four of the core services we inspected remained requires improvement and a further one had gone from good to requires improvement. We rated safe within the acute wards for adults of working age and psychiatric intensive care units core service as inadequate and following inspection of the core services we issued the trust with a warning notice requiring significant improvement with regards staffing and staff supervision. During this inspection we continued to identify concerns present since our last inspection with regards staffing shortages, inefficient systems to ensure staff received supervision, and racism, bullying and discrimination within parts of the organisation, suggesting the trust had not made sufficient improvement in these areas, despite plans in place to do so.

A further risk identified during inspection in 2018 and not yet rectified was in relation to staffing levels. Following the 2018 inspection, we told the trust they must ensure that enough suitable qualified, skilled and experienced staff were working within the acute and psychiatric intensive care unit wards and within the crisis service. However, during the current inspection we found staffing levels in the acute service to still be of concern, with a high level of shifts not meeting the trust's own safer staffing levels.

We subsequently issued the trust with a Section 29A warning notice requiring them to make significant improvement in this area. The warning notice also referenced significantly low staff supervision levels related to 3 of the 5 core services we inspected. Whilst the trust explained some plans to address staffing concerns, such as international recruitment, we were concerned that short-term plans were not in place to address staffing concerns as they arose.

Between 1 February and 29 July 2022, the trust reported 41 serious incidents. Of these, 18 related to deaths within the community mental health service. Following receipt of this information we asked the trust for further information to establish any themes, trends or areas of identified learning following investigation and review of these incidents. We were concerned that the trust was not able to produce this in a timely manner, and once provided found themes and learning to be vague, such as 'record keeping' or 'safeguarding' with no evidence of an action plan or steps taken to make improvements in the service with regards patient safety. We found that whilst information related to serious

incidents was shared with all operational areas in order to disseminate learning, there was no further interface or processes in place to ensure learning was facilitated and embedded. Additionally, the board only received summary updates from the sub-committee chair in relation to serious incidents, rather than more comprehensive reports, which lacked depth for effective board oversight.

The trust had systems in place to identify learning from safeguarding alerts and to make improvements. Staff at core service level knew how and when to make safeguarding referrals and described positive relationships with safeguarding leads within the trust. The trust was thinking constructively about how to upskill staff with regards safeguarding and had introduced safeguarding supervision training to upskill staff to provide additional support to teams.

The trust had a duty of candour policy which was due for review at the time of inspection. The policy was clear and detailed when duty of candour was applicable, responsibilities, examples of applicable incidents and a flow chart to aid staff in completing the process. In the 12 months prior to inspection duty of candour had been followed on 38 occasions. We reviewed 3 of these incidents and it was clear that an apology had been given both verbally and in writing.

The trust had a programme of audits to monitor quality and safety, and systems in place to identify when action needed to be taken. The trust internal audit programme had changed at the beginning of the year with an initial focus on counter fraud and finance. Staff at ward level completed clinical and internal audits relevant to their service. However, at core service level we found concerns in 3 of the 5 services we visited. In the rehabilitation service we found that audits were duplicated, and no clear actions were identified. In the crisis and older people's services we found that audits had not effectively identified issues found on inspection.

The trust pharmacy team provided a comprehensive service to inpatient settings and clinical pharmacy services were well embedded into multidisciplinary teams. The trust had partnered with other local health organisations to offer split placements for trainee pharmacists in recognition of recruitment challenges faced. Medicines optimisation priorities were detailed in the trust medicines optimisation strategy and there was clear evidence that the trust supported these priorities. The Chief Pharmacist could articulate medicines related risks and mitigations in place, and risks were included in the overall trust risk register. However, the pharmacy aspects of the register had not been regularly updated, including some risks not reviewed since 2018. The pharmacy team had an audit plan and were sharing audit results from wards on a dashboard. The pharmacy team described concerns relating to physical health monitoring post-rapid tranquilisation administration and the trust was reviewing the relevant policy and planned to provide additional training for staff to address this.

Information Management

The board received information on service quality and sustainability, but we were concerned information on quality was only delivered by exception through the quality, patient experience and safety committee due to the large number of sub-committees that sat beneath. We could see from board minutes that attendees were encouraged to challenge the reliability of information presented but feedback from some groups, such as governors, was that they were not actively invited to all pertinent meetings and that scrutiny and feedback was not always well received or appropriately considered by the board.

The board received information on service quality and sustainability. The trust had a Chief Information Officer. The trust had introduced a new digital strategy as part of their five-year strategy 'sustainability' priority. This included making the

workforce more digitally enabled and supporting staff to use technology effectively to drive improvement, for example using tablets to digitally record patient observations on wards. The trust was progressing well with the strategy but acknowledged further work was required to support staff within services to use digital technology more effectively to support them further in their roles.

The trust had a dedicated team in place who focused on cyber security. They were part of regional group, allowing the trust to report against other providers and monitor assurance. Information governance systems were in place including confidentiality of patient records. There had been no significant data security breaches at the trust in the 12-months prior to inspection.

Staff had access to the necessary IT equipment and systems needed to do their work, including laptops and mobile phones.

We were concerned that staff at core service level did not receive information about quality and sustainability across the trust as there was a lack of team meetings taking place. Within 3 of the 5 core services we inspected there was a lack of, or staff were unable to attend, regular meetings due to low staffing levels. Equally clinical and managerial supervision levels were significantly low in these core services, which would have provided further opportunity to ensure staff were aware of key messages.

The trust was aware of its performance through the use of key performance indicators (KPIs). For example, the pharmacy team reported against KPIs including prescription volumes, stock levels and medicines reconciliation, and any trends were reported on monthly and discussed at relevant management meetings.

Engagement

The trust 'Participation & Experience' team had been operational since June 2022. This followed an organisational change whereby the previous 'See Me' team had evolved to increase the staffing within the team, promote the awareness of the trust's Expert by Experience programme, and start to look more closely at the experience of service users, families and carers. A key role of the team was to ensure patient, family and carer experience data was captured and reported at a governance level. Members were in the process of attending ward-based meetings as well as governance meetings, improving training and recruitment of experts by experience, and looking at ways to raise the profile and visibility of service users. The trust was aware of the need to continue improvements relating to patient engagement and the ability to provide meaningful feedback and acknowledged this was not yet as advanced as they would like. However, the trust were awarded a 'Recovery for Quality Mark' by trust experts by experience that demonstrated the principles of recovery and co-production with service users and carers.

Communication systems were in place to ensure staff, patients and carers had access to information about the work of the trust and the services they used. However, governors told us that newsletters had ceased during the COVID-19 pandemic and were yet to be reintroduced and we found much of the information on the trust's internet pages to be out of date or difficult to navigate. For example, the workforce race equality standard (WRES) data published on the trust's website was from 2020, even though this had been refreshed twice in the following years.

The trust used the friends and family test as a means of understanding and gathering feedback in relation to patient experience. Between 1 October 2021 and 30 September 2022, the trust received 1708 responses. 81% of respondents had a positive experience of services, and 88% of respondents said they felt the trust listened to them and heard what

they had to say. When given the opportunity to feedback on areas for improvement, respondents highlighted staffing, support, environment and activity as the top areas. We found that the majority of services we inspected conducted regular patient community meetings on the wards and used these forums to gather local feedback and to make changes.

During inspection we spoke with 5 governors from a range of backgrounds. Governors understood their important role in providing the voices of staff, patients and carers to the leadership team and told us that information was provided to them in a format which was understandable and encouraged them to seek assurance and ask questions. However, they told us that they felt their feedback was not always listened to by board members and that action was not always taken when required. They told us that whilst challenge was invited it was not always appreciated, and they cited a lack of compassion and open culture in the trust which required some work to change for them to be able to speak openly and drive improvement where needed. Governors spoke of supporting staff in their roles with regards wellbeing, and told us that whilst groups such as the health and wellbeing steering group and intranet pages on wellbeing were available to staff, not many people knew about these or what was on offer to support them. Governors told us they had asked to see a schedule of executive visits to services, but this had not been provided and they were unsure whether visits were taking place. We asked to see a schedule for upcoming visits whilst on inspection, but this had not yet been devised for the coming year.

The trust did not have a structured system in place for staff engagement. Across 4 of the 5 services we visited we found that staff team meetings did not take place regularly, and the main reason given for this was due to low staffing levels. The Trust told us they were 'committed to ensuring that colleagues have access to appropriate clinical supervision and reflective practice to support high quality clinical care and colleague wellbeing'. However, we found that in the 3 of the services we visited staff compliance with both managerial and clinical supervision was very low, with as few as 8% of staff having received managerial supervision, and as little as 17% of staff having received clinical supervision in line with trust policy on some wards. This meant that important opportunities to gather staff feedback and to share learning and information with staff was missed. Following inspection, we issued the trust with a Section 29A warning notice requiring them to make significant improvement in this area.

The trust was part of the Birmingham and Solihull Integrated Care System (ICS) and had been identified as the lead provider for the Mental Health Provider Collaborative which was due to go live on 1 April 2023. The trust was in the process of developing governance arrangements in relation to this to ensure clear separation of the Trust's provider and commissioner responsibilities.

The trust worked closely with the ICS in developing new roles within the trust to support with quality governance, commissioning and pathway development. Members of the leadership team were also involved with various ICS groups, for example one of the trust's non-executive directors was part of the ICS stakeholder group for the Health and Inequalities board and other leaders were involved in ICS informatics groups which supported in taking strategies forwards as well as with recruitment development in this area.

Learning, continuous improvement and innovation

The trust was committed to learning and continuous improvement although much of this was in its' infancy. The new trust strategy had been in place for a year at the time of inspection and the trust had reviewed their progress against this as part of a five-year plan.

Our findings

The trust actively sought to participate in quality improvement projects. Some of the projects staff were involved in included; a sensory friendly wards project in acute and secure services, choking risk in inpatient settings, and a reducing restrictive practice collaborative. Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented, including implementing wearable activity tracker devices for patients to wear on older adults wards which would alert staff immediately should a patient fall.

The trust used learning from their experience during the COVID-19 pandemic, to develop their digital strategy. They considered how they had been able to use technology in alternative ways to support service users and were continuing to develop this.

The trust had a planned approach to take part in national audits. We saw examples of audits completed in 2022 including national audit of end of life care and national audit of dementia. Whilst actions had been derived from findings it was not clear who's responsibility these were or dates by which they should be completed and reviewed. Staff at service level also engaged in audit, but we found that this process was not robust and included duplication of findings, lack of clear actions identified, and ineffective audits failing to identify issues.

Staff participated in research which was overseen by the research and innovation management board which reported to the board via the quality, patient experience and safety committee. The trust was involved in undertaking National Institute for Health and Care Research (NIHR) portfolio adopted studies in areas including; older adults and dementia, reducing inequalities, and addictions. The pharmacy team were taking part in a research project in conjunction with a homeless charity looking at pharmaceutical outreach support. This was based on an established trial taking place in Glasgow and the trust was working in collaboration to develop the project.

Individual staff and teams received awards for improvements made and shared learning. The trust was nominated as a finalist at the National Service User Awards 2022 for their 'Mental Health Natters' podcast; co-produced by a group of individuals with lived experience of mental health, and the Solihull early intervention team were named Royal College of Psychiatrist's 'Team of the Year' 2022. Individual staff members also received recognition for their contributions at the Health and Social Care Awards, Student Nursing Times Awards, and National Black Asian and Minority Ethnic Health and Care Awards.

Several trust services were accredited including forensic and secure wards who were accredited by the Quality Network for Forensic Mental Health Services, the forensic CAMHS service which was accredited by the Quality Network for Inpatient CAMHS (QNIC), and the Caffra suite which was accredited by the Association of Psychiatric Intensive Care and Low Secure units (NAPICU).

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Apr 2023	Requires Improvement →← Apr 2023	Good →← Apr 2023	Good →← Apr 2023	Requires Improvement →← Apr 2023	Requires Improvement →← Apr 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Ambulance	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Mental health	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Community	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Primary medical	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement →← Apr 2023	Requires Improvement →← Apr 2023	Good →← Apr 2023	Good →← Apr 2023	Requires Improvement →← Apr 2023	Requires Improvement →← Apr 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Trust Headquarters	Requires improvement Jul 2019	Requires improvement Jul 2019	Good Jul 2019	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019
Overall trust	Requires Improvement →← Apr 2023	Requires Improvement →← Apr 2023	Good →← Apr 2023	Good →← Apr 2023	Requires Improvement →← Apr 2023	Requires Improvement →← Apr 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Trust Headquarters

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Jul 2019	Requires improvement Jul 2019	Good Jul 2019	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based mental health services of adults of working age	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Specialist eating disorders service	Good Sep 2014	Good Sep 2014	Good Sep 2014	Requires improvement Sep 2014	Good Sep 2014	Good Sep 2014
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ➔➔ Apr 2023	Requires Improvement ➔➔ Apr 2023	Requires Improvement ➔ Apr 2023	Requires Improvement ➔ Apr 2023	Requires Improvement ➔➔ Apr 2023	Requires Improvement ➔➔ Apr 2023
Specialist community mental health services for children and young people	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Community-based mental health services for older people	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Mental health crisis services and health-based places of safety	Requires Improvement ➔➔ Apr 2023	Requires Improvement ➔➔ Apr 2023	Good ➔➔ Apr 2023	Good ➔ Apr 2023	Requires Improvement ➔➔ Apr 2023	Requires Improvement ➔➔ Apr 2023
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement Apr 2023	Requires Improvement Apr 2023	Good Apr 2023	Good Apr 2023	Requires Improvement Apr 2023	Requires Improvement Apr 2023
Forensic inpatient or secure wards	Requires Improvement Apr 2023	Requires Improvement Apr 2023	Good Apr 2023	Good Apr 2023	Requires Improvement Apr 2023	Requires Improvement Apr 2023
Wards for older people with mental health problems	Requires Improvement Apr 2023	Requires Improvement Apr 2023	Good Apr 2023	Requires Improvement Apr 2023	Requires Improvement Apr 2023	Requires Improvement Apr 2023
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Wards for older people with mental health problems

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff had completed an environmental risk assessment of each ward and at Reservoir Court used observations and mirrors to reduce the risks. However, at Reservoir Court staff had reported to estates the need for lighting in the car park. The ward was isolated at the side of the hospital site, and staff reported they felt vulnerable when leaving or arriving in the dark. There was a delay of two weeks in providing these even though it was classed as urgent which should be the same day.

Staff could not observe patients in all parts of the wards. At Reservoir Court staff were aware of the risks of blind spots and the layout of the ward and this was added to the trust risk register. On Bergamot ward the environmental risk assessment had identified a blind spot in the garden and there was a plan to install mirrors. Staff managed the risk of this by observation of patients in the garden.

The ward complied with guidance to reduce the risks of mixed sex accommodation. There was mixed sex accommodation at Reservoir Court. However, there were separate corridors for male and female bedrooms and bathrooms. There were also separate lounge and dining areas. Staff told us that if they had more women than men or vice versa they could move doors on corridors to adapt the number of bedrooms and ensure they complied with guidance.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The trust had fitted anti ligature doors to bedrooms and ensuites at Reservoir Court due to identified risk. Staff tested the alarms on these doors weekly to make sure they worked and would alert staff if a person had tied a ligature. On other wards the trust had changed the door handles on bedroom doors to anti ligature following ligature risk assessments.

Staff had easy access to alarms and patients had easy access to nurse call systems. All staff had alarms and fobs, so they had access to all areas of the ward. Patients had access to nurse call bells in their bedrooms and bathrooms.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained and, well furnished although Reservoir Court was not fit for purpose. The ward was built around a garden so there were not clear lines of sight and there were blind spots, and it was difficult to navigate the ward easily. The trust had identified that the environment was not fit for purpose and were looking at plans to relocate the ward in the future.

Staff made sure cleaning records were up-to-date and the premises were clean. The trust employed housekeeping staff on all wards, and they maintained cleaning records and ensured the wards were clean.

Staff followed infection control policy, including handwashing. Staff had access to masks, gloves and aprons on all wards. At time of inspection the service followed NHS England guidance and as there were no positive cases of COVID -19 the wearing of masks was not mandatory. We observed staff washing their hands on entering and exiting each ward and after each task. Hand towels and soap were available in all entrances, toilets, bathrooms and kitchens.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. All clinic rooms were clean, and staff checked the resuscitation equipment daily and recorded this. However, in Reservoir Court we saw some gaps in recording of clinic room temperatures and in Rosemary ward there were three missing temperatures of the clinic room in September 2022. Each clinic room had an air conditioning unit and the temperatures recorded showed these were within safe range and there was no variation which reduced the risk of medicines not being stored at safe temperatures.

Staff checked, maintained, and cleaned equipment. Records on all wards showed staff checked physical health monitoring equipment such as blood pressure machines and weighing scales. They checked to make sure it was clean and calibrated so it was effective in monitoring patients' physical health.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. Rotas for all wards showed staffing levels met the numbers identified in the trust's safer staffing plan. However, at Reservoir Court staff said that only having one registered nurse on duty could make it difficult to cover all the nursing tasks required. Occupational therapists worked as part of the nursing rota when needed to provide support during the weekdays, but these staff would not be able to administer medicines.

The service had low and reducing vacancy rates. The vacancy rates on Sage ward, Bergamot ward and Reservoir Court were over the established number not under established. On Bergamot ward the vacancy rate was minus 13%, the ward manager said there were two band 5 vacancies, one had been filled and the other had been advertised again. On Sage ward the vacancy rate was minus 31%, the ward manager said there were two band 6 vacancies and one band 4 vacancy. On Rosemary ward the vacancy rate was 6%, the two band 5 vacancies had been recruited to at time of inspection. At Reservoir Court the vacancy rate was minus 15%, there were two band 5 vacancies and one band 4 with interview dates set in November 2022.

The service had low rates of bank and agency nurses. Managers limited their use of bank and agency staff and requested staff familiar with the service. All ward managers said they asked permanent staff if they wanted to do extra shifts first, then requested bank staff in advance and usually these were regular bank staff who knew the wards. If permanent or bank staff were not available, they would look at skill mix and then utilise agency staff. The service had low rates of bank and agency nursing assistants. During the COVID-19 pandemic the service had over recruited healthcare assistants to meet patients increased acuity and observation levels. This meant that they did not use agency staff and when they used bank staff these were staff that worked on the wards regularly.

Wards for older people with mental health problems

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Managers and bank staff spoken with said that bank and agency staff had a full induction before starting to work on the wards.

The turnover rates of the service had increased to 13% in September 2022 compared to 9% in October 2021. Ward managers said that the reason for this was staff leaving because they had been promoted within the trust or to start nurse or allied health professional training.

Managers supported staff who needed time off for ill health. Managers said that when staff returned after sickness, they would make reasonable adjustments and put support plans in place if needed.

Levels of sickness were reducing on most wards. On Bergamot Ward in September 2022 the sickness level had reduced to 6% from the average in the last 12 months of 11%. Sage Ward in September 2022 had reduced to 6% from an average of 13% and Reservoir Court had reduced in September 2022 to 7% from an average of 10%. However, Rosemary Ward had increased in September 2022 to 10% from average of 6%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. On each ward managers told us how they assessed the number of each band of nursing staff they needed for each shift and how they adjusted these to ensure the skill mix was right to meet patient's needs.

The ward manager could adjust staffing levels according to the needs of the patients. The clinical nurse manager told us they had over recruited support workers during the pandemic and had since kept these staff on. On Sage Ward this meant the established staffing level for support workers was over the required levels as per the service's safer staffing plan, and this meant they had enough staff for increased patient observations without the need to use bank and agency staff.

Patients had regular one- to-one sessions with their named nurse. Patients and staff said, and records showed that patients had a named nurse allocated on admission and had regular one to one session.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Patients told us that activities or escorted leave were not cancelled.

The service had enough staff on each shift to carry out any physical interventions safely. This was assessed by ward managers and rotas showed that enough staff were available.

Staff shared key information to keep patients safe when handing over their care to others. We observed the handover from the day to the night shift on Sage Ward. Staff gave information about each patient and where needed discussed how they needed to be supported during the night.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Staff and patients told us that a doctor was available when needed.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Wards for older people with mental health problems

Mandatory training

Staff had completed and kept up to date with their mandatory training. The overall compliance at time of inspection for mandatory training was 97%. On Bergamot ward it was 97%, Reservoir Court was 98%, Rosemary was 96% and Sage was 97%.

The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training included health and safety, fire safety, first aid, moving and handling, physical intervention, safeguarding adults and children from abuse, food hygiene and infection control. All staff said that managers alerted them to complete or update their training and they knew when any updates were needed.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves. They followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for most patients on admission, using a recognised tool, and reviewed this regularly, including after any incident. Records reviewed showed that on admission staff completed the trust risk screening tool for each patient. However, on Sage ward in two patients' records staff had not completed a falls risk assessment, which is not in line with National Institute for Health and Care Excellence (NICE) guidance.

Where staff had identified risks from the screening tool, they had completed a short-term assessment of risk and treatability (START) risk assessment. These detailed how staff were to support the patient to reduce their risks.

Management of patient risk

Staff did not know about all risks to each patient so they could act to prevent or reduce risks. Staff had not completed a falls risk assessments for two patients on Sage ward and for one of these patients' staff had also not completed a continence assessment or malnutrition assessment on this admission. This meant that staff had not assessed on this admission the person's risks of malnutrition that had previously been identified.

We saw where blanket restrictions were made that these were included on the trust blanket restrictions log. For example, on Sage ward red dementia friendly cups and beakers were used in the ward area due to risks associated with using crockery to harm themselves or others, and the blanket restriction log stated that crockery was available to patients who individually risk assessed and who did not present any risk. However, we saw that all people on Sage ward were offered a red plastic cup including one person whose records did not show they had been individually risk assessed.

Staff had not identified all risks so they could not respond to any changes in risks to, or posed by, all patients. Staff had not completed all the assessments needed for two patients which could mean they were not able to respond to these and to any changes.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff used observations and moved around the wards to minimise risk to patients in areas where they could not easily observe the patient.

Wards for older people with mental health problems

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. On Sage ward it was recorded on the blanket restrictions log that any patient taking section 17 leave is searched on their return from leave for contraband items. It was not clear why this was a blanket restriction as this should be assessed for individual risk and not for every patient.

Use of restrictive interventions

Levels of restrictive interventions were low or reducing. The trust told us that for the six months before our inspection on Bergamot ward there had been five restraints, at Reservoir Court there had been 20, Rosemary ward 39 and Sage ward 51.

Staff participated in the provider's restrictive interventions reduction programme. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff understood the Mental Capacity Act definition of restraint and worked within it. All staff we spoke with were clear that restraint was only used as a last resort. They detailed ways they tried to de-escalate patients first and we observed this during our inspection. Staff spent time talking with patients and trying to distract them by talking about things they knew they enjoyed or changing over to other staff who they knew the patient responded to well. The trust adapted their training to ensure staff were aware of how to use restraint safely when working with older people and this was also included in the trust policy.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Records showed that staff completed patients' physical health observations when they had administered rapid tranquilisation. The trust told us that for the six months before our inspection on Bergamot ward there had been two administrations of rapid tranquilisation to patients, eight at Reservoir Court, 10 on Rosemary ward and six on Sage ward.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff we spoke with told us they had received training on induction, and this was updated yearly and at the appropriate level to their role.

Staff kept up to date with their safeguarding training. At time of inspection 92% of staff across the four wards had received training in safeguarding adults at level 3. However, on Sage ward only 50% of staff had received this, 92% of staff on Bergamot ward and 100% of staff on Reservoir Court and Rosemary ward had received this. 97% of staff had received training in safeguarding at level 2 – 90% Rosemary ward, 96% Bergamot ward and 100% of staff from Reservoir Court and Sage ward.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with had a good understanding of how to protect patients from harassment and discrimination and understood how dementia may increase a patient's risk and the need for staff to safeguard them.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff told us how they would report abuse and which agencies they needed to report to.

Wards for older people with mental health problems

Staff followed clear procedures to keep children visiting the ward safe. There were visiting rooms that were suitable and safe for children to use. Records reviewed showed that staff had asked questions during patients' assessment of any contact with children and had assessed any risks.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew how to make safeguarding referrals when needed. The trust told us that in the 12 months before our inspection from Bergamot ward three safeguarding referrals were made, from Rosemary two referrals, from Sage two referrals and from Reservoir Court four referrals.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. Staff had access to the trusts electronic patient records system. Staff completed patient's observations on a tablet device so this was recorded on the patient records system.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff had access to patients shared care records so could see their GP notes and other hospital admissions or appointments.

Records were stored securely. All staff had a password to access patient records and we observed staff logging off computers when not using them so that records were not visible to any visitors to the ward.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Patients and their relatives told us that they had information about their medicines and were involved in reviews of these.

Staff completed medicines records accurately and kept them up to date. Records we reviewed on each ward were accurate and up to date.

Staff stored and managed all medicines and prescribing documents safely. On all wards we saw that medicines were stored safely. However, on all wards the medicine trolleys were quite full which could mean that medicines past their expiry date may not be evident. We found some out of date eye ointments on Rosemary ward which could mean that staff could use these for patients, and they would not be effective.

Staff followed national practice to check patients had the correct medicines when they were admitted. Records showed that staff checked each patients' medicines when they were admitted ensuring these were correct, and they could continue to administer the medicines each patient needed.

Staff learned from safety alerts and incidents to improve practice. Where there had been errors these were discussed at the medicines safety meeting and plans put in place to reduce these. From March to July 2022 there were two medicine

errors reported at Reservoir Court – one where the registered nurse had prepared two medicines for patients at once. In another, the registered nurse had asked the healthcare assistant to give the medicine to a patient, but the healthcare assistant had misheard the name and given to the wrong patient. The reasons for these were discussed at the medicines safety meeting in September 2022 and an action plan put in place to prevent further incidents.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Medicines charts we reviewed did not show that people were prescribed excessive number of medicines to control their behaviour. The trust told us that in the six months before our inspection on Bergamot ward two patients had received medicine by rapid tranquilisation, eight patients at Reservoir Court, 10 patients on Rosemary ward and six patients on Sage ward.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence (NICE) guidance. Records showed that staff completed observations of patient's physical health when needed.

Track record on safety

The service had reported three serious incidents over the twelve months prior to inspection which were all unwitnessed falls. Two of these occurred on Rosemary ward and one on Sage ward. Two had caused major harm to the patient and one had caused moderate harm. These were all being investigated at the time of inspection.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. All staff we spoke with knew how to report incidents and what to report on the trust electronic reporting system. Staff reported all pressure ulcers that were identified as grade 2 or above in line with the agreed adverse clinical incident reporting procedure.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us and records showed that they followed the trust policy and reported concerns where needed.

Staff understood the duty of candour and gave patients and families a full explanation if and when things went wrong. All staff we spoke with understood the duty of candour. We observed staff speaking with relatives and giving a full explanation following their concerns. Staff listened to the relatives and apologised. Where needed managers escalated incidents to serious incidents that required a full investigation and informed relatives of this.

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service. Staff told us that learning was shared across the service by matrons, ward managers, through emails and newsletters. Staff said the culture was no longer a blame culture and was about what they could learn as a team to improve patient care.

Staff met to discuss the feedback and look at improvements to patient care. Incidents and learning from these were discussed in staff meetings and in staff supervision sessions.

Managers debriefed and supported staff after any serious incident. Psychologists led sessions to support staff following incidents and staff said they found this helpful.

Wards for older people with mental health problems

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the mental health of all patients on admission but not always the physical health needs. Staff developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs and were personalised and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed seven patient records in full and these included a comprehensive assessment of the patient's mental health on admission.

Patients did not always have their physical health needs assessed soon after admission or regularly reviewed during their time on the ward. In two patient records reviewed on Sage ward we found that staff had not fully assessed their physical health needs which included an assessment of their risk of falls.

Staff developed a comprehensive care plan for each patient that met their mental health needs but not always their physical health needs. Where staff needed to support patients who could be distressed or anxious a positive behavioural support plan was in place. These detailed what triggered certain behaviours for the patient and how staff could support them to minimise the impact of their distress.

Staff regularly reviewed and updated care plans when patients' needs changed. Records we reviewed showed that staff had updated care plans when a patient's needs had changed.

Care plans were personalised, holistic and recovery orientated. Staff showed us how improvements had been made to care plans, so they were more person centred and more meaningful to patients. Patients now received a copy of their care plan that was clear in how staff were to support them to meet their current needs.

Best practice in treatment and care

Staff did not always provide a range of treatment and care for patients based on national guidance and best practice. Staff did not always ensure that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. The occupational therapists delivered individual activity programmes. Where patients were assessed as needing psychological support they had individual psychology sessions.

Staff did not always deliver care in line with best practice and national guidance. On Sage ward all patients had a plastic cup to drink from. This was included in the blanket restrictions log that stated that patients would have an individual risk assessment to assess if they could use a crockery cup or the plastic cup. However, in two records reviewed on Sage ward we did not see an individual risk assessment. We were concerned this did not promote the dignity of patients. We

also saw that some of the doors had been damaged on Sage ward and staff told us this was caused by patients wanting to leave the ward. Staff said these had been reported to estates but said they would not use screening to camouflage the doors as they were fire exits. Best practice guidance for people with dementia suggests that as doors can be a trigger to their distress it is recommended to camouflage doors (often using pictures of scenery) or paint the doors, so they are the same colour as the walls, to reduce people's distress. It was not clear that staff had fully considered the needs of patients with regards to a dementia friendly environment.

Staff did not always identify patients' physical health needs and record them in their care plans. Two of the records we reviewed on Sage ward did not include a falls assessment. However, staff completed pressure ulcer risk assessments for patients on admission and had links with local tissue viability nurses. They provided training to staff where needed on specific issues affecting individual patients and their pressure area care.

Staff made sure patients had access to physical health care, including specialists as required. Records showed that staff completed blood tests and depending on the outcome of these referred patients for further scans and investigations and to specialists as needed.

Staff met patients' dietary needs and assessed the majority of those needing specialist care for nutrition and hydration. Records showed that staff had assessed patient's nutritional needs using the Malnutrition Universal Scoring Tool (MUST) and where needed their care plan stated how staff were to support them. Where needed patients were referred to the speech and language therapists for an assessment of their swallowing needs and had individual plans in place and access to thickeners for drinks. However, one patient's records reviewed did not include this assessment, so it was unclear whether their needs were being met

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Records showed that staff helped patients with smoking cessation or dietary advice where needed.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used rating scales to assess patients for depression, anxiety and stress.

Staff used technology to support patients and took part in clinical audits, benchmarking and quality improvement initiatives. Staff used tablets to record observations on all wards and managers told us about a tracker device that was being trialled to record if a patient fell so staff would know quickly and be able to support them.

Managers did not always use results from audits to make improvements. Audits of care plans had not identified that two patients did not have a falls risk assessment and clinic room audits had not identified that staff had not always recorded clinic room temperatures as required.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. However, they did not support non - medical staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Wards for older people with mental health problems

The service had access to a full range of specialists to meet the needs of the patients on the ward. There was not a physiotherapist for each ward and at time of inspection a locum physiotherapist was in post. Staff could refer to the physiotherapist internally and records showed they did this. The speech and language therapist and dietician were also not allocated to a ward however staff could refer to them and said they could easily access support from them when patients needed.

Managers did not always ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Some staff lacked knowledge in delirium and how this may affect patients' wellbeing and presentation. Matrons told us that additional training was being made available which would ensure staff had the skills needed.

Managers gave each new member of staff a full induction to the service before they started work. All staff said they had an induction before they started working with patients.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work. In October 2022 100% of staff on Bergamot ward had received an appraisal, 85% Reservoir Court, and 78% on Sage ward, however only 65% of staff on Rosemary ward had an appraisal.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work. In October 2022 84% of staff across the medical directorate had an appraisal.

Managers supported non-medical staff through regular, constructive clinical supervision of their work but did not ensure this was recorded effectively. In October 2022 65% of staff on Bergamot ward had received clinical supervision, 58% at Reservoir Court, 46% on Rosemary ward and 41% on Sage ward. Staff told us they received regular supervision however, the trust provided information that showed the percentage of staff across the four wards who had received management supervision was 38% in October 2022. 68% of staff on Bergamot ward, 40% at Reservoir Court, 26% on Rosemary ward and only 16% on Sage ward. However, managers said these figures were low because the trust had recently changed how supervisions were recorded and not all staff were aware of how to do this yet.

Managers supported medical staff through regular, constructive clinical supervision of their work. The junior doctors on rotation all had a weekly supervision with the consultant as part of their training agreements.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff said they had regular team meetings and minutes reviewed showed these were well attended and staff were provided with information to support them in their work.

Managers had recently started to identify any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All staff were booked to attend additional training to develop their skills and knowledge, as this had been identified as needed from dementia care mapping completed on Sage ward.

Managers made sure staff received any specialist training for their role. The programme that staff had to attend was tailored to meet the needs of patients using the service and included how to meet the needs of older people and dementia awareness.

All staff on Sage ward had attended an away day in September 2022 based on the dementia care mapping that had been undertaken on the ward. During this training they formulated an action plan which was shared with inspectors. All staff across the wards were being trained in ‘harm reduction’ and ‘superman’ training. ‘Harm reduction’ training was based

on patient stories all included aspects of caring for older people including falls, continence, tissue viability, malnutrition, dysphagia and cold, flu and respiratory symptoms. The 'superman training' included person centred care, effective communication, reducing restrictive practice and safewards (a programme that encourages staff and patients to work together to make wards safer, calmer and a more positive place). All staff were due to complete this training by February 2023.

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The multidisciplinary team discussed each patient and their needs at least fortnightly. Where appropriate and need was identified they also discussed and reviewed patients at 'safety huddles' and 'falls huddles.'

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We observed this in the handover from day to night shift on Sage Ward.

Ward teams had effective working relationships with other teams in the organisation. Staff worked closely with the Community Enablement Rehabilitation Teams (CERTS) and a discharge coordinator attended patient multidisciplinary team meetings. Staff could refer patients to physiotherapists, speech and language therapists and dieticians where needed.

Ward teams had effective working relationships with external teams and organisations. Staff were aware of contacts within the integrated care board and knew who to contact when needed.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff said they had training in the Mental Health Act during their induction and this was updated yearly as part of their mandatory training. At the time of inspection 95% of staff across the four wards had received this training – 88% of staff Rosemary ward, 91% of staff Reservoir Court and 100% of staff from Bergamot and Sage wards.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff were aware of who the administrator was, they visited the ward and staff knew how to contact them.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. The trust had policies and procedures and staff knew how to access these.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Records reviewed showed that staff gave patients information on advocacy and referred patients who lacked capacity.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. An audit had identified that not all patients had their rights explained to them and an action plan was in place to improve this. At time of inspection improvements had been made.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Records showed that patients had their section 17 leave agreed by the Responsible Clinician and a risk assessment was completed before they went on leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Records showed that this was requested, and staff provided the information required about the patient for the SOAD.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Patient's records were stored correctly, and staff knew how to access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. There were signs on the doors that told informal patients they could leave the ward and records showed staff discussed this with patients on admission.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The Mental Health Act was reviewed as part of the audit schedule. The latest audit from September 2022 showed improvements had been made in recording patients consent to treatment. On Bergamot ward it was identified in the audit that not all patients had their rights read, and we found that staff were subsequently identifying this as a task on the staff rota on Sundays so that were no gaps.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. All staff said they had received training, and this was updated as part of their mandatory training. At the time of inspection 95% of staff across the four wards had received this training – 88% of staff Rosemary ward, 92% of staff Reservoir Court and 100% of staff from Bergamot and Sage wards.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. However, we do not have the data for the number of applications made in the last 12 months for this core service.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff spoken with knew how to access advice and knew the trust policy.

Wards for older people with mental health problems

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Records and discussions at multidisciplinary team meetings showed that staff were aware of how to maximise people's capacity to how to support them to make a decision for themselves. We saw that at multidisciplinary team meetings staff discussed whether the person had a Lasting Power of Attorney for health and welfare and for finances and property and recorded this appropriately.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Records showed that staff assessed patients' capacity to decide about having a flu vaccination and their future care on discharge. All staff spoken with had a good understanding of when they would need to give a patient medicine covertly. They knew that they would need to assess the patient's capacity to decide about complying with their prescribed medicines. Where it had been agreed that in a patient best interest, they would need to give medicines covertly there was a care plan that stated the reasons for doing this and how medicines were to be given.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Records showed that where a patient had been assessed as lacking capacity to make a specific decision, a best interest's decisions was made and involved family and advocacy where appropriate.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve. Audits to monitor the Mental Capacity Act were included as part of the monthly audit schedule.

Is the service caring?

Good ↑

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. All patients said that staff were kind, caring, respectful and polite. We observed that staff spoke gently to patients and supported them by holding their hand. Patients said that staff knocked on their bedroom and bathroom door before entering which respected their dignity. Relatives said that their relative was always clean and dressed in clothing of their choice when they visited.

Staff gave patients help, emotional support and advice when they needed it. We observed staff spending time talking with patients and helping them to relieve their distress. Patient's relatives said that staff showed empathy and were kind.

Staff supported patients to understand and manage their own care treatment or condition. Records showed and we observed that staff took time to explain to people about how to manage their treatment. Relatives said they had information about their relatives' medicines and could speak to their doctor when needed.

Staff directed patients to other services and supported them to access those services if they needed help. Patients and their relatives said staff had given them information about how to access services for support.

Patients said staff treated them well and behaved kindly. All patients' said staff were kind and we observed this throughout our inspection. We observed staff listening to patients when they were talking about their lives, their family and employment.

Staff understood and respected the individual needs of each patient. Records showed that staff had access to information about each person's individual needs. Staff asked the person or their relatives for information about their life and what was important to them.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. All staff spoken with told us they would challenge other staff if they were abusive to patients and would feel comfortable to report any concerns to managers who would take immediate action.

Staff followed policy to keep patient information confidential. Staff were aware of the need to keep patient information confidential and followed policy.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that patients had easy access to independent advocates.**

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients said they were shown around the ward on admission and given the information they needed.

Staff involved patients and gave them access to their care planning and risk assessments. Six patients we spoke with said they had a copy of their care plan, and no patients told us they did not have this when asked. However, audits of two patient care plans in October and November on Sage ward showed no evidence that the patient was given a copy of their care plan. Managers were to follow this up with the patients named nurse.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff spent time speaking with patients and provided information in easy read formats where needed.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients said they could give feedback and knew how to do this, if needed staff spent time with them to support them.

Staff supported patients to make decisions on their care. We observed in patients multidisciplinary team meetings that staff gave people the support they needed to make decisions where possible.

Staff made sure patients could access advocacy services. Patients said they had been told about advocacy and had support when needed.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Wards for older people with mental health problems

Staff supported, informed and involved families or carers. Patients said they involved their family and contacted them when needed. Relatives said staff had spoken to them about their relative's life and history to help them understand them as a person. All relatives said they had been involved in their relatives care and knew about their care plan.

Staff helped families to give feedback on the service. Relatives said they were asked for feedback on the service and did this.

Staff gave carers information on how to find the carer's assessment. Relatives where appropriate said they had been given information about this.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Staff managed beds well. However, a bed was not always available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did sometimes have to stay in hospital when they were well enough to leave due to delays in social care.

Bed management

At time of inspection bed occupancy on each of the four wards was 100% and there were 12 people who had been identified as waiting to be admitted. These people were being supported by the local home treatment teams in the community. Managers and multidisciplinary team members from this core service attended daily bed management meetings to review those people waiting for a bed on the wards.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Records reviewed and patients review meetings observed showed that patient's length of stay was reviewed, and each patient had a planned discharge date from their admission.

The service had no out of area placements. People admitted to the wards were from the Birmingham and Solihull areas.

Managers and staff worked to make sure they did not discharge patients before they were ready. Records showed that where needed staff changed patients planned discharge date dependent on their needs. If a patient's needs changed which meant they were not ready for discharge this was discussed, and plans altered.

When patients went on leave there was always a bed available when they returned. Although there were 12 people waiting for a bed this did not mean that if a patient went on leave their bed was taken but it was held for them to return.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient. Records showed patients were only moved when there was a clinical reason. Although the wards were separated to meet people's needs based on their diagnosis, for example Sage ward was mainly for men with a diagnosis of dementia or neurological disease, exceptions were made to balance patients' needs and at the time of inspection there were male patients on Sage ward who did not have these diagnoses.

Staff did not move or discharge patients at night or very early in the morning. Although patients might be admitted at night staff understood it was detrimental to people's health to be moved or discharged at these times. When patients were moved or discharged this was carefully planned.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The trust told us in September 2022 there were 781 days delayed transfers of care across the four wards. This was the lowest across the previous 12 months and had reduced from 1295 days in May 2022. Staff said the main reasons for patients' discharge being delayed was due to shortage of social care packages or transfers to social care accommodation. This was despite a discharge plan being in place from when patients were admitted.

Patients did have to stay in hospital when they were well enough to leave when there was not a package of care available to allow them to return home safely or a place available in a social care environment that could meet their needs.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. The Community Enablement and Rehabilitation Teams (CERTS) team discharge coordinator worked on each ward and was involved in patients multidisciplinary team meetings. At the multidisciplinary team handover, we observed the discharge coordinator was present and that patients discharge plans were discussed. The team discussed what support would be available for the patient when they were discharged to ensure their mental and physical health needs were monitored.

Staff supported patients when they were referred or transferred between services. Staff were allocated to support patients where needed and if needed transport was arranged.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support patients' treatment. They did support patients' privacy and dignity. Each patient had their own bedroom although not all had an en-suite bathroom. Patients could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Patients told us they could personalise their bedrooms and we observed that patients had personal items in their bedroom. At Reservoir Court patients did not have an ensuite bathroom but there were enough bathrooms situated close to patient's bedrooms.

Patients had a secure place to store personal possessions. Patients had a secure place in their bedroom to store their belongings and there were locked storerooms on each ward where patients could store other belongings.

Staff used a full range of rooms and equipment to support treatment and care. On each ward there were rooms where patients could relax and others where they could do activities.

The service had quiet areas and a room where patients could meet with visitors in private. At Reservoir Court there was a small area off the corridor that staff had made into a library which patients said was a nice, quiet space.

Patients could make phone calls in private. On each ward there was a payphone and at Reservoir Court there was a telephone box that people could use to make phone calls. Some people had their own mobile phone and we observed staff ensuring these were charged for patients unable to do this themselves.

Wards for older people with mental health problems

The service had an outside space that patients could access easily. There was a garden on all wards, and we observed people going in and out with staff support where needed. Patients said they had helped with gardening during the summer months which they had enjoyed.

Patients could make their own hot drinks and snacks and were not dependent on staff where they were able to make these themselves. This was based on individual risk assessment, and throughout the inspection we observed staff offering patients hot drinks and snacks as needed.

The service offered a variety of good quality food. Patients told us the food was good and there was always a choice. On Rosemary ward we saw there was a choice of three hot dishes including a vegetarian option at lunchtime and sandwiches were also available if patients preferred these.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, and family relationships.

Staff helped patients to stay in contact with families and carers. All relatives spoken with told us that staff kept in touch with them if they were not able to speak with their relative. At the time of inspection, there was a requirement for newly admitted patients to isolate for seven days due to NHS England COVID-19 guidance. However, we saw staff discussed where this was detrimental to a patient and risk assessed this to ensure their family could visit.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. On each ward there was an activity programme. These included visits from people in the local community for pet therapy, music sessions and art sessions.

Meeting the needs of all people who use the service

The service did not always meet the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could not support and make adjustments for disabled people on all wards. The bath at Reservoir Court was not accessible to people with a physical disability. There were profiling beds available for patients who needed support to access their bed, or support to relieve the pressure on their skin.

Wards were not all dementia friendly. On Sage ward staff showed us that damage had been made to doors by patients trying to leave the ward. Staff said that doors couldn't be screened to camouflage them as they were fire exits and it was a health and safety risk. However, it was unclear whether staff had considered this decision in line with guidance, as recommended dementia care practice would be to utilise camouflage to reduce people's distress when trying to access locked doors.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Patients and relatives told us they had information about treatment, medicines, their rights if detained under the Mental Health Act and how to make a complaint.

The service had information leaflets available in languages spoken by the patients and local community. Information was provided in a variety of languages and in easy read versions and this was given to individuals as needed.

Managers made sure staff and patients could get help from interpreters or signers when needed. Records showed that where needed interpreters had been provided. Staff said the interpreting service was easy to access.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. All patients we spoke with told us that there was a variety of food that met their individual needs. We saw that there were three choices available at lunchtime which included a vegetarian option. If patients wanted a different option, this was provided also, and sauces and condiments were available to individual taste.

Patients had access to spiritual, religious and cultural support. Records showed and patients told us they could access spiritual and religious support. On each ward there was a multi faith space for people to use if they chose to.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. All patients and relatives we spoke with told us they knew how to make a complaint if they needed to. We observed staff speaking with patients and relatives to resolve any concerns they had and ensuring they were satisfied with staff response. Relatives said they were given a booklet on the complaints process. One patient told us they had complained, and it was resolved to their satisfaction.

The service clearly displayed information about how to raise a concern in patient areas. We saw information on each ward.

Staff understood the policy on complaints and knew how to handle them. All staff we spoke with knew how to handle complaints and said they would try to resolve them locally first before escalating this to a formal complaint.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Managers told us how they investigated complaints and shared themes from these across the service so that staff could learn, and improvements could be made.

Staff protected patients who raised concerns or complaints from discrimination and harassment. All staff told us they would not discriminate against any patients who made a complaint and saw complaints as a way of making improvements.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff understood how to deal with complaints and provided feedback to patients and their relatives following investigations.

The service used compliments to learn, celebrate success and improve the quality of care. Compliments were displayed on the wards and team meeting minutes showed that these were shared with staff.

Is the service well-led?

Requires Improvement ↓

Our rating of well led went down, we rated it as requires improvement.

Wards for older people with mental health problems

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff said the clinical nurse manager was visible and approachable, they also had contact with the assistant director who responded promptly to emails and was available when needed.

The new ward manager on Rosemary ward was conscious that there had been several changes in ward managers over the past two years, and staff meeting minutes showed they had given staff an opportunity to discuss this and to form mutual expectations with each other going forward.

Ward managers said they were supported and had been given opportunities to develop and undertake leadership training.

Ward managers had good working knowledge of their wards as did matrons and the clinical nurse manager.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Staff said they liked working for the trust and some staff told us they did not work for a more local trust because they preferred to work for this trust. All staff were aware of the trust vision and values and how these applied to their job role.

Ward managers showed us the action plans for each ward based on audits and staff meetings. On Sage ward there had been a recent dementia care mapping audit and the outcome of this was discussed at ward staff away day. From this an action plan had been developed which was in draft format at the time of inspection.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All staff told us they felt respected, supported and valued in their role. The trust had a system where staff could be nominated for an excellence award. Staff said they had nominated others, and some had been nominated and received an award which made them feel valued.

Staff said they thought the culture of the trust was shifting and there was more celebration of diversity. They felt that the recognition of diversity as something to be valued had improved in the last few years.

All staff we spoke with said they would feel comfortable to raise concerns and these would be listened to.

A wellbeing room had been created at Juniper centre based on staff feedback and following the COVID-19 pandemic. Staff had access to a coffee machine and a space where they could have a break in comfortable surroundings.

Staff valued the support of the psychologists who attended staff meetings and in meetings following incidents where staff involved had an opportunity to debrief. Staff said they felt listened to and had an opportunity to discuss the incident without feeling blamed.

Wards for older people with mental health problems

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level which meant that performance and risk was not always managed well.

The trust had an audit schedule and allocated staff to complete these. However, the systems to assess performance and risks to patients were not effective. For example, we found that not all patients had their risks assessed including their risk of falls, but audits had not identified this. We also found that there were gaps in the recording of temperatures in clinic rooms where medicines were stored but audits had not identified this.

Staff performance and supervision was not accurately recorded. The figures for staff who had received supervision were low. Managers told us this was due to the trust implementing a new system for recording supervision, but staff had not been trained in how to use the system.

Blanket restrictions were used for all patients not based on individual risk assessment. For example, all patients were to be searched on return from leave off the ward. This did not show the least restrictive interventions were used based on individual patient risk.

Staff were not always following good practice in dementia care and governance systems had not fully identified this. However, on Sage ward a recent dementia care mapping assessment had been completed and the outcome of this included training for staff in person centred dementia care.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Ward managers were clear about what was on the risk register and what action was being taken to reduce these risks. However, it was not clear that all blanket restrictions had been considered on an individual basis.

Ward managers met monthly with staff from the trust human resources department. In this meeting they discussed their key performance indicators for staff training, sickness, supervision and appraisals.

However, the trust had implemented a new system for recording supervision but not all staff had been trained in how to use this. This meant that the supervision figures were low as it was reliant on each staff member creating a session on the system and staff told us they did not yet know how to do this.

Information management

Staff engaged actively in local and national quality improvement activities.

Staff told us about quality improvement initiatives. This included introducing a tracker device for patients to wear to track if they fell so staff could assist immediately. This was a wrist band that the patient wore and would alert staff if they fell. They were going to trial this on Rosemary ward soon after our inspection. They then planned to evaluate this before rolling out to other wards.

Staff had also made changes to care plans and the recordings of multidisciplinary team patient review meetings.

Wards for older people with mental health problems

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Staff engaged with local organisations for people living with dementia and engaged with care home providers and social care agencies that provided support at home to patients.

Managers met with other providers across the system to review pressures including bed management meetings and urgent care meetings.

Learning, continuous improvement and innovation

Managers shared learning with staff in team meetings, through emails and newsletters. Minutes of team meetings were kept so that all staff had a copy of these. We saw that where there had been incidents where patients had fallen and sustained an injury staff had looked at how they could improve their response. This included implementing an activity tracker device for patients to wear which would alert staff immediately.

Staff had on all wards started to reimplement Safewards initiatives. The aim of Safewards is to be minimising the number of situations in which conflicts arise between healthcare workers and patients that may lead to the use of restrictive interventions such as restraint or restricting the freedom of patients around the ward.

Mental health crisis services and health-based places of safety

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean environments

All clinical premises where people received care were safe, clean, well equipped, well furnished, and fit for purpose but not all were well maintained. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified.

Health based place of safety

There were two rooms for people brought into the health-based place of safety that were both being used at the time of inspection. We looked at the rooms from outside so as not to disturb the people there. The rooms were clean, and the doors unlocked. People could see a clock from the room which stated the correct time and were able to see outside from the window. The rooms were sound proofed so conversations could not be overheard.

Psychiatric Decisions Unit

The ligature risk assessment for the Psychiatric Decision Unit dated March 2022 stated that soap and hand towel dispensers were fitted to the wall with tape to reduce the risk and we saw this. Other risks were reduced through use of individual patient observations and removing patient access to areas where a risk was identified. There were two recliner chairs in the unit that were awaiting repair. This reduced the number of people able to use the unit to six. There were three people in the unit at time of inspection.

Home treatment teams

The home treatment teams had access to interview rooms in the buildings they were based in to see people, and these were safe and clean.

All interview rooms had alarms and staff available to respond.

Health based place of safety

We saw in the health-based place of safety that there were alarms for staff to use. These were checked regularly to make sure they worked.

Psychiatric Decisions Unit

We saw in the psychiatric decisions unit that there were alarms for staff to use. These were checked regularly to make sure they worked.

Mental health crisis services and health-based places of safety

Home treatment teams

Staff from community teams carried a portable 'Skyguard' alarm which could track a staff members' location within the city so they could, for example, see if they had left a patient's home. However, when visiting a high-rise block of flats staff had to manually input the floor of the flat they were visiting to ensure they could get help in an emergency. Managers said they regularly reminded staff to do this to ensure their safety. Staff in the street triage team told us they worked with ambulance staff and relied on using their alarms when needed, which they said was more responsive than the Skyguard.

Health based place of safety and psychiatric decisions unit

The clinic room did not only store medicines. There was some patient's property stored there including knives that had been removed from patients. It was not clear who these belonged to and how long they had been there. Staff removed these to a safe place at time of inspection. The necessary equipment for people to have thorough physical examinations was available.

Home treatment teams

All clinic rooms in the home treatment teams were used only to store medicines. The necessary equipment for people to have thorough physical examinations was in a separate room. These rooms had equipment for staff to carry out checks on peoples' blood pressure, temperature and pulse.

All areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Rooms where patients were seen were clean and fit for purpose.

Staff followed infection control guidelines, including handwashing. Staff in all offices, the health-based place of safety and psychiatric decisions unit followed infection control guidelines. All rooms where people were seen included hand wash and towels and we observed staff regularly washing their hands. At the time of inspection, the trust policy was that staff did not need to wear masks at work unless there was a Covid outbreak. We observed that all staff adhered to this. Hand hygiene audits at Erdington and Kingstanding Team showed that staff had improved hand hygiene from 58% compliance in January 2022 to 100% in the following months.

Staff made sure equipment was well maintained and clean, but it was not always checked to ensure it was in working order. In the Psychiatric Decisions Unit (PDU) staff checked the emergency bag daily but it was not clear what they were checking as the tag on the bag did not relate to the checklist. In the emergency bag were five separate packs which were not clearly labelled so staff were not aware what they were checking. A clear equipment checklist would ensure staff knew what should be there and what they needed to check.

Safe staffing

The service had enough staff, who received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

The service had enough nursing and support staff to keep patients safe. Each morning the home treatment team managers had a video call where they stated their staffing levels for the early and late shifts and their caseloads. They rated their staffing as red (high risk), amber (medium risk) or green (low risk). We observed that teams worked together to share staff where there was a shortage of staff or a high caseload, and they did not have capacity to visit the people they needed to. At night there were three staff across the home treatment teams who were based at the Oleaster Urgent Care Centre. There were two occasions in October in the Sparkhill team where staff had reported an incident of not

meeting safe staffing guidelines. On one day the team were three members of staff short on the early shift and one member of staff short on the late shift. On the other day the team were three members of staff short on the early shift and two members of staff short on the late shift. Staff prioritised which patients needed to be seen to ensure this did not impact on patient safety.

The Psychiatric Decisions Unit and health-based place of safety were staffed separately, and rotas showed there were sufficient staff to cover this safely. There were two registered nurses and four support workers and a manager who was also part of the bed management team. The street triage team was staffed separately to this and had additional staffing. If there was a person in the health-based place of safety, then their local home treatment team was requested to provide support. Staff said this could be difficult, but this was discussed at the daily call with each manager, and they worked together to provide support as needed.

The service had reducing vacancy rates except for the Southeast and Southwest home treatment teams which was at 19% in September 2022. The vacancy rate across the home treatment teams in September 2022 was 15%. In the Central team was 0.2%, Erdington and Kingstanding was 1%, Handsworth 0.2%, Ladywood – 8%, Solihull 7%, Sparkhill – 0.8% and Sutton 19%.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service did not use agency staff. Data provided by the trust showed that the teams had filled the vacant posts and covered sickness using the required number of bank staff. Managers told us they used bank staff familiar with home treatment and often permanent staff took on extra shifts to cover when needed.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. All bank staff had a full induction and had access to specialist training when required. All bank staff had access to the electronic patient record system so they could update this during their shift and were aware of the needs and risks of patients who used the service.

The service had increasing turnover rates. The turnover across the home treatment teams in September 2022 was 8% which was a rise from 6% at September 2021 and rose to 9% in all three months of January, February and March 2022. The North (Erdington and Kingstanding and Sutton) home treatment teams had the highest turnover rates, and this was at 21% in September 2022 compared to 4% in October 2021.Managers told us this was due to some staff starting their nurse training and others moving to other jobs within the trust as part of their development.

Managers supported staff who needed time off for ill health. Staff told us they were well supported by managers when they were absent due to sickness.

Levels of sickness were reducing. The average staff sickness rate across the home treatment teams for the last year from October 2021 to September 2022 was 6%. This had risen to 9% in July 2022 but reduced to 6% in September 2022. Managers said there had been long term sickness absences in July where staff had been off sick due to serious health needs, but these staff had now returned to work.

Managers used a recognised tool to calculate safe staffing levels and the number and grade of staff matched the provider's staffing plan. Managers told us that there was to be a review of the staffing establishment of the service in December 2022 using the 'Safer Staffing' tool. Managers had identified as part of this what staffing levels were needed for each team.

Mental health crisis services and health-based places of safety

Medical staff

The service had enough medical staff. A consultant psychiatrist was allocated to each home treatment team who was also the psychiatrist for the local acute wards. There were also associate specialist doctors and registrars in the teams.

Managers could use locums when they needed additional support or to cover staff sickness or absence. Managers made sure all locum staff had a full induction and understood the service.

The service could get support from a psychiatrist quickly when they needed to. Records reviewed showed that patients had a medical review with a psychiatrist within 48 hours of contacting the service. Staff said they could always contact a doctor quickly and if they did not attend in person, they would provide support by telephone.

Mandatory training

Staff had completed and kept up to date with their mandatory training. At the time of inspection across the home treatment teams 93% of staff had completed their mandatory training. Mandatory training included health and safety, fire safety, first aid, moving and handling, physical intervention, safeguarding adults and children from abuse, food hygiene and infection control.

The mandatory training programme was comprehensive and met the needs of people who used the service and staff. There was information available in the offices and on the computer shared drive for staff about how to support autistic people. Formal training was not offered at the time of inspection, but this was planned and was a requirement from 1 July 2022.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they knew when their training was due and had time to update it when needed.

Assessing and managing risk to persons and staff

Staff assessed and managed risks to people who used the service and themselves. They responded promptly to sudden deterioration in a person's health. When necessary, staff working in the mental health crisis teams worked with people and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of person risk

Staff completed risk assessments for each person at their first contact with the crisis team, using a recognised tool, and reviewed this regularly, including after any incident. Staff had to complete a risk assessment within 24 hours of the patient being referred to the home treatment team. Records reviewed showed staff had done this. Risk assessments were clear and stated the patient's current risks and how staff were to manage these.

Staff completed an initial risk assessment at the time of admission to the psychiatric decisions unit or health-based place of safety. These were updated where needed during the time the patient stayed if further risks were identified.

Staff used a recognised risk assessment tool. Staff used the five Ps risk assessment tool – Presenting, Predisposing, Precipitating, Perpetuating and Protective. Managers showed us they were working to improve the use of the tool by auditing monthly as part of a quality improvement project. Audits showed that managers had highlighted where the five Ps had not been used and that further audits showed improvement. Records reviewed during inspection showed that risk assessments were completed using the tool and all risks assessed.

Mental health crisis services and health-based places of safety

Staff could recognise when to develop and use crisis plans according to patient need. Staff developed a crisis plan with the patient from the point of referral which included their early warning signs of relapse of their mental health.

Management of people's risk

Staff responded promptly to any sudden deterioration in a patient's health. Staff told us, and records showed, that all patient risks were discussed in multidisciplinary team meetings and in daily 'risk huddles' to identify any sudden deterioration.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. Staff had 'risk huddles' where they discussed patient's risks and prioritised who needed to be seen quickly. Staff kept the boards in the offices up to date with changes in patient's risk and actions from handovers, telephone calls, risk huddles and bed management meetings.

Staff followed clear personal safety protocols, including for lone working. All staff we spoke with were aware of the lone working protocol and how to use it. All patients were assessed before staff went out to visits them and staff were clear of who needed two staff to visit them. If staff had limited previous knowledge of a patient or were not clear on potential risks, they always visited in pairs. All staff in the crisis teams carried a personal alarm when they visited patients in the community. However, some staff said they had asked for further personal protection when visiting areas where they felt more at risk, but this had not been provided. There were also alarms in the offices where patients were seen.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. This was at the required level depending on their role and included children and adults.

Staff kept up to date with their safeguarding training. All staff had level 1 training in safeguarding adults and children from abuse. Dependent on their role some staff had training in levels 2 and 3 safeguarding adults and children from abuse training. All teams were at 100% of eligible staff to complete level 2 training except Southeast home treatment team and Sparkhill home treatment team where 90% of staff had completed this. All teams were at 100% of eligible staff to complete level 3 training except Southeast home treatment team where only 62% of eligible staff had completed at time of inspection.

Staff could give clear examples of how to protect persons from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff showed they considered the needs of all people including those who were refugees. Staff respected people's cultural needs and visited them at places they chose.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff clearly explained to us how they would recognise abuse and how important this was when visiting patients in their homes. Staff talked about always thinking about the family that surrounds the patient particularly children who the patient may have parental responsibility for. We observed staff asking about the welfare of children and if there were concerns about parenting during the time the patient was in crisis. Staff told us how they worked with local domestic violence agencies, local refugee and asylum-seeking charities, local substance misuse organisations and social services to protect patients from harm.

Mental health crisis services and health-based places of safety

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust provided data which showed staff made referrals from all home treatment teams, place of safety and the street triage team. The Sutton home treatment team were part of a pilot project that involved working with the trust safeguarding team. They met every six weeks to discuss a safeguarding situation. Staff said this had improved nurses' confidence in safeguarding and lead to an improvement in safeguarding being discussed at each patient's multidisciplinary team meeting. For example, if the person had a child, we saw staff discussing what support there was for the parents, and any court action or criminal charges which may have an impact.

Managers took part in serious case reviews and made changes based on the outcomes. Staff told us how they had learnt from a serious incident that occurred when a patient was contacting their children on discharge from hospital. The home treatment team did not have the information from the hospital about the risk of this. From this they are developing a triage tool for access to the home treatment teams to ensure they have all the information needed at the time of referral. This will guide staff to ask questions about safeguarding to explore all risk.

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of peoples' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient's notes were comprehensive, and all staff could access them easily. Records reviewed showed that these included the information needed for staff to know individual patient risks and needs. All staff including bank staff were able to access the electronic records system and the trust had provided further laptops to assist staff.

When patients transferred to a new team, there were sometimes delays in staff accessing their records. Staff told us that sometimes they received referrals with very little information about the patient. They went back to the referrer to request this information. They always visited in pairs if they did not have all the information about the patient's risk.

Records were stored securely. Each staff member had a password to access patient records. Throughout our inspection we observed staff closing laptops when not in use or logging out of records, so they were not visible to anyone walking through the office.

Medicines management

The service did not always use systems and processes to safely administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each person's mental and physical health.

Staff followed systems and processes to prescribe medicines safely but did not always follow systems and processes for storage and administration of medicines. We saw out of date medicines and gaps in daily monitoring of the temperatures of the clinic room and medicines fridge in Solihull. In Solihull there were no gaps in October but there were 10 gaps in September and eight in August. There were two boxes of out-of-date medicines in the medicine cabinet at the psychiatric decisions unit. In all home treatment teams staff showed us they wrote the patient's prescription on a piece of paper before going on home visits rather than take their laptops to patient's homes. This meant there could be a risk of giving the patient the wrong medicines or losing the piece of paper.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We observed this during medical reviews and in records reviewed. For example, patients spoke about the side effects of medicines and why they did not want to take them, and this was listened to, and medicines were changed where possible and appropriate.

Mental health crisis services and health-based places of safety

Staff did not always complete medicines records accurately. Staff in home treatment teams did not complete these at the time of administration on the electronic prescribing system but did this on return to the office as they did not take the record with them. We did not review the medicine records for patients in the psychiatric decisions unit or health-based place of safety during this inspection.

Staff did not always store and manage all medicines and prescribing documents safely. In Solihull home treatment team clinic room, we saw out of date medicines in the medicine cabinet. There were 70 risperidone tablets that had been out of date since 31 July 2021. There were flu vaccines out of date since June 2021. In another cabinet we also saw a carrier bag that had several boxes of tablets in it which were out of date. Staff did not know how long they had been there or why they were stored there. An audit completed in August had not identified this. Following feedback, staff disposed of these safely at the time of inspection. In the psychiatric decision unit medicines cabinet, we found two boxes of medicines that had been out of date for ten days. Staff had checked and signed to say they were there but had not identified they were out of date.

The trust used electronic prescribing for patient's medicines. The 'electronic prescribing and medicines administration policy for home treatment teams' guided staff to use the nursing desktop to record and administer medicines to patients using the electronic record. It also provided a function for staff to print off a copy of the electronic prescription. However, we observed staff writing down on a piece of paper the medicines to be administered to the patient at home. This included depot injections which were not labelled with the patient's name. Staff often visited three patients at home per visit in order to reduce travelling time, so potentially had three patient's medicines with them at any one time. We were concerned this could mean there was a risk of staff giving the wrong medicine to the patient. The trust provided incident data which showed there had not been incidents of this in the last six months.

Medicines were stored in the medicines fridge in the Psychiatric Decisions Unit. However, there was no record to show that staff had recorded the fridge temperature to ensure medicines were safely stored. In Solihull home treatment team, there were no gaps in recording the medicines fridge temperature in October 2022. However, there were 10 gaps in September 2022 and eight in August 2022. There were 13 gaps in recording the temperature of the clinic room in September and five gaps in August. Audits had not found that this had not been done so were not effective.

There was no pharmacist support for the home treatment teams and staff told us they would benefit from this support if it were available.

Staff followed national practice to check patients had the correct medicines when they were admitted or moved between services. However, staff said they did not always receive the correct information about the patient's medicines from the referrer and had to follow this up with a telephone call.

Staff learned from safety alerts and incidents to improve practice. Team managers shared information in team meetings, newsletters and multidisciplinary team meetings. The Solihull team manager shared with staff learning from medicines found out of date by the inspection team.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance. However, at Sparkhill the team did not have a comprehensive system to ensure all staff did this, but records showed physical health checks were completed. At Solihull they had started a Saturday morning clinic and arranged transport if needed to ensure patients attended.

Mental health crisis services and health-based places of safety

Track record on safety

The service did not have a good track record on safety but there was evidence that staff learnt from this, and procedures were in place to reduce risks.

We reviewed two serious incidents investigations from March 2022 that had resulted in death, both patients had taken their own life. We saw that learning had been shared amongst the teams, reviewed in clinical governance committees and shared through quarterly trust serious incidents bulletins. Staff were to have alcohol awareness training following one of these incidents.

Staff told us that last year there was an incident where the psychiatric liaison team referred a patient via email, but this was not seen as it went to the wrong email address. The patient subsequently took their own life. Following this all referrals from professionals had to be followed up with a phone call to ensure it reached the crisis team.

Reporting incidents and learning from when things go wrong

The service managed safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave people honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. All staff we spoke with knew how to report incidents on the trust electronic incident reporting system.

Staff reported serious incidents clearly and in line with trust policy. Staff told us they reported incidents, alerted their managers and recorded this on the person's records.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff contacted the patient whose referral they did not receive via email and apologised to their family. The trust has now made changes to the referral system so that an email was followed up by a telephone call.

Managers debriefed and supported staff after any serious incident. Staff told us they had debriefs after incidents but also discussed incidents in regular team meetings. Minutes of these showed that staff had the opportunity to discuss these incidents and were supported by managers and other staff in the team. Following a death of a patient or serious incident that staff were involved in they were invited to a TRiM (Trauma Risk Management) meeting. This was led by a psychologist and was a peer support system designed to help staff who had experienced a traumatic, or potentially traumatic event. This followed guidance from the National Institute for Health and Care Excellence (NICE).

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient's care. Staff told us this was through monthly newsletters and in team meetings where they had an opportunity to ask questions and learn from them.

There was evidence that changes had been made as a result of feedback. All referrals via email were now followed up with a telephone call. Staff had further training as a result of learning from incidents.

Mental health crisis services and health-based places of safety

Managers shared learning about never events with their staff and across the trust. This was through team meetings, emails and newsletters.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient. This was done through assessments prior to the patient being referred to home treatment teams, in medical reviews and in the first visit from a nurse to the patient.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Records reviewed showed this had been completed. However, at Sparkhill there was not a system in place to make sure this was always completed. The team manager said they were setting up a regular clinic to resolve this.

Staff regularly reviewed and updated care plans when patients' needs changed. Records reviewed showed staff reviewed and updated patient's care plans in response to their changing needs and risks. Each home treatment team had a weekly multidisciplinary team meeting where they discussed patients whose needs had changed and the most recent referrals.

Care plans were personalised, holistic and recovery orientated. Records reviewed showed that staff assessed all the patients' needs such as housing, social, emotional, communication and future goals and ambitions to aid their recovery.

Best practice in treatment and care

Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. This included medicines, psychological support, distress tolerance and anxiety management groups and family liaison support. However, there were no occupational therapists in the home treatment teams.

Staff delivered care in line with best practice and national guidance. Since our previous inspection there were psychologists that were aligned to two home treatment teams five days a week, so each team had access to a psychologist.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Patients had physical health observations completed during medical reviews, and community nurses completed patient

physical health observations in the community and ensured patients that needed them had blood tests. Some nursing staff were trained as phlebotomists. In Solihull staff had set up a physical health clinic on Saturdays to make it more accessible to patients who worked during the week. Records showed that staff supported a patient to attend hospital to have their electrocardiogram, and we saw that going forwards staff were being trained in taking electrocardiograms.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. Patients said staff gave them advice on nutrition and exercise and some patients said they had received smoking cessation advice.

Staff used recognised rating scales to assess and record the severity of patient's conditions and care and treatment outcomes. Records reviewed, and appointments observed, showed that staff used recognised rating scales for depression, anxiety and psychosis. They reviewed these at each contact with the patient to assess if their health had improved. Psychologists used assessments with patients at the beginning of distress tolerance groups and said they would do this through the course at each session.

Staff used technology to support patients. They offered the distress tolerance group via video call to reach more patients and used email and texts to communicate with patients. Staff used a messaging service to provide information to patients and staff said this was particularly useful to provide information about medicines.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff across the home treatment teams had a regular audit schedule of patient records, infection control and hand hygiene, medicines and environmental checks. Staff told us about quality improvement initiatives they were involved in. Staff were reviewing the structure of the multidisciplinary team meeting to streamline this and to be more prepared for meetings. They were also improving risk assessments and working with the trust safeguarding team on a pilot project to improve staff confidence in safeguarding.

Managers used results from audits to make improvements. However, audits were not always effective in identifying problems. For example, we found out of date medicines that had not been identified through audit.

Skilled staff to deliver care

The mental health crisis teams did not have access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. However, they did not support staff with regular supervision. Managers provided an induction programme for new staff.

The service did not have access to a full range of specialists to meet the needs of patients. None of the teams had an occupational therapist to support although there was no evidence that this impacted on patient care. However, all teams had access to a family liaison officer for support and each team now had access to a psychologist.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. All staff completed mandatory training including bank staff. Information was provided to staff about autism and training was planned to give staff the skills to support autistic people.

Managers gave each new member of staff a full induction to the service before they started work. Staff told us they had completed an induction and spent time shadowing other team members when visiting patients as part of their induction.

Managers supported staff through regular, constructive appraisals of their work. At the time of inspection 87% of staff had received an appraisal in the last 12 months.

Managers did not always support staff through regular, constructive clinical supervision of their work. At time of inspection only 30% of staff across the home treatment teams had received management supervision. This included none of the staff in the Solihull team, and only 10% of staff in the Handsworth team. Additionally, only 46% of staff had received clinical supervision, this was as low as 25% in Sutton and 30% in Central teams.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff told us there were monthly team meetings which they were encouraged to attend, and these were repeated so that all staff could attend whatever shift they were working. However, there were no team meeting minutes for July and September meetings in Central and Sparkhill home treatment teams, so it was unclear if meetings had taken place.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff said they had fortnightly reflective practice sessions, and Mindfulness sessions which they found useful.

Managers made sure staff received any specialist training for their role. Managers had identified that staff needed more training in how to work with autistic people and this had been arranged.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers told us they identified where staff needed support to improve their performance and provided support where needed.

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. They had effective working relationships with other relevant teams within the organisation but did not always have with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed a multidisciplinary team meeting where all staff were involved. The team worked together well to discuss the best outcome for people who used the service. The person's records were updated as the meeting progressed to ensure all actions were recorded.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Staff could access patient's shared care record with GPs and told us that this had improved the information they had about people's physical health needs. Staff were also able to share clear information with the person's GP about their mental health needs.

Crisis teams had effective working relationships with some of the other teams in the organisation, however not always with the psychiatric liaison teams. Managers from the psychiatric liaison teams (PLT) said that home treatment staff often questioned referrals of people to the team. They said this was without having met the person and seemed to question the PLT staff judgement. PLT managers were aware that the person may not always be in crisis at the time home treatment staff saw them but often referrals were sent back at the time of receipt. They had arranged regular meetings with the home treatment team managers to discuss this and were working together to resolve these issues.

Mental health crisis services and health-based places of safety

Teams did not always have effective working relationships with external teams and organisations. Staff spoke about lack of understanding of the police and sometimes poor communication from them. They said that police did not support them on joint visits to people who used the service when requested which they had done previously. Managers had arranged informal meetings with the urgent care team and police to discuss these issues.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff received this training as part of their mandatory training and compliance was 93% at time of inspection. Staff told us about the shortage of Approved Mental Health Professionals and the impact this had on their work. This was discussed at Urgent Care staff meetings and the issue escalated within the integrated care system.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff told us this was available through the trust Mental Health act administrators. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. These were available to staff on the intranet, shared drive and copies available in staff offices.

People had easy access to information about independent mental health advocacy. We observed staff giving advice to people about advocacy. Most people who used the service were not detained under the Mental Health Act unless on a community treatment order so would not automatically have access to independent mental health advocacy.

Staff explained to each person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the person's notes each time. Records showed that staff explained these to people on a community treatment order.

For persons subject to a Community Treatment Order, staff completed all statutory records correctly. Records showed that staff completed these. Managers discussed at their daily video calls who on their caseload was on a Community Treatment Order and were aware of the person's needs and risks.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Regular audits were completed, and staff took action where needed to make improvements.

Good practice in applying the Mental Capacity Act

Staff supported people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for people who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. This was part of the mandatory training which 93% of staff had completed at time of inspection.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff knew where to get accurate advice on Mental Capacity Act. This was available to staff on the intranet, shared drive and copies available in the offices.

Staff gave people all possible support to make specific decisions for themselves before deciding a person did not have the capacity to do so. Staff gave people information in a format they would understand to help them make specific decisions about their health.

Staff assessed and recorded capacity to consent clearly each time a person needed to make an important decision. Staff discussed people's needs and risks in the multidisciplinary team meeting and discussed the person's capacity to make specific decisions. This was recorded clearly in their records. We observed a person being asked if they consented to their care coordinator being present on a call, the person did not consent, and staff respected this.

When staff assessed people as not having capacity, they made decisions in the best interest of the person and considered their wishes, feelings, culture and history. Records showed that where a person was assessed as not having capacity to make a specific decision a best interests meeting was held, and the outcome of decisions made were recorded. Staff worked with the persons GP to ensure that the person was supported to take prescribed medicines and improve their physical health and wellbeing.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve. Records showed that managers completed audits and staff took action to make improvements where needed.

Is the service caring?

Good 

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated people with compassion and kindness. They respected peoples' privacy and dignity. They understood the individual needs of people and supported people to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for people who used the service. We observed staff talking with people in a kind and compassionate way. Staff took time to listen to people and how they were feeling. Staff showed empathy and understanding. Staff respected where the person preferred to be seen either at home or in the home treatment team office. This meant that staff respected the wishes of the person and other family members. When requested to do so, staff visiting a person at home removed their identity badges to ensure the person's privacy.

However, in the health-based place of safety we observed several staff walking through a corridor where they could see people waiting or who were being seen by staff in the interview rooms. There was an alternative route which staff could have taken which would have reduced the impact on people's privacy and dignity while using these rooms, but it was not clear staff had been asked to consider this.

Mental health crisis services and health-based places of safety

Staff gave patients help, emotional support and advice when they needed it. We observed staff talking with a person about their coping strategies and staff reassured them that they were doing the right things to help their mental health improve.

Staff supported patients to understand and manage their own care treatment or condition. We observed staff talking with people about the things they could do such as diet, sleep, medicines and exercise to help them understand how to manage their treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help. We observed staff spending time contacting people's GP's, local charities and support agencies depending on the patient's needs. Staff spent time helping patients to clean and tidy their home and showed that they thought about the person as a whole and not just their mental health needs at the time. Where a patient had pets, staff took time to arrange support for them when the patient was admitted to hospital.

Staff had access to food bank vouchers to give patients and where needed went to collect and deliver the food to them. They also had petty cash available if a patient needed food or a top up of their electricity and gas.

Patients said staff treated them well and behaved kindly. Patients told us that staff were kind and supportive and staff support had helped to improve their mood.

Staff understood and respected the individual needs of each patient. Records showed and we observed that staff knew patient's individual needs. Staff knew some patients well who they had supported in the past. We observed that staff respected patient's individual needs and took time to listen to them and their family and friends.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff were clear that they would report any concerns they had and said these would be listened to.

Staff followed policy to keep patient's information confidential. We observed staff shutting down their laptops when moving around the office so that patient's electronic records were not visible to others.

Involvement in care

Staff in the mental health crisis teams involved people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that people had easy access to advocates when needed. Staff informed and involved families and carers appropriately.

Involvement of people

Staff involved patients and gave them access to their care plans. We observed staff involving people in their care and people said they knew what care they would receive from the home treatment team. However, eight of the 15 people we spoke with told us they did not receive a copy of their care plan. Staff told us that often people were too unwell to know about their care plan, but they acknowledged that they should ensure they always offered people a copy of their care plan to enable them to make a choice.

Staff made sure patients understood their care and treatment (and found ways to communicate with persons who had communication difficulties). Staff told us how they helped patients to understand their care and treatment by using interpreting services or by providing information in easy read formats. They also used a messaging service which they said sent out messages and was particularly useful for giving patients information about their medicines as they had this to refer to when needed.

Mental health crisis services and health-based places of safety

Staff involved patients in decisions about the service, when appropriate. Staff said that they involved patients as they got better as often at the beginning of their time in the service this was not possible.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients told us they had opportunities to feedback on the service and they often did this when their mental health was improving, not at the crisis stage. Results from the trust's friends and family test from October 2021 to September 2022 showed 92% of comments about the service were positive.

Staff supported patients to make advanced decisions on their care. Records reviewed showed that these had been discussed with patients often after they were no longer in crisis. Patients had support to make decisions about how they wanted to be treated if they were in crisis again.

Staff made sure patients could access advocacy services. Staff said they always asked patients if they wanted an advocate and gave them information.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. There was a family liaison worker who was available to all nine home treatment teams to support families where needed. Staff told us there was a carers group starting at the end of October 2022 to give carers an opportunity for further support and to be more involved in their relative's care where this was appropriate. We observed staff spending time speaking with family members to help them understand what their relative was experiencing and how they could support them.

Staff helped families to give feedback on the service. Staff gave families information about how they could feedback on the service.

Staff gave carers information on how to find the carer's assessment. Records reviewed showed that staff had given carers this information where appropriate.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

Access and discharge

The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude people who would have benefitted from care. Staff assessed and treated people promptly. Staff followed up people who missed appointments.

Mental health crisis services and health-based places of safety

The service had clear criteria to describe which people they would offer services to and offered people a place on waiting lists. We saw the Erdington and Kingstanding and Sutton teams had a 'book of excellence' that clearly stated the role of the team, who to refer to and guidance for staff on making referrals. The home treatment teams did not have a waiting list but saw people as needed depending on their risks.

The trust set and the service met the target times seeing patients from referral to assessment and assessment to treatment. The trust set a target of four hours for the home treatment team to make initial contact with the patient following referral, and this was adhered to. Patients were seen by the home treatment team within 24 hours of assessment. If staff in the psychiatric liaison teams, A&E or street triage teams thought the patient needed further assessment, they referred them to the Psychiatric Decisions Unit. The length of time for a patient to be in the psychiatric decisions unit was a maximum of 12 hours according to the trusts statement of purpose. However, at time of inspection one patient had been there over 24 hours. Staff told us that there had been occasions when a patient had been there several days while waiting for admission to a hospital bed. Staff followed the trust protocol and raised this as an incident as the environment was not suitable to be in long-term. People slept in recliner chairs and staff said that hot meals could not always be provided.

Staff saw urgent referrals quickly and non-urgent referrals within the trust target time. We observed that staff responded quickly to phone calls and arranged to go and see the person quickly if an immediate risk was identified. However, psychiatric liaison team managers told us that some staff did not accept their referrals or wanted a follow up phone call as well as an email to the home treatment inbox. They said this often meant the person was not seen quickly and they spent longer in A&E which put pressure on the system and was frustrating for the person. They said that home treatment staff questioned their referrals without having seen the person who was in crisis at the time they were in A&E. Managers were addressing this through meetings with the psychiatric liaison team managers and home treatment teams.

The crisis team had skilled staff available to assess people immediately 24 hours a day seven days a week. However, as there were only three staff working across the service at night it was not always possible to go and visit people in person, so people were responded to by telephone. The staffing was funded differently at night and not per home treatment team. Psychiatric liaison team managers said that sometimes people were told to go to their local Accident and Emergency at night which made it difficult as on occasion patients had waited outside hospitals in an ambulance depending on the system pressure. Managers had escalated this issue and it was regularly discussed at Urgent Care meetings across the Integrated Care Board.

The team responded quickly when people called. Records reviewed showed and we observed that staff responded quickly to people's request for help.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. We observed staff spending time to engage with people in assessments and re-visiting people's homes if they were not in the first time they called.

The team tried to contact people who did not attend appointments and offer support. Records reviewed showed and we observed that staff followed the trust policy for people who either were not in when staff visited or did not attend appointments.

People had some flexibility and choice in the appointment times available. People told us and we observed that staff tried to ensure appointments and visits were at a time convenient to the person.

Staff worked hard to avoid cancelling appointments and when they had to, they gave people clear explanations and offered new appointments as soon as possible. Staff and people who used the service told us that appointments were rarely cancelled. If needed another staff member would cover the visit or appointment although this did not always suit people who preferred to see the same staff member.

Appointments ran on time and staff informed people when they did not. We observed staff telephoning people if they were going to be delayed and ensuring they stated what time they would be visiting.

The service used systems to help them monitor waiting lists and to support patients. Each morning managers from the home treatment teams identified in their handover meeting who was waiting for an inpatient bed. They then attended a bed management call and clearly stated the risks and needs of each person and discussed the priority and timescale for when the person needed to be admitted. The trust tried to keep people as near to home as possible if they needed to be admitted. This also meant that people would have the same doctor if they were an inpatient or if they were supported by the home treatment team.

Staff supported people when they were referred, transferred between services, or needed physical health care. Staff had recently gained access to patient's shared care records so they could see when they had visited their GP or the local accident and emergency department and could also see information relevant to their physical health needs.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms did not always support peoples' treatment but did support people's privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Each home treatment team office had access to interview rooms where they could see people who preferred to come to the office rather than be seen at home. Interview rooms in the service had sound proofing to protect privacy and confidentiality.

In the Psychiatric Decisions Unit (PDU) lights could not be dimmed. It was not expected that people would spend more than 12 hours in the PDU. However, recliner chairs were provided for people to sleep if needed and often people had spent time in the Accident and Emergency Department before coming to the PDU so may be tired. The trust told us that as it was a communal area where staff needed to be safe it was not possible to reduce the lighting. It was not possible in any room to dim the lighting including where recliner chairs were situated for people to sleep in.

Peoples' engagement with the wider community

Staff supported people with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work and supported people. Staff referred patients to a day centre if needed which helped to reduce isolation for people who had little social support. They also referred people to a 'Crisis house' if they thought the risk of them being in the community was too high. Staff asked patients about their work or education and tried to arrange visits around these. They also spoke with patients about how they could be supported to go back to work or education if they were off sick. At Solihull staff had set up a physical health clinic on Saturdays so that patients who worked during the week could attend.

Staff helped patients to stay in contact with families and carers. We observed and records showed that staff always asked patients about their family relationships. Staff supported patients to connect with their families if this would help promote their mental and emotional wellbeing.

Mental health crisis services and health-based places of safety

Staff encouraged patients to develop and maintain relationships in the wider community. We observed that staff signposted patients to local services and support in the community.

Meeting the needs of all people who use the service

The service met the needs of all people – including those with a protected characteristic. Staff helped people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The offices where the home treatment teams were based were accessible to people with limited mobility. Staff signposted people to organisations that could support to make adjustments to their home where needed. Staff provided information and support with communication where needed.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Patients we spoke with were aware of the treatment they were having, the service and how to complain.

The service provided information in a variety of accessible formats so the people could understand more easily. Information was provided in easy read formats, via a messaging app and using British Sign Language where needed.

The service had information leaflets available in languages spoken by the people and local community. Information was provided in a variety of languages spoken by the local community. If needed staff had access to an interpreting service where information leaflets could be translated to the language spoken by the person.

Managers made sure staff and people could get hold of interpreters or signers when needed. We observed staff used an interpreting service during a visit to a patient. Staff said they could access interpreters either on the phone or if time allowed, they would attend in person.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

People, their relatives and carers knew how to complain or raise concerns. Patients and their relatives told us they knew how to make a complaint if they needed to.

The service clearly displayed information about how to raise a concern in areas where people were seen. We observed this in the offices and reception areas.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to handle complaints and said they would always try to resolve any concerns to help the patient to get the service they needed.

Managers investigated complaints and identified themes. The trust told us there were nine formal complaints made by people who used this service from 1 October 2021 to 30 September 2022. Managers were investigating these and provided information about themes from these and other complaints made across the trust services. Team meeting minutes showed that following a complaint additional equipment had been provided across the service to enable staff to monitor patients' physical health needs.

Mental health crisis services and health-based places of safety

Staff protected people who raised concerns or complaints from discrimination and harassment. Staff said that they would ensure that patient's views were listened to, and they would not be discriminated against if they made a complaint.

Staff knew how to acknowledge complaints and people received feedback from managers after the investigation into their complaint. Staff said they acknowledged complaints made and if they could not resolve them quickly, they would refer them to their managers. Managers contacted patients to provide feedback.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers shared feedback from investigations in team meetings, via newsletters and in reflective practice sessions.

The service used compliments to learn, celebrate success and improve the quality of care. Staff proudly showed us their compliments and thank you cards were displayed around the service. Staff recorded these onto the trust system for feedback from patients and their carers.

Is the service well-led?

Requires Improvement

Our rating of well led went down. We rated it as requires improvement.

Leadership

Local leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for people and staff.

Staff told us, and we observed, that team managers from the home treatment teams had the skills, knowledge and experience to manage the teams. They could explain clearly how the teams were working to provide high quality care. Team managers had all previously worked in the home treatment teams and had a good understanding of how the service was run.

Managers were visible and staff said they were approachable. However, some staff told us senior managers in the trust were not always visible and only visited when there had been a problem.

Leadership development opportunities were available, including opportunities for staff below team manager level. Managers told us they had opportunities to do leadership training which had helped them to be promoted to their post.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. All staff we spoke with were aware of the trust values and how these applied to their work in the team.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Staff said this was available on the trust intranet and vision and values were displayed on posters in the offices.

Mental health crisis services and health-based places of safety

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff told us they were involved in the planned staffing review taking place in December this year. They said they were also involved in reviewing policies related to police powers under the Mental Health Act 1983.

Staff could explain how they were working to deliver high quality care within the budgets available. All staff we spoke with told us how they ensured they were delivering care that met patient's needs and although this could be challenging within the budgets available, they were proud of what they achieved.

Culture

Staff felt respected, supported and valued, but not all staff felt that the trust promoted equality and diversity in daily work. The trust provided opportunities for development and career progression and staff felt they could raise any concerns without fear.

Staff told us they felt respected and valued by their managers and other members of their team.

Staff felt positive and proud about working for the provider and their team. Staff worked as a team and were proud of their work and achievements.

Staff felt able to raise concerns without fear of retribution. Staff said they would always raise concerns if they needed to and would not be afraid to do this.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Staff were aware of the Speak Up process and how to contact the Speak Up Guardian if they needed to. There were Speak Up champions in place across the trust and in local teams who they could contact when needed.

Teams worked well together and where there were difficulties managers dealt with them appropriately. We observed that all home treatment team managers had a daily call where they discussed the number of patients on their caseload and their staffing for that day and the next day. Where needed they shared staff to meet each team's needs. Staff from the home treatment teams worked with staff in the Urgent Care centre and supported the health-based place of safety when needed. Managers from the home treatment teams attended bed management meetings so they could ensure that where needed patients on their caseload could access a bed. However, managers from the psychiatric liaison teams reported that there were sometimes conflicts with the home treatment teams not accepting their referrals. They had escalated this to managers, and this was being dealt with and discussed across the urgent care system.

Staff appraisals included conversations about career development and how it could be supported. Staff said they had access to career development including training and opportunities to take on roles that would help them to develop their skills.

Some staff reported that the trust did not promote equality and diversity in its day-to-day work. They said that the Black, Asian and Minority Ethnic network was not visible in the trust or promoted. However, some staff said that recruitment process had changed, and this had meant that staff from different cultural backgrounds were more represented in management roles. Staff were not aware of reverse mentoring, and some said they had mentoring outside of the trust but would welcome this being available within the trust.

The service's staff sickness and absence rates were similar to the trust target. This was 6% across the home treatment teams.

Mental health crisis services and health-based places of safety

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff said this was available and responsive when needed.

The provider recognised staff success within the service. The North home treatment teams (Erdington and Kingstanding and Sutton) won the trust bronze award for clinical team of the year. They said the money they won from this was going towards their Christmas party and this had helped them to feel valued.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level although performance and risk were managed well.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Team meeting minutes reviewed showed a set agenda was used. However, in Sparkhill and Central team meetings we found minutes of July and September 2022 were missing and there was no record of which staff attended in August. Staff said they discussed complaints and learning from incidents in team meetings.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Staff told us they had reviewed the duty worker responsibilities following an incident where a person had rung the crisis team several times but not had a response which resulted in a serious incident. Duty workers were subsequently allocated to be based in the office so that all phone calls could be responded to.

Staff undertook or participated in clinical audits. However, the audits were not always sufficient to provide assurance. In the Solihull home treatment team we did not see that medicines audits provided assurance. An audit completed in August 2022 did not identify that there were out of date medicines in the medicine cabinet and did not identify gaps in checking the temperature of the clinic room and medicines fridge.

Staff understood arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. Staff worked well with other home treatment teams across the trust. However, psychiatric liaison team managers said that home treatment team staff did not always accept referrals from them and respond quickly to the need for supporting the person in crisis.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when required from a team level. All staff told us they could add items to the trust risk register. Managers were aware of what was on the trust risk register and how these related to their team.

Staff concerns matched those on the risk register and staff were able to add items to the risk register.

The service had plans for emergencies. Each team had a contingency plan for COVID-19 outbreaks and staff knew what this was and what action to take.

Where cost improvements were taking place, they did not compromise patient care.

Mental health crisis services and health-based places of safety

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. The provider had purchased additional laptops so that all staff had access to these. All staff had mobile phones for use at work.

Information governance systems included confidentiality of patient records. Staff were aware of the trust information governance systems and policies. We observed they always logged out of laptops and patient records when they moved away from their desk.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Managers showed us they could access this information easily.

The provider had trained staff in quality improvement. Staff showed us they were involved in several different quality improvement initiatives to improve the service for the benefit of the people using it.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service worked actively with some partner agencies to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting.

Staff, people who used the service and carers had access to up-to-date information about the work of the provider and the services they used. Staff had developed a booklet in the North teams that showed people the role of and what to expect from the home treatment teams.

People who used the service and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The results for Urgent Care services of the friends and family test from October 2021 to September 2022 showed 92% of comments about the service were positive.

Managers and staff had access to the feedback from people, carers and staff and used it to make improvements. Staff told us how they had learnt from feedback and were working on improvements as a result including risk assessments and the information available in multidisciplinary meetings.

Directorate leaders engaged with external stakeholders – such as commissioners and Healthwatch. The police were part of the provider collaborative for Urgent Care services and we saw there were discussions as to how to improve working together to support people during a crisis related to their mental health.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Staff showed us how they developed quality improvement projects as a result of learning from incidents.

Mental health crisis services and health-based places of safety

Staff used quality improvement methods and knew how to apply them. Staff told us about quality improvement projects taking place within the teams. This included improving risk assessments. Also, for multidisciplinary meetings staff were looking at how they could extract all the information needed about the patient to improve planning in advance of meetings. Staff said this was currently taking about 20 minutes for each person at the start of each meeting and felt that if improvements were made, significant time would be saved. in the North teams had developed a booklet about the role of the home treatment teams to give to people, so they knew what to expect from the service.

In May 2022 there was an audit of people living with dementia who are on bed waiting lists and how community teams work with home treatment teams. The recommendations from this were closer working between the home treatment teams and community teams to develop a quality improvement project to ensure closer working together. The service would then be re- audited next year to review progress made. At time of our inspection this work had not started.

In May 2022 there was an audit of the use of police powers under the Mental Health Act 1983 at City hospital. There were recommendations from this about re-education of the police on the importance of contacting mental health services prior to detaining people under the Mental Health Act and more collaborative working between services and the police. The trust planned to assess the effectiveness of the Street Triage services. From this a quality improvement project was developed in relation to shortening the waiting times for Mental Health Act assessments. The trust was asked to consider expanding the number of spaces available at the health-based place of safety to reduce use of A&E as a place of safety for persons who did not require medical clearance. Staff were asked to provide clear documentation as to the cause of any delays in Mental Health Act assessments after four hours had been exceeded. At time of inspection there was no data as to how this project was developing and the impact of any improvements made.

The Liaison Psychiatry Teams are subscribers to the Royal College of Psychiatrists Psychiatric Liaison Accreditation Network (PLAN) accreditation scheme. The next accreditation submission is scheduled for June 2023.

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement ➔➔

Is the service safe?

Inadequate ➔➔

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Managers completed environmental risk assessments and ligature audits annually. Risks identified were mitigated against through the use of individual patient risk assessments, staff placement in communal areas and mirrors. The trust had identified a ligature risk over bedroom and bathroom doors following a series of serious incidents and were in the process of fitting door alarms to both bedroom and bathroom doors.

The ward complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms, however patients did not always have access to nurse call systems. Patients were individually risk assessed as to whether they required a portable nurse call bracelet to wear to mitigate the lack of call system. Most patients did not have access to a nurse call system.

Following our previous inspection visit to Meadowcroft ward, we told the trust that they must ensure all staff had access to a key and fob. At this inspection, all staff on the wards had access to a key, fob and alarm. A system was in place to monitor that keys, fobs and alarms were given back at the end of the shift.

Maintenance, cleanliness and infection control

Ward areas were well maintained, well furnished and fit for purpose but not all areas were clean. Whilst the majority of patient areas were clean the seclusion suite on Caffra ward was visibly dirty. There were stains on the walls and ceilings, smears on the windows and above the toilet area and the metal door in the bathroom area was rusty. This was despite staff telling us the area had recently been cleaned.

At our previous inspection to Meadowcroft, we told the ward that they must ensure that the nurse office area is tidy, clean and organised. Although some improvements had been made, it was still disorganised with patient food and drinks stored there, and boxes were on the floor.

Staff followed infection control policy, including handwashing. Staff completed hand hygiene and infection prevention and control audits.

Seclusion room

Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock and a courtyard for outside space. However, staff also secluded patients in their bedrooms when seclusion rooms were already in use.

Acute wards for adults of working age and psychiatric intensive care units

We reviewed incidents from the six months prior to our inspection and saw that patients had been secluded in bedrooms on 95 occassions. This was highest on Lavender ward and Caffra suite at 32 and 30 incidences respectively. Bedrooms were not suitable to be used for seclusion due to several blind spots where patients could not be observed. For example, when bedroom doors were closed, there were at least 2 blind spots; 1 if a patient was in the bathroom and another behind the bathroom door when this was opened. Furniture in bedrooms could cause a risk of harm, especially when a patient was agitated or upset. We reviewed 2 incidents that highlighted how the environment had made the patient unsafe. Additionally, staff could not easily see into bedrooms at all times as the vismatic in the window had to be constantly turned by a key and did not stay open. This meant that patients were not being continuously observed whilst in seclusion as per the provider's policy.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff completed daily checks on emergency grab bags.

Staff checked, maintained, and cleaned equipment. Cleaning records were up to date and equipment was maintained in line with the manufacturer's guidelines.

Safe staffing

The service did not had enough nursing staff, who knew the patients. However, most staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. We reviewed the staff rotas for all the wards from 29 August to 16 October 2022. All the wards had a short fall of qualified nurses on more than one shift. Lavender ward had the highest short fall of 151 qualified nurse shifts across the period and Caffra suite had the least with 53.

We reviewed the provider's safer staffing plan which indicated how many staff should be on duty as a minimum at any one time. During this period, the wards required 2156 qualified nurse shifts, to cover both days and nights. They were short of 301 which equated to 14% of qualified shifts.

Staff and patients told us that the wards were often short staffed. Incident data from the six months prior to the inspection showed that staff had recorded inadequate staffing levels 172 times. This was worst on Meadowcroft and Mary Seacole ward 1 at 45 and 38 times respectively.

Ward managers told us they often had to work 'in the numbers' when the ward was short staffed. For example, the ward manager on Melissa had worked shifts so a newly qualified nurse had not worked on her own. Other members of the multidisciplinary team said staffing had effected their ability to run groups and facilitate therapy sessions.

Following inspection, we issued the trust with a Section 29A Warning Notice from the Health and Social Care Act 2008 requiring them to make significant improvements in relation to staffing levels and oversight.

The service had high vacancy rates. Melissa ward was the lowest with a 11% vacancy rate and Meadowcroft was the highest at 33%. This equated to a total of 39.9 whole time equivalent vacancies for both qualified nurses and healthcare assistants. The trust advised managers that they could fast track the recruitment process for bank staff that they wanted to recruit to their wards, to address the staffing gaps.

Managers requested bank or agency nurses when required. However, the wards could not always fulfil the shifts. In the 6 months prior to our inspection, Endeavour house fulfilled the most shifts at 83% and Caffra and Melissa fulfilled the least at 61%.

Managers tried to use bank and agency staff that were familiar with the service and made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health. Levels of sickness for all the wards was 9%.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift, although they could not always meet their safer staffing numbers. The ward manager could adjust staffing levels according to the needs of the patients such as nursing observations or seclusion.

Patients had not always received a regular one to one sessions with their named nurse, due to staffing issues. Patients and staff told us their escorted leave or activities were cancelled at times. We also saw this recorded in patient care notes. Whilst we were on inspection, we observed at least 3 instances when patient leave from the ward could not be facilitated due to low staffing levels. We spoke with 26 patients and five told us their escorted leave had been cancelled because of staffing levels, but 6 said they had been able to take their escorted leave.

However, the service had enough staff on each shift to carry out any physical interventions safely and staff shared key information to keep patients safe in the daily safety huddle and when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover and they had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and generally kept up-to-date with their mandatory training. Caffra suite were most up to date at 95% completion and Saffron was the least up to date at 88%. The majority of courses were completed, although Immediate Life Support (ILS) was lower than expected on 4 wards; Mary Seacole ward 1 at 78%, Meadowcroft at 67%, Melissa at 70% and Saffron at 63%.

The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. The majority of training was by e-learning, however staff attended face to face training in courses including basic and immediate life support, physical intervention training and breakaway techniques.

Assessing and managing risk to patients and staff

Staff assessed risks to patients and themselves well although it was not always clear how staff would manage these risks. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Safety alerts were clearly displayed. We reviewed 24 patient care records and all contained risk assessments which were fully completed and up to date.

We saw that staff had good knowledge of patients risks. We attended a seclusion review and observed staff discussing the patients vulnerability and their risk from other patients due to their behaviour. They were able to plan and manage the risk well.

Management of patient risk

Staff knew about any risks to each patient and but did not always act to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. Members of the multidisciplinary team and the ward management team met daily to identify and discuss risk, plan for any changes required to staffing, treatment plans or the ward to ensure patients were safe. However, when specific risks had been identified in care records, it was not always clear how staff should manage them. For example, one patient had been identified as being physically aggressive to staff but there was no clear plan of how to manage this included in the risk management plan.

Two patients had absconded from Mary Seacole ward 1 courtyard over a bush in the month prior to our inspection. Following the first absconsion, the ward had requested for the bush to be removed. A further patient was able to abscond the same way before the bush had been removed. Staff said maintenance or estates work was not always completed quickly.

Staff followed procedures to minimise risks where they could not easily observe patients, such as staff placement or convex mirrors.

We reviewed patient observation records. They were completed appropriately and showed patients had been observed according to their individual treatment plans.

The wards had a list of contraband items. Managers and staff told us that access to other items was individually risk assessed and apart from contraband there were no blanket restrictions.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff completed a search on admission or when they were concerned about risk or thought contraband had been secreted.

Use of restrictive interventions

Levels of restrictive interventions were low. There were no blanket restrictions on the wards we visited.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. The trust recorded every restraint as an incident. Between April 2022 and September 2022 Caffra suite had the highest incidences of restraint at 91 and Endeavour house had the lowest at 5 incidences.

Staff followed NICE guidance when using rapid tranquilisation. Between April 2022 and September 2022, the wards had used rapid tranquilisation 151 times. This was highest on Caffra suite at 54 times and lowest on Endeavour house where it was used only once. We reviewed 24 patient care records and saw that physical health observations had been recorded following rapid tranquilisation, or it was noted when patients refused.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Between April 2022 and September 2022, 105 patients had been placed in seclusion. The average duration across the wards was 102 hours for each patient. We reviewed 8 seclusion records and saw that staff followed policies and procedures.

We observed 2 seclusion review meetings. Staff were respectful and kind. However, one of the patients was secluded in their bedroom, and staff discussed their decisions in the corridor which meant it was not discreet or private as other patients overheard the discussion.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. Between April 2022 and September 2022, 2 patients had been put in long-term segregation. One was on Caffra suite, and 1 on Meadowcroft.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role and they kept up-to-date with their safeguarding training. Clinical staff completed up to level 3 for safeguarding adults and safeguarding children; staff had completed 78% and 85% respectively.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff were knowledgeable about safeguarding and had a good relationship with the safeguarding team. They were supportive and responsive when they had concerns or queries. Staff discussed safeguarding concerns in multidisciplinary team meetings and ensured concerns were followed up with appropriate agencies.

Staff followed clear procedures to keep children visiting the ward safe. The hospitals had separate visiting rooms away from the clinical areas.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had made 10 safeguarding adults and 1 safeguarding children referrals in the 12 months prior to our inspection. Staff liaised with the trust safeguarding team when they had concerns about a patient or required advice.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. The trust used an electronic patient care record system. Staff had access to a handheld electronic device to record clinical observations including physical health and patient observations. When patients transferred to a new team, there were no delays in staff accessing their records and they were stored securely.

Medicines management

The service used systems and processes to prescribe, administer, record and store medicines, although they were not always used safely. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed medicines records accurately and kept them up-to-date. The trust used an electronic prescribing system and staff said the system helped prevent medicine errors. Staff completed managing medicines training. However, whilst on inspection we were told that one patient's medicine had been accidently omitted for a number of days and the system nor staff had picked this up.

We reviewed 30 patient prescription charts and found that staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Patients told us they had received enough information and advice about their medicines. The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff generally stored and managed all medicines and prescribing documents safely. However, we found 1 box of olanzapine in the drug trolley on Mary Seacole ward 1 which was out of date. We gave it to staff for destruction.

Staff monitored room and fridge temperatures in the clinic room daily, however they were not fully completed on Mary Seacole ward 1 or Lavender ward. Room temperatures were missing 9 times in August 2022 on Mary Seacole ward 1 and 10 times in September 2022 on Lavender ward. Fridge temperatures were missing 7 times in August 2022 on Mary Seacole ward 1 and 8 times on Lavender ward in September 2022.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Medical staff completed a medicine reconciliation form on admission and provided a discharge summary which included current prescribed medicines to GPs when patients were discharged.

Staff learned from safety alerts and incidents to improve practice through the trust pharmacy staff and staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Patients received regular blood tests and an electro cardiogram (ECG) when required. Staff followed guidelines for physical health monitoring following administration of rapid tranquilisation.

Track record on safety

The service did not have a good track record on safety.

Reporting incidents and learning from when things go wrong

The service generally managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with trust policy. Physical assault, threats or intimidation to staff and aggressive behaviour were the highest recorded incidents for all the wards except Mary Seacole ward 1 where it was the second highest. Incidents were discussed daily at handover meetings.

We reviewed 17 incident reports in patient care records. Generally, incidents were recorded appropriately and copies were seen on the incident reporting system and in the patient's progress notes. However, 2 were in the incident reporting system and not in the progress notes and 1 was in the progress notes but not in the incident reporting system.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff said they supported patients when they were involved in, or witnessed an incident.

Staff reported serious incidents clearly and in line with trust policy. Managers debriefed and supported staff after any serious incident. Staff told us this was often completed informally although they had accessed the support from the psychologist at times.

Acute wards for adults of working age and psychiatric intensive care units

Managers investigated incidents. We reviewed several incidents whilst on inspection and saw managers had reviewed them. Staff received feedback from investigation of incidents that they had reported through email.

Staff did not always meet to discuss the feedback and look at improvements to patient care. We did not see any evidence of lessons learned being discussed within team meeting minutes or in the acute care governance meetings. Teams did not always have regular team meetings or clinical supervision where learning could be discussed. For example, Melissa and Mary Seacole ward 1 had not had team meetings for over 3 months, due to staffing issues and the demanding tasks required on the ward. Clinical and managerial supervision was low for all the wards.

There was evidence that changes had been made as a result of feedback. Patients were unable to have a bath due to the ward bathrooms being out of use following a patient death. The incident was still being investigated by the trust and coroner, but initial recommendations had been made which advised that all bathrooms with baths be locked until further safety recommendations could be instigated.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. Care plans were reviewed regularly through multidisciplinary discussion but interventions were not updated as needed. Care plans did not always reflect patients' assessed needs, and were not always personalised, holistic and recovery-oriented.

We reviewed 24 patient care records. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The assessment included an electrocardiogram (ECG), blood tests and other tests relevant to the individual patient. We reviewed a selection of physical health observation records and saw they had been completed in line with the trust policy. Some health care assistants had received specific physical health training and wards had a physical health lead.

However, body maps were not routinely completed on admission, which was not in line with the trust physical health policy. We also reviewed 17 incidents and did not always see completion of body maps when a patient may have or had received an injury following an incident. Of the 17 incidents we reviewed, 8 should have had a completed body map but only 2 had.

Staff had not always developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans varied in quality. The majority were basic, not written in the first person and did not include all the patients identified needs. They were not necessarily comprehensive. However, many included physical health needs and medicine management.

Staff regularly reviewed care plans when patients' needs changed, but interventions were not always updated. Care plans were reviewed in the weekly multidisciplinary team meeting, and information from the meeting was updated directly onto the care plan. However, the update was task orientated and interventions were not specific to the update or how the need was going to be met.

Care plans were not always personalised or recovery-orientated. They did not always include therapeutic interventions to promote recovery and they did not include goals or specific discharge plans. Staff said care planning felt like a tick box exercise and patients were rarely involved. Some care plans included patient's view and what was important to them but did not detail how these would be addressed. For example, one patient stated that he was worried about the side effects from his medication, but it was not acknowledged how this was going to be managed.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service which was delivered in line with best practice and national guidance. Occupational therapy and psychology used a range of assessment tools to ensure patients received appropriate treatment. However, psychology provision was not in line with National Institute for Health and Care Excellence (NICE) guidance because there was not enough staff to deliver it for patients who required it.

Staff identified patients' physical health needs and recorded them in their care plans. We saw this within the patient care record. Staff made sure patients had access to physical health care, including specialists as required. Staff referred patients to speech and language therapists and physiotherapists when required. They also referred patients to specialists from external providers.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. Staff could make referrals for a dietician when required. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Health instructors supported patients in the gym and provided a physical activity assessment.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used Health of the Nation Outcome Scale (HoNOS; a method of measuring the health and social functioning of people with severe mental illness). Occupational therapists provided initial screening using tools such as the model of human occupational screening tool (MoHOST) and the vocational lifestyle questionnaire.

Staff used technology to support patients. Staff used a handheld device to record patient observations and physical health measures which directly inputted onto the inpatient portal.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Caffra suite had completed a quality improvement project to reduce episodes of seclusion by 20% by March 2022. Results showed they had reduced seclusion episodes by 30%. Staff had highlighted learning points and next actions.

Managers could benchmark against other wards within their locality and directorate to help measure their performance. Staff participated in audits. This included physical health, hand hygiene, care plans and mattress audits. Results were monitored by matrons and managers and results were used to make improvements.

Acute wards for adults of working age and psychiatric intensive care units

Skilled staff to deliver care

The ward teams had access to the full range of specialists required to meet the needs of patients on the wards, however the provision of occupational and psychology was limited. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills, although they did not receive regular supervision. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the wards including nurses, medical staff, occupational therapists and psychologists.

However, the provision of occupational therapy and psychology was limited and varied across the service. Psychology was not consistent across the wards and psychology staff said it was difficult to meet the demands of the service when they were under resourced.

Occupational therapy was also inconsistent. There was a lack of activity workers across the wards, although posts were being recruited to. Staff and patients said there was no structure to daily activities which meant patients could get bored or they did not want to participate in activities they did not enjoy. Activities were not individualised.

Some occupational therapists worked 'in the numbers' on the ward and were involved in the daily management of the ward. This prevented them from focusing on their role as an occupational therapist.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. Staff said it was comprehensive. Newly qualified nurses participated in a preceptorship programme.

Managers supported staff to develop through yearly, constructive appraisals of their work, although not all staff were up to date. Lavender ward was the best performing at 91% and Endeavour house was the worst at 56%.

Managers did not support staff through regular, constructive clinical supervision of their work. The trust policy stated that staff should receive supervision every 6 weeks. By 16 October 2022, all wards had low supervision rates. For management supervision, Meadowcroft was the highest performing at 38% and Saffron ward was the lowest performing at 14%. For clinical supervision, Meadowcroft was the highest performing at 44% and Melissa ward was the lowest performing at 17%. Managers said low staffing levels had prevented staff receiving regular supervision. Following inspection, we issued the trust with a Section 29A Warning Notice requiring them to make significant improvement in this area.

Managers did not always make sure staff attended regular team meetings or gave information from those they could not attend. We reviewed team meeting minutes. Meadowcroft had monthly meetings, however there was no consistency for the other wards. Caffra suite had not had monthly meetings and the other wards had cancelled or sent out email updates due to low staffing levels and increased clinical activity for at least the last 3 months. Melissa and Mary Seacole ward 1 had cancelled the last 3 meetings due to staffing levels and clinical activity. Caffra suite had team meetings but they were not monthly.

Acute wards for adults of working age and psychiatric intensive care units

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. For example, healthcare assistants had the opportunity to access physical health training. Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff from a range of disciplines attended regular multidisciplinary meetings to discuss patients and improve their care. Patients and families were invited to attend and participate.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Ward staff attended handover at the change of each shift and participated in daily safety huddles.

Ward teams had effective working relationships with other teams in the organisation. Staff worked closely with community teams and home treatment teams to support care and discharge planning.

Ward teams had effective working relationships with external teams and organisations. External teams were invited to participate in ward reviews.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff had completed Mental Health Act legislation training and were 93% compliant.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice and staff knew who their Mental Health Act administrators were and when to ask them for support. Staff we spoke with were knowledgeable about the Mental Health Act.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Information was displayed in ward areas. Patients told us they had accessed the advocacy service and had found them helpful. Staff audited patients use of the independent mental health advocacy to ensure they made use of the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary. We saw this was recorded clearly in the patient's notes each time and staff completed monthly audits to ensure compliance.

Acute wards for adults of working age and psychiatric intensive care units

Staff did not always ensure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician or with the Ministry of Justice due to staffing issues.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Audits were completed monthly and actions were in place when improvements were required, although the wards were generally compliant.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff had completed Mental Capacity Act level 1 training and were 90% compliant.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Knowledgeable staff in the Mental Health Act office were available to offer advice and support.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We saw this reflected in patient care records.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. Audits were completed monthly to ensure capacity assessments where in place on admission and any associated actions were monitored.

Acute wards for adults of working age and psychiatric intensive care units

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness but they did not always respect patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke with 26 patients. Patients said the majority of staff were discreet, respectful, and responsive when caring for patients. We observed staff treating patients respectfully and they gave them help, emotional support and advice when they needed it. However, staff were not discreet and respectful when they discussed a patient's care in the corridor following a seclusion review.

Patients said they felt safe on the wards and staff responded quickly when they needed to and they were easily available. We observed that staff were located within communal areas and were accessible when patients needed them.

Staff supported patients to understand and manage their own care treatment or condition. Patients saw a range of staff and all helped dependent on their role. However, occupational therapy and psychology services were not always readily available due to staffing levels.

Staff directed patients to other services and supported them to access those services if they needed help, such as advocacy.

Patients said staff treated them well and behaved kindly and they understood and respected the individual needs of each patient. The majority of patients said staff were nice, happy to help and were supportive. They got on well with staff and staff understood patients individual needs. However, patient's individual needs were not always reflected in their care plans.

Not all patients were happy with their care. Five patients felt that staff were too busy and didn't always listen to them or help them. They did not like it when leave or activities were cancelled.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Patients told us they knew how to make a complaint.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff did not always involve patients in care planning and risk assessments. They sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Acute wards for adults of working age and psychiatric intensive care units

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients received an information pack and staff discussed the ward regime and gave patients clear information.

Staff did not always get patients involved in their care plans. We saw that patients were able to contribute to their care plans but they were not written in the patient voice. Staff did ask patients whether they wanted a copy and most did have a copy, but staff felt this was a tick box exercise to meet key performance indicators rather than a meaningful activity to aid patient recovery.

One patient said they wanted to be more involved in their care plan because it did not contain information on what he liked to do, such as listening to music which would aid his recovery.

The patient's view of what was important was included on the care plan when they wanted to participate.

Some patients did not enjoy the activities available, they said there was not enough of them and they were not tailored to each individual.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff on Lavender ward had introduced a weekly welcome meeting for patients, following feedback to help integrate them to the ward environment. One patient said she had requested more activities and it was actioned almost immediately.

Patients on the wards participated in community meetings every week or two. Actions were raised and logged. 'You said, we did' actions were displayed following feedback.

Staff made sure patients could access advocacy services. Information was displayed on the wards and staff could help patients make referrals when required.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. With the patients' consent, families and carers were encouraged to attend multidisciplinary team meetings. Staff contacted family members before multidisciplinary team meetings to gain feedback. We saw family feedback recorded in patient care records.

Staff helped families to give feedback on the service through the friends and families test.

Staff gave carers information on how to find the carer's assessment and a carers forum was available.

Is the service responsive?

Requires Improvement  

Our rating of responsive went down. We rated it as requires improvement.

Acute wards for adults of working age and psychiatric intensive care units

Access and discharge

Staff did not manage beds well. There was not always a bed available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was not always a bed available when they returned. From 1 August to 30 September 2022, leave beds were used 88 times. Staff managed the situation by reviewing the patient for consideration of more leave or finding a bed elsewhere.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. Staff did not move or discharge patients at night or very early in the morning.

The psychiatric intensive care unit (PICU) did not always have a bed available if a patient needed more intensive care. The trust had 3 PICUs; 2 for male patients and 1 for female patients. Staff from the PICUs assessed patient's suitability and could accept or decline the referral. Staff said they were managing patients whose behaviour often challenged and levels of illness had increased since the COVID-19 pandemic. PICU beds were limited to 30 for the acute care pathway. This meant staff on the acute wards often managed patients who were waiting for a PICU bed or whose behaviour or mental state required more intensive support.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Three wards had recorded patients whose discharge was delayed between October 2021 and September 2022. They were Melissa, Saffron and Endeavour house. Endeavour house was by far the ward with highest delayed discharge days at 372 days. This equated to 21 patients. We did not see detailed discharge plans in care plans.

However, the majority of patients did not have to stay in hospital when they were well enough to leave. Staff and discharge coordinators worked together to ensure patients were discharged quickly and efficiently.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff discharged patients with the support of the home treatment or community teams.

Staff supported patients when they were referred or transferred between services. Care coordinators and home treatment teams attended multidisciplinary team meetings when patients were discharged when required. Information was shared to other teams. GPs received discharge summaries so they were aware of medication requirements and treatment plans.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise and they had a secure place to store personal possessions. Storage was available within bedrooms and restricted items were kept in lockers and only accessed by staff.

Staff used a full range of rooms and equipment to support treatment and care. Quiet areas and a gym were available. Various items and equipment were available across the wards; some had table tennis and pool tables. All had access to books and arts and crafts. Patients on Caffra suite could get their hair cut in a designated area.

The service had quiet areas and a room where patients could meet with visitors in private and patients could make phone calls in private. Patients had access to their mobile phones. Caffra suite and Meadowcroft charged patient phones in the nurse office, and access to mobile phone chargers was risk assessed on the other wards.

The wards had an outside space that patients could access easily. Caffra suite had four outdoor courtyards and Meadowcroft had a large outdoor space.

Patients on the acute wards could make their own hot drinks and snacks and were not dependent on staff. Patients on Caffra suite and Meadowcroft had to ask staff for hot drinks, due to the risks to other patients and the restrictions of being a PICU.

The service offered a variety of good quality food. Patients said they enjoyed the food and there was a good choice.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff helped patients to stay in contact with families and carers. Families and carers were invited to multidisciplinary reviews and they could visit patients at the hospitals.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. However, patients could not be involved with this if they were unable to access their Section 17 leave.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Wards at the Oleaster and Zinnia centre had high dependency bedrooms which meant they were bigger and were more accessible. Accessible bathrooms were available on all the wards, although they were locked as their fixtures and fittings were not ligature proof. A patient on Saffron ward had an air flow mattress due to his physical health.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The wards had information boards which included occupational therapy activity timetables and community meetings.

The service could access information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed. The wards had several patients whose first language was not English. Patients had access to a interpreter daily.

The service provided a variety of food to meet the dietary and cultural needs of individual patients and they had access to spiritual, religious and cultural support. Religious leaders could attend the wards.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Between October 2021 and September 2022, the wards had received 10 complaints. Lavender ward received the most at 5; Meadowcroft and Saffron wards received none.

Patients told us they knew how to make a complaint and they were confident that managers would investigate.

The service clearly displayed information about how to raise a concern in patient areas and staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers gave examples of change made following patient complaints such as Lavender ward commencing a welcome meeting for newly admitted patients.

The service used compliments to learn, celebrate success and improve the quality of care. The trust participated in an excellence reporting scheme, which allowed staff to show their appreciation to their colleagues. Between October 2021 and September 2022, 5 excellence reports had been made; 3 for Melissa ward and 1 each for Saffron and Mary Seacole ward 1.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Ward managers had the skills, knowledge and experience to perform their roles. They had a good understanding of the service they managed.

Acute wards for adults of working age and psychiatric intensive care units

Staff said ward managers were supportive, open and approachable. The ward managers had received leadership training.

Staff felt supported by their locality leaders such as matrons and nurse managers. However, they did not feel supported by senior managers and said they were not visible in the service. Some staff did not know who the senior leaders were.

Vision and strategy

Not all staff knew and understood the provider's vision and values and how they applied to the work of their team.

Not all staff were aware of the trust vision and values because they had recently changed. We did not see the trust's vision and values displayed across the wards.

Culture

Staff did not feel respected, supported and valued. They said the trust did not always promote equality and diversity in their daily work or provide opportunities for development and career progression. Staff did not always raise concerns.

Most staff said they felt respected, supported and valued by each other and by their locality leadership team. However, staff said they didn't feel valued and respected by senior management within the trust. For example, they said that senior managers listened to concerns but that staff still didn't feel heard. They hadn't seen that any changes had been made following feedback.

However, 3 staff on 2 of the wards had experienced or overheard derogatory comments, including racist comments, made by other colleagues. This had not always been reported as staff didn't believe anything would be done about it.

Morale was low across the wards. Staff told us that patients had become increasingly more unwell since the COVID-19 pandemic and staffing was low. This was cited as the primary reason for low morale. Senior managers were aware of the lack of morale and the latest staff survey had highlighted this. Managers promoted and encouraged teams to participate in away days so they could focus on team building or have time to reflect. Senior managers had a recruitment strategy in place to attract, recruit and retain staff.

Staff said working on the wards could be stressful. Many had experienced physical and verbal assaults and racial abuse. Physical assault, threats or intimidation to staff and aggressive behaviour were the highest recorded incidents for all the wards except Mary Seacole ward 1, where it was the second highest. We did not see any actions by the trust to try to rectify this.

However, even though staff said working on the wards was challenging, they enjoyed working with the patients.

The trust tried to promote equality and diversity. However, some staff from different cultural backgrounds had experienced racist comments from patients and staff, or believed their careers had not progressed because of their individual characteristics which included their race and culture. This was not limited to one particular culture or ethnicity. The equality and diversity lead attended team meetings if required and had done so in the past and staff from Meadowcroft told us this had been helpful, following concerns found at a previous inspection.

Acute wards for adults of working age and psychiatric intensive care units

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well. Lessons learnt from incidents were not embedded at local or directorate team level.

Managers attended local governance meetings and wider directorate governance meetings. The agenda for clinical governance meetings provided a framework to ensure essential information was shared and discussed. However, learning lessons did not appear to be a standing agenda item for team meetings or governance meetings. This meant we were not assured that lessons learnt were cascaded to staff on the wards as they had not received regular supervision and could not all attend regular team meetings. Although, there was a learning lessons bulletin available on the intranet.

The directorate governance records showed that not all items on the agenda were discussed, including any ongoing actions. The reason for this was cited as time pressures. Actions and decisions made from the meeting were recorded, and some, but not all of the previous actions were reviewed to discuss whether they were completed or ongoing.

Staffing and staff incidents were reviewed and managers were aware of the pressures staff on the wards were experiencing and took time to discuss how this could be rectified and progress being made on their recruitment strategy. However, it was not evident how managers acted on immediate staffing pressures, such as when wards were not meeting safer staffing numbers.

Managers from the PICUs attended a forum to discuss themes and trends. However, ward managers did not have a similar forum.

Management of risk, issues and performance

Teams did not have access to the information they needed to provide safe and effective care.

The acute care directorate had a risk register although most wards did not have anything on them, despite issues being identified, such as seclusion in bedrooms and associated risks. However, issues with staffing was on the risk register.

Meadowcroft ward had produced an action plan following a CQC inspection in June 2022. We reviewed the action plan and could see that improvements had been made.

Learning, continuous improvement and innovation

Caffra suite was accredited with the Association of Psychiatric Intensive Care and Low Secure units (NAPICU).

The Caffra suite had participated in a quality improvement project to reduce the incidences of seclusion.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

All wards were clean, well equipped, well furnished, well maintained and fit for purpose. However, not all wards were safe.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. However, there were potential ligature anchor points in the service identified on the wards that were not all mitigated against. On most wards, due to the nature of the service, the environment was made as homely as possible and staff supported patients using individual patient observation and relational security. However, on Endeavour Court the environment was more secure and patients were admitted with a higher degree of risk. The ligature risk assessment contained risk items that had not been addressed or completed. According to the trust operational framework and clinical service manager, Endeavour Court was expected to provide a similar environment to an acute mental health ward but we found that staff had not addressed or mitigated potential ligature risks on the doors and en-suite toilets. The trust policy was not clear as to the ward position on ligature risks and what mitigations were required.

Staff could not observe patients in all parts of the wards. Staff carried out regular general observations and positioned themselves in key areas of the ward to maintain patient safety.

The ward complied with guidance for mixed gender accommodation. Three of the wards were mixed gender, including Rookery Gardens, Forward House and Grove Avenue. Each patient had their own flat with en-suite and cooking facilities.

Staff had easy access to alarms and these were provided at the start of every shift. However, not all patients had access to call alarms in their rooms.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. They had appropriate furnishings for the client group and staff ensured that any issues with the premises or equipment were reported.

Staff made sure cleaning records were up-to-date and the premises were clean. We saw evidence of cleaning in progress and staff updating cleaning records for the previous three weeks.

Staff followed infection control policy, including handwashing. Managers completed a handwashing audit every week to ensure staff followed the infection control policy. We saw handwashing notices in all communal and staff toilets.

Long stay or rehabilitation mental health wards for working age adults

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The equipment checks were in date and staff provided evidence to show that clinic room were regularly cleaned. The clinic rooms for Forward House and Endeavour Court were small and provided a cramped environment for staff to work in. The wards had recently submitted a capital bid, which was awaiting approval from the board, to relocate these clinic rooms to provide additional space.

None of the clinic rooms contained a patient couch for observations and treatment. Staff informed us that they generally used patient bedrooms when they needed a private space to complete physical observations or other treatment programme.

Staff checked, maintained, and cleaned equipment. We saw evidence of equipment being cleaned and checked on a regular basis, including the display of portable appliance testing (PAT) stickers.

Safe staffing

The service did not always have enough nursing and medical staff to provide safe care for patients. Staff knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. Almost every ward, with the exception of David Bromley House, had significant vacancy rates. Of all the wards, Forward House, Grove Avenue, Hertford House and Rookery gardens faced the most vacancies with rates varying between 19% and 44% of their total staffing establishment levels.

In a seven-week review of the staffing rotas from 29 August to 10 October 2022, across six of the wards, we noted that there were eight occasions where the service did not have any qualified nursing staff on shift. This meant that the wards did not always have access to nurses in an emergency or to support with the administration of medication. We were concerned this was a high risk for wards that were standalone such as Hertford House and Grove Avenue, which did not have other hospital units around them for support. We raised our concerns with the trust and following inspection they provided further data which showed that a qualified nurse was always available to the wards by utilising staff from other wards to provide support. However, we were still concerned that staffing levels did not always meet the trust's safer staffing plan and that staffing contingencies were not robust.

Managers utilised bank nurses and nursing assistants where possible to fulfil shifts, but this was not always possible and the wards were sometimes still short staffed.

Managers limited their use of agency staff and requested staff familiar with the service. At the time of the inspection, the service did not make use of any agency staff.

Managers made sure all bank and agency staff had an induction and understood the service before starting their shift. Some wards had produced an induction booklet for bank staff but this was not consistent across all wards. Induction was usually carried out with a checklist of information that was passed on to the new staff member.

The service had high turnover rates. Almost every ward, with the exception of David Bromley House and Dan Mooney House, had significant turnover rates. The average turnover rates for the period October 2021 to September 2022 were between 2.7% and 17% across the wards. The turnover rate had increased for Endeavour Court, Rookery Gardens, Dan Mooney House, Grove Avenue and Hertford House within the same period.

Long stay or rehabilitation mental health wards for working age adults

Managers supported staff who needed time off for ill health. At the time of our inspection, several staff were on long-term sick leave or in a phased return to work programme.

Levels of sickness were reducing across most wards, except for Hertford House where the sickness rates had increased from 11.4% in October 2021 to 20.9% in September 2022.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. Managers used a 'safer staffing' tool to identify how wards were to be staffed appropriately. However, we found there were shifts without a qualified nurse on duty and this was not in line with the safer staffing plan.

Patients had regular one- to-one sessions with their named nurse. Patients were aware of who their named nurse was and said they saw them regularly.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Where possible, staff told us they rearranged leave for another time.

The service did not always have enough staff on each shift to carry out any physical interventions safely. There were times when there were no nursing staff on shift, and this meant that physical interventions could not always be supervised by a qualified member of staff to ensure patient and staff safety.

Staff shared key information to keep patients safe when handing over their care to others. Staff carried out handovers at the start of every shift and had protected time in order to facilitate this.

Medical staff

There was no permanent consultant cover for Forward House. This post had been vacant for three years, and recently cover was provided by the substantive consultant who worked on Endeavour Court and Rookery Gardens which meant one consultant was providing care for 49 patients. This meant that patients could not always have timely access to a consultant for questions on their care and treatment.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift. All new staff received a standard induction to the ward including an orientation and handover of patients.

Mandatory training

Not all staff had completed and kept up-to-date with their mandatory training. In October 2022, wards across the service had a compliance rate of 96 per cent or higher for the mandatory training requirements.

However, only 75 per cent of staff at Hertford House and 67 per cent of staff at Forward House had completed the immediate life support training offered by the trust. In addition, only 50 per cent of staff on Hertford House had completed their safeguarding adults Level 3 training.

The mandatory training programme was comprehensive and met the needs of patients and staff. The training included fire safety, infection prevention control, medicines management, safeguarding, immediate life support and manual handling among others.

Long stay or rehabilitation mental health wards for working age adults

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received email alerts and reminders during their supervision of any upcoming or refresher training required.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 16 care records and found that staff completed a risk assessment for each patient on admission.

Staff used a recognised risk assessment tool which was the Level 1 risk screening tool.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. We reviewed 16 care records and found that the risk assessment for each had been completed and regularly updated. Staff we spoke with were able to articulate the primary risks to each patient and how they mitigated these risks. Staff provided detailed handovers at the beginning of each shift which detailed any historical and new risks that staff needed to be aware of.

Staff identified and responded to any changes in risks to, or posed by, patients. We saw risk assessments that had been updated due to changes in patients' presentation and following any incidents.

Staff followed procedures to minimise risks where they could not easily observe patients. Due to the nature of the wards, most patients who were admitted did not have any active risks of self-harm or suicidal intent. Where risks were identified, staff mitigated these through individual patient observations.

Staff did not always follow trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. The policy stated that patients in the Steps to Recovery pathway were to be searched on admission, and 'on return from unauthorised leave based upon individualised risk assessments'. We found that staff on most wards, except for Grove Avenue, were searching all patients returning from leave, regardless of their risk assessment.

Use of restrictive interventions

Levels of restrictive interventions were low. Staff had worked with patients to eliminate some of the blanket restrictions on the wards, such as access to certain areas of the wards and patients accessing outdoor space. Several blanket restrictions remained on the ward, such as set smoking times and the laundry and kitchen being accessible under staff supervision only. This was due to current risks in some of the patients on the wards and to manage the staff shortages that sometimes occurred on the wards. The blanket restrictions present on the wards were not always individually risk assessed.

Long stay or rehabilitation mental health wards for working age adults

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff and managers informed us that where a patient required repeated restrictive intervention techniques, such as restraint or seclusion, they would be referred to a more appropriate setting as the wards were not suitable environments for high risk patients.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. There had been nine incidents of restraint in the six months leading up to the inspection. There had been no restraints reported for Forward House, Hertford House or Grove Avenue.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

There had been no use of rapid tranquilisation across any of the wards in the six months leading up to the inspection.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. There had been one episode of seclusion on Endeavour Court where a patient was secluded in their bedroom for three hours. There had been no other episodes of seclusion or long-term segregation across the service in the six months leading up to the inspection.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. The trust provided training in safeguarding adults and children at different levels.

Staff usually kept up-to-date with their safeguarding training with the exception of Hertford House staff. Only 50 per cent of staff at Hertford House had completed their Level 3 safeguarding adults training. Across the service, the compliance rate for the Level 3 safeguarding adults training was 91.7%. In addition, the compliance rate for the Level 1 safeguarding adults was 98.6%, and 97.2% for the Level 2 safeguarding adults training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff had good relationships with the trust safeguarding team and felt able to approach them with any queries regarding safeguarding.

Staff followed clear procedures to keep children visiting the ward safe. Any visits including children were pre-arranged and staff ensured that these visits took place in a safe space in an allocated visitors room or away from the ward.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There had been six referrals to safeguarding made by staff in the Steps to Recovery service in the twelve months leading up to the inspection.

Managers took part in serious case reviews and made changes based on the outcomes. For example, one patient in the service had a choking episode in their sleep. Following this incident, the service had introduced dysphasia care plans for every patient admitted to rule out any potential risks around choking, and provide support where necessary.

Long stay or rehabilitation mental health wards for working age adults

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.

Patient notes were comprehensive and all staff could access them easily. All staff, including bank staff, had a login for the electronic system and could access records easily.

When patients transferred to a new team, there were no delays in staff accessing their records. Most patients were transferred from other wards within the trust, such as acute, psychiatric intensive care units, forensic secure wards and other wards within the Steps to Recovery Service. As a result, staff had immediate access to any previous records of care.

Records were stored securely on an electronic system.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Staff used an electronic prescribing system and we noted no gaps in the administration of medication. Any known allergens for patients were clearly noted. All prescriptions matched the requirements set in the patients' consent to treatment form.

However, patients who self-medicated did not always have a care plan associated with this. Different stages of their administering routine were noted on the electronic prescribing system but with no accompanying care plan for staff or patients to follow.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Medications were reviewed and discussed with patients at every ward round.

Staff completed medicines records accurately and kept them up-to-date. We reviewed 15 prescription charts and saw that each was signed and dated appropriately.

Staff on most wards stored and managed medicines and prescribing documents safely. However, on Endeavour Court, we noted that there was an excess storage of medication and that clinic room cupboards were overloaded with stock of new medication.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Staff ensured that medicine reconciliation took place at admission.

Staff learned from safety alerts and incidents to improve practice. There had been 156 incidents related to medicines management across all wards in the twelve months leading up to the inspection. These had been of low harm level and without serious impact on patients.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. We saw evidence of staff discussing patients' presentation, particularly those that were on high dose antipsychotics. During one ward round, staff arranged an electrocardiogram (ECG) for a patient due to the possible side effects of their medication.

Long stay or rehabilitation mental health wards for working age adults

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. There had been 449 incidents across the service in the six months leading up to the inspection. Most incidents themed around verbal threats, patient on staff assaults, patients not returning from unescorted leave at the agreed time, substance misuse and staffing levels impacting ward safety.

Staff reported serious incidents clearly and in line with trust policy. There had been two serious incidents in the service within the twelve months leading up to the inspection. One was of a patient choking to death in their sleep due to regurgitation, and the second was due to untimely support at an acute general hospital.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave patients and families an explanation if and when things went wrong. Managers investigated incidents thoroughly. However, some patients told us they did not always receive feedback from incidents that were investigated.

Managers debriefed and supported staff after any serious incident. Staff received immediate debriefing after any serious incidents, and this was followed by a reflective session with the psychology team.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received feedback through staff meetings, supervision and newsletters.

Staff met to discuss the feedback and look at improvements to patient care. Staff discussed any changes implemented in the service during staff meetings and at incident debriefings.

There was evidence that changes had been made as a result of feedback. For example, one patient died through aspiration after choking – the patient was awake at the time of the incident. Management across the service had introduced dysphasia assessments that had to be completed for every patient on admission to ensure that any potential risks were identified.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Long stay or rehabilitation mental health wards for working age adults

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. This included an assessment of the patient's capacity, and a review of their mental health diagnosis.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. This included the patient's height, weight and body mass index (BMI). This was reviewed on at least a monthly or more frequent basis where this was indicated. Where patients had additional physical health needs, such as diabetes or substance misuse issues, they had access to further support.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. For example, we saw care plans for self-neglect, substance misuse, educational advancement and managing physical health problems.

Staff regularly reviewed and updated care plans when patients' needs changed. For example, if patients were progressing in their substance misuse treatment, staff updated the care plan to support patients onto the next stage.

Care plans were personalised, holistic and recovery-orientated. Each patient had their own care plan based on their strengths and weaknesses. The care plans recorded patients' needs that were identified in their initial assessment.

Best practice in treatment and care

Staff did not always provide a range of treatment and care for patients based on national guidance and best practice. Patients did not always have access to occupational therapy and psychological therapies which supported the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. Staff participated in clinical audits but did not always carry them out regularly or take action following the completion of audits to make improvements in care.

Staff did not always provide a range of care and treatment suitable for the patients in the service. Most patients across all the wards told us that activities were lacking and that they often experienced boredom. There was a lack of therapeutic input from occupational therapists and psychologists across the wards as they were not always available for every ward. We observed patients sitting in bedrooms or communal areas without much to do. There was an activity timetable for each ward but some activities were cancelled or postponed due to lack of staffing.

Staff did not always deliver care in line with best practice and national guidance. Patients were not offered psychological therapies in line with National Institute for Health and Care Excellence (NICE) guidance.

We spoke with three carers who also told that they felt the wards lacked in activity and that there was usually not a lot going on when they visited or spoke with patients.

Staff identified patients' physical health needs and recorded them in their care plans. All patients had a physical health assessment on admission to the wards which included their baseline observations for height, weight, body mass index and bloods.

Staff made sure patients had access to physical health care, including specialists as required. Patients requiring further support with their physical health, for example diabetes, had their blood glucose levels checked regularly and were supported by the diabetic nursing team in the trust. Patients were also supported to register with the local GP surgery, dentist and opticians where needed.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff supported patients to access recreational community activities such as swimming or bowling. Staff also signposted any patients with substance misuse issues to the drug workers within the team to support them to reduce their intake.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The occupational therapy team used a range of tools to support patient outcomes, including Mayers lifestyle questionnaire and Recovery Star.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Audits included those reviewing infection prevention and control, hand hygiene, mattresses, the environment, consent to treatment documents, and care plans. The audits were comprehensive and looked in detail at each of the areas of note. However, the clinical audits did not always take place as frequently as stated in the trust audit policy for the service.

Managers were not always able to use results from audits to make improvements. We noted during our review of audits that there were duplicates of audits saved under different dates. This suggests that staff did not always carry out the audits as intended and that learning from audits could not always be identified on a regular basis.

Where audits did take place, there were no clear actions identified. Staff noted any areas where care did not meet trust compliance but had not always noted what actions would need to be taken to make improvements. We noted several audits identifying similar areas for improvement which suggests that audits do not always lead to change and progress in the care delivered.

Skilled staff to deliver care

The ward teams did not have access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. Managers did not, however, support staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service did not have access to a full range of specialists to meet the needs of the patients on the wards. Some wards did not an occupational therapist or psychologist to provide valuable therapeutic input into patients' care. Some wards had access to a residential drug worker who supported patients in managing issues related to substance misuse.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff recruited through the bank pool usually worked on wards within the Steps to Recovery service and provided regular support on these wards.

Managers gave each new member of staff a full induction to the service before they started work. Staff received protected time to complete any e-learning prior to working on the wards and were supported to shadow experienced staff members to accustom themselves to the wards.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work. The service had achieved an average 88% compliance in their annual appraisals across the wards as at October 2022. However, only 61% staff on Grove Avenue, and 73 per cent of staff on Forward House, had received their annual appraisals as at October 2022.

Managers did not support non-medical staff through regular, constructive clinical supervision of their work. The average rate of supervision across all wards was 30%in October 2022. Out of 140 staff, only 42 staff members were in date with their supervision. In addition, the service's clinical supervision rate was 70% in October 2022. In particular, the figures were lower than the 75 per percent compliance target on Endeavour Court, Forward House and Grove Avenue. Following inspection, we issued the trust with a Section 29A Warning Notice requiring them to make significant improvement in this area.

Managers did not make sure staff attended regular team meetings or did not give information from those they could not attend. Staff did not always have access to regular staff meetings due to staffing challenges and lack of leadership on one of the wards.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff usually had protected time to complete any outstanding or refresher training. Staff were also supported to develop further in their roles, and one healthcare assistant had been supported to complete their nursing training.

Managers made sure staff received any specialist training for their role. For example, some staff had completed specialist training in autism, phlebotomy, tissue viability and professional nurse advocacy.

Managers recognised poor performance, could identify the reasons and dealt with these. There were no staff members being performance managed at the time of our visit.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff from services providing care following a patient's discharge and engaged with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff held weekly multidisciplinary meetings and ward rounds. Members from across the different disciplines attended some of these meetings including consultants, nurses, occupational therapists and assistants, psychologist, pharmacist, discharge coordinators and the bed management team.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. During ward rounds, staff discussed and reviewed patients' medication, care plan, leave allocation, discharge plan and any ongoing physical health support. Staff had good knowledge about the patients, their backgrounds and family involvement.

Ward teams had effective working relationships with other teams in the organisation. Staff worked well with the bed management team to facilitate admissions and discharges in a timely manner. Staff also worked closely with the trust safeguarding team and other wards within the Steps to Recovery service.

Long stay or rehabilitation mental health wards for working age adults

Ward teams had effective working relationships with external teams and organisations. Staff had good relations with the housing associations in the area and the local authority and social workers' team to develop plans for discharge for patients in their care.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Across all wards, 97% of staff had completed training in the Mental Health Act Legislation.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The trust had Mental Health Act administrators, but staff did not always know who their Mental Health Act administrators were and when to ask them for support. However, managers were aware and were able to signpost staff where needed. Managers informed us they had access to Mental Health Act administrators within the trust who worked in various regions of the city.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We saw evidence of staff reading patients their rights and this being recorded in patients' notes. Patients also informed us that staff reminded them of their rights regularly.

Staff tried to ensure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Patients told us that escorted leave was sometimes postponed or cancelled due to staffing shortages, but that unescorted leave was always accommodated.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Staff told us the SOAD response was usually quick and that they did not have to wait long for an assessment.

Staff could access copies of patients' detention papers and associated records when needed but did not always store these correctly. We found that staff did not always archive old records in relation to the Mental Health Act appropriately and that old documents were sometimes stored in the same folder as current records. For example, staff did not always archive old patient consent forms (such as T2 and T3) which were no longer relevant. We found these in the same folder as current consent to treatment forms. This could lead to confusion when treating or administering medicines to patients.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. We saw these displayed in communal across the wards and information regarding this was also included in patient welcome packs.

Long stay or rehabilitation mental health wards for working age adults

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. However, we found that audits were not always completed regularly and that learning from audits was not always followed up.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Across all wards, 100% of staff had completed training in the Mental Capacity Act.

There were no Deprivation of Liberty Safeguards applications made in the last 12 months.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. The policy was stored on the staff intranet and was easily accessible to all staff.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us they usually approached their ward managers who were able to signpost them in the right direction.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff ensured they supported patients to make decisions for themselves by communicating in plain English, or patients' chosen language through interpreters, and using family members or carers to communicate with patients effectively.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We saw evidence of this in the patient records we reviewed.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Long stay or rehabilitation mental health wards for working age adults

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Patients spoke highly of the staff that supported them and said they were empathetic in their care. Patients were aware of who their key workers were.

Staff gave patients help, emotional support and advice when they needed it. Staff provided advice on local amenities, recreational activities and other forms of support patients could access both within the trust and in the local area.

Staff supported patients to understand and manage their own care treatment or condition. Staff involved patients during ward rounds and ensured that they were offered a copy of their care plan. Patients felt that they were listened to by staff when they raised issues with their care and treatment, during ward round or at other times.

Staff directed patients to other services and supported them to access those services if they needed help. For example, staff directed patients to make use of the trust's recovery college which supplied patients with educational and vocational courses for building their skills and self-esteem.

Patients said staff treated them well and behaved kindly. Patients said they got on well with staff and could approach them for help if needed.

Staff understood and respected the individual needs of each patient. One patient told us that staff got them a jumper which signified their religious colours and that this helped them feel valued.

Staff followed policy to keep patient information confidential. All information was stored securely online and could only be accessed via a staff login. Staff ensured noticeboards with patient information were not visible outside of the nurses' station.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that patients had easy access to independent advocates.**

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients were shown around the ward. Endeavour Court used an introduction booklet which was provided to all patients.

Staff involved patients and gave them access to their care planning and risk assessments. Patients we spoke with told us they had access to their care plans.

Staff made sure patients understood their care and treatment and supported patients to make decisions on their care. We observed notice boards across most wards containing information about various medications and their uses.

Staff involved patients in decisions about the service, when appropriate. Staff sought patient feedback on issues affecting their care, such as blanket restrictions, food and their activity preferences.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff held community meetings on a weekly basis across all the wards. The community meetings were chaired by staff and focused on any changes on the ward, patient's likes and dislikes, activities for the week and any improvements that could be made. However, at David Bromley House we noted that community meetings did not always take place regularly. Patients also had access to a feedback form which they could complete.

The Friends and Family test carried out in October 2021 received 127 responses, of which 89% of people said that they had had a positive experience of the recovery service.

Staff made sure patients could access advocacy services. Patients we spoke with had heard of the advocacy service and there were posters around the wards on how to access this.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Carers we spoke with told us staff always tried their best to accommodate visits and gave them space and privacy. They also said it was usually easy to get hold of staff on the ward, whether during a visit or by phone. At Hertford House, staff had developed a carer's booklet to introduce carers to the wards and provide any relevant information that might be useful for them.

Staff helped families to give feedback on the service. Carers told us they felt able to approach staff if they had any concerns and felt listened to.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Most wards were almost fully occupied at the time of our visit.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. As of September 2022, there were five delayed discharges across the service with most patients delayed between one and three months.

The service had low out-of-area placements. These were only allocated in an emergency and managers worked with local bed management teams to transfer patients closer to home as quickly as possible.

Long stay or rehabilitation mental health wards for working age adults

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned. Patients told us their bed was always available when they returned from leave. Staff told us that they sometimes exchanged patients' bedrooms depending on escalated health risks such as a sudden physical health trauma or where patients required enhanced observations. They ensured that each patient always had a room and did not over occupy the wards.

Patients were moved between wards during their stay only when there were clear clinical reasons or it was in the best interest of the patient. For example, if a patient presented with a higher risk than the wards could safely manage, they were transferred to an acute or more appropriate setting.

Staff did not move or discharge patients at night or very early in the morning. Patients were discharged at a reasonable time during the day and staff supported patients with the discharge process. For example, they assisted patients in finding furniture or housing essentials to ensure they would be comfortable in their new surroundings.

Staff were able to transfer patients to acute wards for adults with mental health problems without much difficulty and had good links with other teams including bed management to facilitate these transfers.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. As of September 2022, the service had five delayed discharges across all the wards. These were due to patients awaiting further support with their mental or physical health with another provider or funding for their next placement.

Patients did not have to stay in hospital when they were well enough to leave. Staff sought to discharge patients who were well enough to leave and had regular bed management and discharge meetings to this effect.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We saw evidence of a discharge action plan in all the care records we reviewed, and these detailed what actions staff and the patient were taking to facilitate discharge. This included patients' journey in self-medication, social worker support and actions completed by the ward-based staff to support the patient in meeting their goals.

Staff supported patients when they were referred or transferred between services. Staff visited any onward placements, such as supported or independent housing, with the patients prior to discharge to ensure patients felt comfortable in their new environment.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. These bedrooms were not always en-suite but patients had access to a sufficient number of bathrooms on the wards for their needs.

Patients had a secure place to store personal possessions. Patients were provided with a locker to store their snacks and other belongings.

Staff did not always have access to a full range of rooms and equipment to support treatment and care. The activity room on Forward House was not suitable for patient purposes. The ward manager on Forward House had recently submitted a capital bid to have multifunctional rooms added on the grounds and at time of inspection was awaiting trust approval. Following our inspection the trust told us the required funding was approved and works would be completed 7th March 2023. Dan Mooney House also did not have enough room to provide activities in and staff relied on taking patients off the ward for most meaningful activities. This was problematic as patients without leave allowance were not always able to attend.

The service did not always have quiet areas and a room where patients could meet with visitors in private. Carers and patients told us staff readily accommodated any visits but that these usually took place in patient bedrooms, communal areas or away from the wards, such as a coffee shop, where patients had unescorted leave.

Patients could make phone calls in private. Patients told us they tended to use their bedrooms for private phone calls.

The service had an outside space that patients could access easily. All wards, except for Endeavour Court, had open access to the garden and courtyards. Patients on most wards were free to move about the wards. Patients on Endeavour Court had to seek staff support to access the laundry, kitchen and outdoor space.

Patients could make their own hot drinks and snacks and were not dependent on staff. We saw drinks dispensers on the wards in communal areas that patients could access easily.

The service offered a variety of good quality food. Most patients cooked or were supported to cook their own food. At other times, staff made the meals. Patients we spoke with told us they enjoyed cooking with staff and that the food was good.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Two patients were supported to access college to complete a diploma and a-levels.

Staff helped patients to stay in contact with families and carers and encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Some of the wards, such as Hertford House, were situated in old Victorian buildings with limited accessibility for wheelchair users. However, managers informed us that if a patient required wheelchair access, they would allocate them to a more suitable ward such as Forward House.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community. The trust had a variety of leaflets available on the staff intranet which staff could download and print in the patient's preferred language.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us staff supported them with their dietary needs, such as halal or vegetarian food.

Patients had access to spiritual, religious and cultural support. Most patients told us they were able to access religious support while on unescorted leave. Two patients told us they did not always get supported to access religious support and that they were waiting to see a religious leader.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. There were posters on how to contact the Patient Advice and Liaison Service, the trust complaints process and how to contact the Care Quality Commission.

Staff understood the policy on complaints and knew how to handle them. Staff told us they usually tried to deal with complaints locally, but if patients wanted to raise formal complaints, they would signpost them to their manager.

Managers investigated complaints and identified themes. There had been no formal complaints to the service in the twelve months leading up to the inspection.

Managers shared feedback from complaints with staff and learning was used to improve the service. Any learning from formal and informal complaints was fed through to staff during staff meetings, handovers and supervision. Any specific learning related to specific members of staff was communicated on a one-to-one basis.

The service used compliments to learn, celebrate success and improve the quality of care. These were shared with staff and in the service newsletter that was circulated on a monthly basis.

Is the service well-led?

Requires Improvement ↓

Our rating of well-led went down. We rated it as requires improvement.

Leadership

The leaders supporting the wards had the skills, knowledge and experience to perform their roles. Leaders were visible in the service and approachable for patients and staff. However, they did not always have a good oversight of the services they managed.

Long stay or rehabilitation mental health wards for working age adults

Staff spoke positively of their managers and said they were approachable. We saw that leaders knew the patients well and did their best to mitigate any risks in the service within the resources they had.

However, we did find that managers were not always able to complete audits and reviews of the service effectively and that this sometimes presented issues in correctly identifying areas for improvement.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff recalled discussing trust values during their supervision and appraisals and had developed artwork on trust values in collaboration with patients.

Culture

Some staff did not always feel respected, supported and valued. They said the trust promoted equality and diversity in daily work but that this did not always translate in practice. Staff felt the trust provided opportunities for development and career progression. They felt they could raise concerns but were not confident change occurred as a result.

Some staff across the different wards told us that there were cliques of colleagues which sometimes affected how they felt about their work environment. Some staff felt that the cliques led to exclusions and that they could not always build strong team and support networks with their colleagues.

Some staff also told us that they had been racially discriminated against and felt that there was an underlying culture of bullying and discrimination among staff on some of the wards. Two staff members told us that they had taken issues up with their line managers and that there had been no change as a result. Some staff had told us that they had approached the trust freedom to speak up guardian without much success in resolving their issues. Most of the staff we interviewed were not aware of the freedom to speak up guardian for the trust and the services they offered.

The staff survey from summer 2022 also listed experience of discrimination, abuse, bullying and harassment as one of the main priorities for the trust. Staff we spoke with said they were not clear on any action being taken to address these concerns. However, the service manager shared with us the pieces of work that were underway to address the findings of the staff survey. Managers had visited each unit and staff group to discuss these results face to face and set out individual work plans to address the issues. These activities included: workshops on enablement, compassion toward each other, patient safety and culture change.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that management did not always have a good oversight of ward-based performance and risk.

We found that out of 140 staff across the service, only 42 staff members were in date with their supervision. Managers across the service were not able to provide adequate support to staff through regular supervision, appraisals and team meetings and did not have effective oversight of this. Supervision can provide an important means for staff to discuss any issues in their work and development needs. Considering the high number of staff who had experienced or continued to experience harassment and bullying, we were concerned that the lack of individual support may make it difficult for staff to raise concerns such as these internally. Following inspection, we issued the trust with a Section 29A Warning Notice requiring them to make significant improvement in this area.

Long stay or rehabilitation mental health wards for working age adults

We reviewed seven weeks' rotas between September and October 2022 and found that staffing levels often did not meet the trust's own safer staffing plan. Despite senior managers being aware of staffing concerns it did not appear that robust action had been taken to address shortfalls effectively.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but did not always use that information to good effect.

We found that audits across the wards were not carried out regularly and effectively. We found examples where audits had been duplicated across different dates and where actions for improvement were not clear once an audit had been completed. There were gaps in the completion of audits across all wards and most of these gaps spanned two to three months. We found no evidence to show that findings from audits were regularly discussed or reviewed to ensure the ongoing performance of the service.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The trust engaged in local and national audits to measure their performance against other providers and seek improvement. For example, the trust carried out audits in prescribing high dose and combined antipsychotics and around their physical health assessment policy.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Managers engaged widely with colleagues internally within the Steps to Recovery service, and also with organisations external to the trust that were key to the patient care that was delivered. For example, we saw that services had good links with local housing associations, local authorities, social care teams and some voluntary organisations that provided work opportunities for patients on the wards.

Learning, continuous improvement and innovation

The ward manager for Hertford House had recently partaken in a peer review of another ward in the Steps to Recovery service. They audited care plans and shared learning from incidents and complaints and any changes on the wards as a result. Wards supported each other with a peer review every six months and this helped the improvement of the ward and development of the manager as well.

Forensic inpatient or secure wards

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean, well equipped and well furnished. However, they were not always well maintained or fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas but did not always remove or reduce any risks they identified. Environmental and ligature risk assessments were comprehensive and up to date and accurately identified risks. However, staff did not always mitigate the risks they identified. We saw that the laundry room on Avon ward had exposed pipework, which posed a ligature risk. This room had been identified on the ward ligature risk assessment but had not been assigned a risk score. The ligature risk assessment stated that the laundry was kept locked when not in use and patients could only have supervised access. However, the laundry was unlocked when we visited the ward. Staff were not adhering to the risk management plan documented as they told us the laundry remained unlocked during the daytime and the area was supervised by the staff member who was present in the communal areas.

New doors had been installed on Citrine ward in July 2022 and the anti-barricade mechanism on these doors operated differently to the previous doors. The trust security team had assessed the competency of 16 members of staff to ensure they were able to operate these doors. We reviewed training records and found that seven of the 16 staff had been identified as requiring further assessment, as they had been unable to successfully open the doors. We observed that staff could not always easily operate the doors on Citrine ward during our inspection. Although staff tested the anti-barricade mechanism of these doors regularly, we were concerned that this could lead to delays in staff being able to access patient bedrooms in an emergency. Managers had identified this issue on the risk register and had planned for the security team to deliver further training to staff.

Staff could observe patients in all parts of the wards. Managers allocated a staff member to observe the communal areas on each ward, for every shift.. The staff member was always present in the communal area and positioned themselves so that they could see all parts of the ward. We saw that staff appropriately monitored communal areas during our inspection.

The wards complied with guidance and there was no mixed sex accommodation. Reaside and the Tamarind Centre only had male wards. Ardenleigh was a female service but also had a mixed sex forensic Child and Adolescent Mental Health Service (CAMHS). There was only one female admitted to the CAMHS service at the time of our inspection. Staff ensured that the young person had access to their own lounge, kitchen, and outdoor areas. Their bedroom was located on a separate ward to the males. The two wards were linked by a central staff office and staff worked across both wards. However, staff ensured that the female young person could still socialise and access activities with their male peers.

Forensic inpatient or secure wards

Staff had easy access to alarms and patients had easy access to nurse call systems. Each staff member had an alarm and there were enough alarms on the ward for staff and visitors. Staff members were assigned to respond to alarms during each shift. Most staff members told us that staff responded quickly enough to alarms. However, one staff member who worked at Ardenleigh told us that there had been one occasion where staff did not respond quickly enough when they activated their alarm during an incident. There were four reported incidents where staff had failed to respond to alarms between March and September 2022, with three of these happening at Ardenleigh. Patients did not routinely have access to fixed nurse call systems in their bedrooms, however staff used risk assessments to identify patients who were vulnerable and gave these patients mobile call systems. Patients could also ask staff for a mobile call system if they wished to.

Maintenance, cleanliness and infection control

Ward areas were clean and well-furnished but were not always well maintained or fit for purpose. Cleaners visited the ward every day and maintained daily cleaning records. Nursing staff completed daily cleaning of high touch areas. Wards at the Tamarind centre were modern, spacious and well decorated. However, Reaside and Ardenleigh were older buildings and wards were in need of redecoration. Wards at Reaside had narrow corridors and a lack of natural light. Patients had to use communal bathroom facilities at Reaside as there were no ensuite bathroom facilities. We saw that there was evidence of recurring damp in some of the ward bathrooms on Avon ward. Senior managers were aware of the limitations of some buildings within the trust, such as those at Reaside, and were considering how best to invest in the redevelopment of these areas.

Staff followed infection control policy, including handwashing. Staff were bare below the elbow and were aware of the current guidance on wearing personal protective equipment (PPE). PPE and hand sanitiser was available at the entrance to each ward.

Seclusion room

Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. Each seclusion room had ensuite bathroom facilities with anti-ligature fittings. All areas of the seclusion room could be viewed through a viewing panel and CCTV.

However, staff sometimes had to seclude patients in their bedrooms, if the seclusion room was in use. We reviewed incidents that occurred between March and September 2022 and found there were 10 occasions where patients on Severn ward had been secluded in their bedrooms. Bedrooms on this ward did not have ensuite bathrooms, so staff had to support patients to use the communal bathroom facilities when they were in seclusion. One staff member told us that a patient had injured a member of staff during an incident that had occurred whilst escorting a secluded patient to the bathroom. Managers told us they only secluded patients in their bedrooms as a last resort.

Clinic room and equipment

Clinic rooms were not always fully equipped. Most clinic rooms were well equipped but the clinic room on Coral ward was very small and had limited work surface space for staff to safely prepare and manage medicines. Clinic equipment such as scales and blood pressure monitoring devices were stored in a separate room. Due to limited space, staff had to complete patient psychical examinations in their bedrooms.

Staff checked, maintained, and cleaned most equipment. Clinic rooms had accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked clinic room temperatures every day and kept a record of

these. An automated system was in place to check the temperature of the clinic room fridge and an alert was sent to managers if the temperature went out of range. Although clinic rooms were clean, we found that the clinic room on Blythe ward was untidy and disorganised. We found urinalysis strips that had expired on 30 September and an overfull clinical waste bin. Another clinical waste bin had been awaiting collection for eight days when we visited the ward.

Safe staffing

The service did not have enough nursing staff. Not all staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. We reviewed rotas for 16 wards from 29 August 2022 until 23 October 2022 and compared staffing levels with the service's safer staffing plan. These showed that each ward regularly had shifts where there were not enough qualified nurses. During this period the wards required a total of 6608 qualified nurses to fill shifts, but we found 1141 (17%) of qualified nurse shifts were unfilled. Sycamore ward had the highest number of unfilled qualified nurse shifts in this period, with 139 out of 168 (83%) of qualified nurse shifts unfilled. This was followed by Citrine ward, where 124 out of 168 (74%) of qualified nurse shifts were unfilled. Over 60% of shifts on Severn, Laurel and Myrtle wards did not have enough qualified nurses. Lobelia ward had the lowest number of unfilled qualified nurse shifts, with 21 out of 168 shifts unfilled (13%). Some wards had overfilled their healthcare assistant shifts to try and reduce the impact of the lack of nurses, however 88% of shifts on Sycamore and 47% of shifts on Kennett ward did not have enough healthcare assistants. Following inspection the trust provided further data to demonstrate that a qualified nurse was always available to support the wards but we remained concerned that the trust's safer staffing levels were not consistently met.

Although managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift, wards did not always have the correct skill mix. Managers reviewed staffing levels across each site at a daily safety huddle meeting and moved staff to cover wards with the highest level of need. The service had a staffing contingency plan which outlined the action that staff and managers should take when staffing levels were low. For example, it outlined that ward managers and senior members of the nursing team would cover qualified nurse shifts when there were five or fewer qualified nurses on site. Each ward was required to have at least 1 qualified nurse on shift but despite these contingency measures, this did not always happen. We identified 68 shifts from 29 August 2022 until 23 October 2022 where there was no qualified nurse on shift. 27 of these occurred on Citrine ward and 11 on Myrtle ward.

Ward managers could not always adjust staffing levels according to the needs of the patients. Although ward managers could request additional staff from the site manager, this was not always enough to cover the staffing shortfall on the ward.

The service had high vacancy rates. We reviewed the vacancy rates for each of the 16 wards we visited, as of September 2022. Wards at Ardenleigh had the highest overall vacancy rates out of all forensic and secure wards at 23%. Tourmaline ward had the highest vacancy rate of 29%, followed by Pacific ward at 28%. Pacific ward was a forensic CAMHS ward at Ardenleigh. Managers told us that the ability to fill CAMHS vacancies was impacted by the CAMHS service being co-located with the women's service, as CAMHS staff were regularly asked to work on the women's wards. The service planned to advertise rotational nursing and healthcare assistant posts, to give staff the opportunity to gain experience of working across both the CAMHS and women's wards. Managers at Ardenleigh had stopped all new admissions in June 2022 due to the high number of vacancies and low staffing levels. Most wards started to admit patients again in October and November 2022, but managers told us that Citrine ward would not accept new admissions until January 2023.

Forensic inpatient or secure wards

The service had high rates of bank nurses and healthcare assistants. We reviewed bank and agency usage for each of the 16 wards we visited and found that on average 70% of all shifts in this period were filled by bank staff. Agency nurse were rarely used across the service, although they were sometimes used at Ardenleigh. The use of agency nurses had increased on Coral ward from 11% in July to 15% in September. Managers requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. They used an induction checklist to ensure that bank and agency staff knew key information about patients and ward procedures.

The service had high turnover rates. The average turnover for forensic and secure wards was 11% as of September 2022, but the turnover for some wards was much higher than this. For example, staff turnover on Blythe ward had increased from 13% in April 2022 to 20% in September. Acacia and a turnover rate of 25% and Coral had a turnover rate of 26% in September 2022.

Managers supported staff who needed time off for ill health. Managers kept in contact with staff who were off work and referred them to the occupational health team when required.

Levels of sickness were high. The average sickness rate was 9% as of September 2022 but was as high as 17% on Avon ward. The sickness rate for Avon had peaked at 20% in June 2022. Reasons for sickness varied but included work-related stress and COVID-19.

Patients often had their escorted leave or activities cancelled, due to low staffing. We reviewed data provided by the trust regarding patient leave that was cancelled between April and September 2022, but this did not clearly show the reasons why leave had been cancelled or which wards the cancellations related to. For example, the data showed 40 occasions where leave had been cancelled because the patient had not used it, but it did not state why the patient had not used their leave. There were a further 35 occasions where leave was cancelled but no reason was recorded. However, patients and staff told us that escorted leave and recreational activities were regularly impacted by low staffing levels. Staff tried to ensure that therapeutic activities went ahead and patients told us that they had regular one to one sessions with their named nurse.

The service had enough staff on each shift to carry out any physical interventions safely. Managers ensured there were enough staff allocated to carry out patient observations and to respond to emergencies. This was reviewed in the daily safety huddle meeting.

Staff shared key information to keep patients safe when handing over their care to others. Most wards used a handover tool which was on the electronic system. The handover included key information about patient risk, observation levels and incidents. Staff told us that the handovers were detailed and useful.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Staff discussed the medical cover for the day during daily safety huddle meetings. The service had a 24 hour on call medic rota and managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training courses included basic and immediate life support, safeguarding, Mental Capacity Act, clinical risk assessment and

equality and diversity training. All staff were required to complete Approaches to Violence through Effective Recognition and Training for Staff (AVERTS) on induction. This was a five-day course, and staff were then required to complete an annual one day refresher course. All staff were required to complete See Think Act training as part of their induction, which informed staff about the importance of maintaining relational security on secure wards. Relational security is the knowledge and understanding that staff have of patients. An important part of relational security is the ability for staff members to maintain professional boundaries whilst maintaining a therapeutic relationship.

Staff did not always complete and keep up-to-date with their mandatory training. We reviewed mandatory training compliance for each for the 16 wards we visited. Although the overall training compliance rate was 94%, compliance was significantly lower for some training courses. The overall training compliance for emergency life support training was 74%. All healthcare assistants were required to complete this course, and qualified nurses were required to complete the higher level immediate life support training course. Six wards had a compliance rate of 68% or below for emergency life support. The compliance rate was lowest on Dove ward, where only six out of 13 staff (46%) were up to date with their emergency life support training. However, 89% of all qualified nurses were up to date with their immediate life support training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received an automated email when their training was due. Staff told us that they had enough time to complete their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 20 patient records and saw that each patient had a risk assessment in place. We saw that most of these were detailed and had been regularly updated. However, one patient's risk assessment had not been reviewed for three years and had not been updated when they had moved wards.

Staff used a recognised risk assessment tool. Staff used the trust's risk assessment tool on the electronic patient care record system.

Management of patient risk

Staff identified and responded to any changes in risks to, or posed by, patients. Staff reviewed patient risk during daily safety huddles and regular multidisciplinary team meetings. We observed that staff shared essential information about patients and incidents that had occurred during a safety huddle meeting at Ardenleigh. This was attended by managers and members of the multidisciplinary team for all wards. Staff reviewed patient observation levels following incidents or changes in their level of risk.

Staff followed procedures to minimise risks where they could not easily observe patients. There were blind spots in some ward areas. Mirrors had been installed where there was no clear line of sight and a staff member was always present to observe patients in communal areas to minimise risk. There were plans to install CCTV in some communal areas at Ardenleigh.

Forensic inpatient or secure wards

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff complied with the trust's patient search policy to manage the risk of contraband items entering the ward. The policy required staff to search patients in medium and low secure settings every time they returned to the hospital after going on unescorted leave. We reviewed a sample of search records from July 2022 to September 2022 and saw that staff did this. Staff searched patients' bedrooms at least once a month and increased the frequency of patient and bedroom searches as needed.

Use of restrictive interventions

Levels of restrictive interventions were high. We reviewed trust restrictive practice data collected between April and September 2022. There were 141 episodes of seclusion on forensic and secure wards during this period. The use of seclusion was highest on Severn ward, which had 28 episodes of seclusion in this period, followed by Citrine ward (26) and Sycamore ward (25).

Coral ward had the highest number of episodes of restraint and rapid tranquilisation, 129 out of a total of 312 episodes of restraint (41%) occurred on Coral ward. Forty three out of 58 episodes of rapid tranquilisation (74%) occurred on Coral ward. However, there was an overall decrease in the use of rapid tranquilisation on secure and forensic wards, with 296 episodes of rapid tranquilisation were recorded between June 2020 and May 2021, compared with 116 episodes between June 2021 and May 2022.

Each ward had its own list of blanket restrictions. There were some blanket restrictions that applied across all of the forensic and secure wards. For example, staff searched all patients when they returned from unescorted leave and patients could only access takeaway food once a month. This was to promote healthy eating. Restrictions were displayed in communal ward areas and staff and patients regularly met to review these.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. For example, Sycamore ward had promoted the use of sensory items on the ward by having staff who were sensory champions and had developed a new sensory room. The aim of this was to provide early support to patients, to reduce the need for restrictive practices. Staff at Ardenleigh had participated in a quality improvement initiative to develop sensory self soothe boxes for patients, which contained individualised items to help to reassure patients when they were anxious or distressed.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We saw evidence of this in the patient care records we reviewed and staff we spoke with had a good understanding of de-escalation techniques. Staff understood the Mental Capacity Act definition of restraint and worked within it.

Generally, staff followed NICE guidance when using rapid tranquilisation. However, we found that staff on Coral ward had not monitored one patient's physical health after rapid tranquilisation was used. We raised this with the ward manager and lead pharmacist, who had noted that staff did not always monitor this within a recent audit. We saw that managers had reminded staff about the need to complete post rapid tranquilisation monitoring in staff meetings.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We reviewed seclusion records for four patients. Each patient had a detailed seclusion care plan in place which outlined what needed to be achieved for seclusion to end. Nursing and seclusion reviews were carried out in line with the code of practice for three patients. However, we saw that there had been four occasions between 1 September and 7 October 2022 where there were not enough nurses to complete the 2 hourly reviews. Staff had reported these as incidents.

Forensic inpatient or secure wards

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. Data provided by the trust showed that there had been four episodes of long term segregation between April and September 2022, related to two patients. We reviewed a recent episode of long term segregation for one of these patients and saw that staff had developed an appropriate care plan in conjunction with the patient, their family and the external care coordinator.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had training on how to recognise and report abuse.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff were required to complete safeguarding children's and adults training. The level of training required varied depending on staff roles.

Not all staff kept up-to-date with their safeguarding training. Over 95% of staff had completed safeguarding children and adults training to level 2. However, compliance with safeguarding level 3 training was low on some wards. Level 3 safeguarding adults training was as low as 50% on Dove and Swift wards, 33% on Kennett ward and 25% on Trent ward, where only one out of four eligible staff had completed safeguarding adults levels 3 training.

Only one out of four eligible staff (25%) were up to date with their safeguarding children level three training on Severn ward, and one in three were up to date on Trent ward. Training compliance was 67% on Pacific ward.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Ninety-eight per cent of staff had completed equality and diversity training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff on the forensic CAMHS wards worked closely with external social workers to support young people who were on child in need or child protection plans.

Staff followed clear procedures to keep children visiting the ward safe. Visits with children took place in designated visitor rooms off the wards and were supervised by staff. Staff considered whether visits were in the best interest of the child or young person.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had made 10 safeguarding referrals in the past 12 months. Three of these were for children and young people, 7 were for adults. Staff told us that they felt confident about how to make a safeguarding referral and could describe the process. Managers in the CAMHS service had monthly safeguarding supervision sessions with the children's safeguarding lead in the trust. Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. Staff used several different electronic systems to record patient notes. All staff, including bank and agency staff had access to these systems and could find the information they needed. When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely.

Forensic inpatient or secure wards

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed medicines records accurately and kept them up-to-date. Staff used an electronic prescribing system. We reviewed 25 prescription records and saw that these were accurate. We noted that staff recorded patient weights in separate electronic systems, this meant that staff had to use both systems to safely prescribe medicines. However, staff were able to navigate both systems to find the information they needed. Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff reviewed patient records during regular multidisciplinary team meetings, which were well attended by doctors and pharmacists. Staff involved patients in these meetings.

Staff generally stored and managed all medicines and prescribing documents safely. Most clinic rooms we visited were well organised, clean and clear. However, the clinic room on Blythe ward was messy and the clinic room on Coral was very small and had limited counter space to safely prepare medicines.

Staff learned from safety alerts and incidents to improve practice. For example, we saw that the monitoring of patients' routine physical observations had improved on Coral ward, after this was raised as an issue by the ward manager at team meetings. The ward manager and ward pharmacist continued to work with staff on Coral ward to improve the monitoring of patients' physical health following the use of rapid tranquilisation.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Medicines were administered within British National Formulary (BNF) guidelines. However, staff did not always record the reasons for giving 'as required' medicine. We found that staff had regularly administered 'as required' medicines to three patients on Coral ward and one patient on Citrine ward but had not recorded the reasons why the medicine had been administered.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff regularly checked patient's physical health when they received high doses of antipsychotic medicines. However, we saw that staff had not monitored one patient's physical health on Coral ward after the use of rapid tranquilisation. We discussed this with the medical lead, who informed us that a recent audit had found that staff were not regularly recording patients' physical health observations following rapid tranquilisation.

Track record on safety

The service did not have a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Forensic inpatient or secure wards

A total of 2634 incidents were reported between March and September 2022. The most common incident category was assaults, violence and harassment, this accounted for 544 (21%) of all incidents. This was followed by self-harm and patient behaviour, which accounted for 530 (20%) of all incidents. Most incidents occurred at Ardenleigh, with 1051 (40%) of all incidents taking place on the blended women's service and 574 (22%) of all incidents taking place on the forensic CAMHS wards.

There had been four serious incidents between April and September 2022. All of these had occurred at Ardenleigh. The trust had completed investigations into two of these incidents, with investigations ongoing for the other two incidents. Staff reported serious incidents clearly and in line with trust policy.

Staff knew what incidents to report and how to report them. Staff knew how to report incidents using the trust's electronic incident reporting system. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff informed and involved patients and families when they completed investigations into serious incidents and provided them with feedback.

Managers debriefed and supported staff after any serious incident. Staff told us that managers and the psychology team offered support following incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. For example, we saw that staff had involved a patient's family in their investigation into a serious incident and had arranged for a family support worker within the trust to provide emotional and practical support.

Staff did not always meet to discuss feedback from investigations of incidents, or look at improvements to patient care. Staff discussed incidents in team meetings and reflective practice sessions, however these did not happen regularly on most wards due to low staffing levels.

There was evidence that changes had been made as a result of feedback. For example, there had been a serious incident at Ardenleigh where a patient had absconded from the service. A review into this incident had found that staff had not correctly engaged the lock in the security gate. Since this incident, the security team had increased their manual checks of all gates across the site.

The anti-barricade doors on Citrine ward had been replaced following a patient death. However, we were not fully assured that all staff were able to easily operate the new doors.

Is the service effective?

Requires Improvement  

Our rating of effective stayed the same. We rated it as requires improvement.

Forensic inpatient or secure wards

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements..

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed 20 patient care records, each of these showed that a mental health assessment had been completed upon admission.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff assessed patients physical health on admission and monitored physical health on a regular basis. Staff clearly recorded occasions where patients had declined a physical health check.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were holistic, personalised and recovery-orientated. Care plans reflected patients individual needs, risks and preferences. Patients were involved in the creation of their care plans. Each of the care records we reviewed contained a clear and detailed management plan. Staff regularly reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance. The forensic and secure service used the SCALE model of care, this focused on stabilisation and gradually supporting patients to achieve goals and working towards planning their discharge. The Forensic CAMHS service had recently developed a new model of care called the Encompass model. This was similar to the SCALE model but was specifically tailored for children and young people. Patients had access to a range of therapies that reflected their needs. Available therapies included dialectical behaviour therapy, trauma informed care and art and music therapies. Patients also had access to education, woodwork and sporting facilities.

Staff in the CAMHS service delivered a specific programme of 1:1 and group sessions for the young people, such as a life skills group, a transition group for young people who were due to move into adult services and a group focused on preparing for section 17 leave. The CAMHS service had a school onsite, which the young people attended daily. The occupational therapy team worked with young people and the school to develop adapted timetables for some young people.

Staff in the CAMHS service had worked with young people to develop an enrichment timetable during the school holidays, to complete projects that the young people were interested in. For example, they had completed a cultural project where young people delivered presentations about cultures they had researched.

Staff identified patients' physical health needs and recorded them in their care plans. We saw evidence of this in the records we reviewed. Staff made sure patients had access to physical health care, including specialists as required. Staff supported patients to attend health appointments and to access specialist health services, such as neurology.

Forensic inpatient or secure wards

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. Specialist diets were available for patients with specific dietary and cultural needs. Staff referred patients to dieticians and speech and language therapists for additional assessment when this was required.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, staff in the CAMHS team ran a healthy bodies group, which provided support and advice to young people about puberty.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, staff used the Health of the Nation Outcome Scale (HONOS) to measure the health and social functioning of patients with severe mental health needs.

Staff used technology to support patients. Staff used electronic tablets to record patients therapeutic and physical observations.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Ward managers and matrons completed regular audits in areas including room searches, therapeutic observations, seclusion reviews and infection prevention and control. Staff had taken part in various quality improvement initiatives including reducing restrictive practice, improving the experiences of patients with sensory needs and improving the discharge planning across the women's blended secure service.

Managers used results from audits to make improvements. For example, managers completed a monthly 'sharps' audit to check that the allocated staff member was completing daily checks of sharp items on the ward. We reviewed the sharps audit completed in September 2022 on Lobelia ward, and this identified that some checks had been missed. We saw that the manager had emailed the staff team to remind them to complete all checks. Ward managers also completed infection prevention and control audits and discussed the results of these with staff during team meetings.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. Managers provided an induction programme for new staff and opportunities for staff to update and further develop their skills. However, managers did not always support staff with supervision.

The service had access to a full range of specialists to meet the needs of the patients on the ward. Each multidisciplinary team consisted of a variety of professionals including psychiatrists, occupational therapists, psychologists, and nurses. However, members of the multidisciplinary team told us that they sometimes had to support nurses on the ward due to low staffing and high vacancies. They also told us that low staffing impacted on nursing staff's ability to engage in meaningful activities with patients.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. Staff received a detailed security induction which covered physical procedural and relational security and key training. Managers completed a local ward induction checklist with new members of staff. Staff told us that they had felt well supported during their inductions to the ward.

Managers supported staff through regular, constructive appraisals of their work. Eighty six per cent of staff on forensic and secure wards and 89% of staff on forensic CAMHS wards had received their annual appraisal. However, only 15 out of 24 staff on Blythe ward had received their annual appraisal.

Managers did not always support staff through regular, constructive clinical supervision of their work. The average clinical supervision compliance rate for all secure and forensic wards was 58%. The lowest compliance rate was on Avon ward at 25%, only four out of 16 staff working on this ward were up to date with their clinical supervision. Staff also had limited access to managerial supervision, the average managerial supervision compliance for all secure and forensic wards was 38%. Following our inspection, we issued the trust with a Section 29A Warning Notice under The Health and Social Care Act 2008, requiring them to make significant improvement in this area.

We saw that staff on Cedar, Lobelia and Sycamore wards had regular reflective practice sessions and were able to attend regular reflective practice sessions led by psychology.

Managers did not always ensure staff attended regular team meetings. Ward managers told us that team meetings were sometimes unable to go ahead due to low staffing levels. We reviewed team meeting minutes for several wards and found that these did not always take place regularly. For example, Hibiscus ward were supposed to have a weekly team meeting but only four team meetings took place between December 2021 and August 2022. Team meetings were supposed to take place monthly on Coral ward but there had not been a team meeting since June 2022. No team meeting took place on Trent ward between February and July 2022.

However, staff told us that managers sent them emails with important updates and they received essential information during daily handover meetings. We saw that the ward manager on Avon ward sent a monthly email to staff members to provide important updates.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, we saw that Cedar ward had a monthly staff development session, where managers delivered bitesize training sessions to staff on topics such as information technology. Managers on Pacific ward had supported several staff to complete the nursing associate course. Staff told us that they had opportunities to progress. Managers recognised poor performance, could identify the reasons and dealt with these.

Managers made sure staff received any specialist training for their role. Specialist training for staff working on forensic and secure wards included key training, DBT awareness, therapeutic boundary training and trauma informed training. Staff in the CAMHS service had access to various specialist training courses including child development and working with families. All new staff members were required to complete training on relational security.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Some wards had several multidisciplinary meetings per week as patients were assigned to different clinical teams, based on the location of the GP surgery. Healthcare assistants on some wards told us that they did not attend the multidisciplinary meetings but got feedback during handover meetings and by email. We observed two multidisciplinary meetings and saw that these were well attended by different disciplines, and that patients were involved in these where appropriate.

Forensic inpatient or secure wards

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Some wards used a structured handover tool which covered patient risk, physical health and tasks that needing completing during the shift. Staff we spoke with told us that they got clear information during handover meetings. Staff members were allocated at each handover to complete security checks, including anti-barricade door checks, and checks of sharp items stored on the ward.

Ward teams had effective working relationships with other teams in the organisation. Staff regularly worked across all forensic and secure sites to cover staffing shortages. Staff had good links to the forensic intensive recovery support team (FIRST). This team was based at Reaside and aimed to support timely discharge and to prevent re-admission.

Ward teams had effective working relationships with external teams and organisations. The forensic CAMHS wards had good links to the local authority social services team. A local music production company also delivered weekly sessions for young people. Staff at Ardenleigh worked closely with a local charity which offered support to patients in the women's service, and we observed that a representative from the charity was present during a multidisciplinary meeting. The service also had close links with the police. For example, a police liaison officer visited ward teams regularly as part of an initiative to encourage staff to report incidents of assault from patients to the police.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Ninety six percent of staff on forensic and secure wards were compliant with this. All staff who worked on Forensic CAMHS wards were up to date with their Mental Health Act training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Information about advocacy was displayed in communal ward areas. Advocates visited wards regularly and patients knew how to access them if they needed to.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We saw evidence of this in the patient records we reviewed.

Staff did not always ensure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician or with the Ministry of Justice. Data showed that section 17 leave was regularly cancelled between April and September 2022, however the data did not clearly show the reasons why leave had been cancelled or which wards the cancellations related to. However, staff and patients told us that access to leave was impacted by low staffing levels. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Copies of these were saved within patients' electronic records and were easily accessible.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. Patient records showed evidence that section 117 aftercare arrangements were discussed with patients during review meetings, where this was relevant.

Managers and staff made sure the service applied the Mental Health Act correctly by completing monthly audits and discussing the findings. For example, The Mental Health Act audit completed for Reaside in September 2022 identified that one patient had not been read their Mental Health Act rights on admission on Avon ward. Managers raised this with the Avon ward team.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received, and were consistently up-to-date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. Ninety-five per cent of staff on forensic and secure wards were compliant with this. All staff who worked on Forensic CAMHS wards were up to date with their Mental Capacity Act training.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We reviewed a mental capacity assessment for a patient on Blythe ward in relation to managing finances, that this was detailed and staff had maximised the opportunities for the patient to make their own decision before concluding that they lacked capacity.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Each patient had a consent to treatment form in their medical records. Staff completed mental capacity assessments when these were required for specific decisions.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. For example, staff had found that a patient on Blythe ward lacked capacity to manage their finances. The patient had become increasingly concerned that people were accessing their finances, and this was causing them distress. Staff had considered whether the patient had any family who could support with this. As they did not, they referred the patient to the local social work team, for further support.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. Staff completed monthly audits of the Mental Capacity Act. We reviewed audits completed at the Tamarind Centre and Reaside for September 2022. The Tamarind centre scored 100% on their Mental Capacity Act audit in September 2022. However, audits completed at Reaside identified issues with Mental Capacity Act compliance for two patients on Blythe and one patient on Avon ward. Managers discussed the outcome of the audits with these teams.

Forensic inpatient or secure wards

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it. Patients said staff treated them well and behaved kindly. Most patients we spoke with told us that staff were kind, supportive and understanding. We observed staff and patient interactions and found staff to be knowledgeable about patients' individual needs and were compassionate.

However, on Citrine ward we observed that staff had allowed two patients to display posters with nicknames on their bedroom doors. Staff told us that the patients had chosen these, but we felt that the nicknames were inappropriate and could impact on the boundaries between staff and patients. We raised this with the hospital manager and the posters were removed.

Staff supported patients to understand and manage their own care treatment or condition. One patient told us that staff had responded in a fair and proportionate way when they had absconded, and had worked together with them to agree a plan to gradually increase their leave.

Staff directed patients to other services and supported them to access those services if they needed help. Patients told us that staff had helped them to access advocacy.

Staff understood and respected the individual needs of each patient. For example, a patient on Dove ward told us that staff had respected their sensory needs and had provided specialist sensory equipment to support their wellbeing.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. One patient told us that staff had supported them to report an incident to the police when they had been assaulted by another patient. The local police had also worked with staff to increase their reporting of assaults they experienced from patients.

Staff followed policy to keep patient information confidential. Ninety five percent of staff were up to date with their information governance training.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Forensic inpatient or secure wards

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff showed patients around and provided them with written information about the ward.

Staff involved patients and gave them access to their care planning and risk assessments. Patients told us that staff involved them in their care planning and involved patients in meetings when this was appropriate. We saw evidence that patients were offered a copy of their care plan in the records we reviewed.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). For example, staff on Coral ward ensured that an interpreter attended multidisciplinary team meetings to support a patient to understand their care and treatment.

Staff involved patients in decisions about the service, when appropriate. For example, staff and patients at the Tamarind Centre had worked together to develop a radio podcast, which gave patients the opportunity to understand and discuss barriers to discharge. Staff and patients met regularly to discuss and review blanket restrictions that were in place on each ward. Patients we spoke to were aware of the restrictions that were in place, such as those around vaping and takeaways, and understood why these were needed.

Patients could give feedback on the service and their treatment and staff supported them to do this. The Trust used the Friends and Family Test to collect feedback on patient and carers' experiences of using the service. We reviewed feedback collected for patients between October 2021 and September 2022. 79 per cent of 122 respondents gave positive feedback about their experience of forensic and secure wards, 7% gave negative feedback and 15% gave neutral feedback.

Staff supported patients to make advanced decisions on their care. We saw that staff had accurately recorded a patients advanced decision in one record we reviewed.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Staff invited carers to review meetings, with the consent of patients. The service held family and carer days where they could visit the service and meet staff. Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment. For example, we saw that staff had identified that a carer for a patient on Sycamore ward required support and had referred them for a carers assessment.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Forensic inpatient or secure wards

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' moves to another inpatient service or to prison. As a result, patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Managers and staff worked to make sure they did not discharge patients before they were ready.

The service had high out-of-area placements. The CAMHS service provided beds for children and young people throughout the country and therefore some patients were placed far away from their homes. However, the service worked well with patients' home teams to try and identify services in patients' local areas that they could be discharged to.

When patients went on leave there was always a bed available when they returned. Staff kept patients' bedrooms available when they went on leave to their future discharge placement.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. For example, the women's service was part of a blended service pilot and provided care to patients who needed low or medium secure care. This aimed to reduce the number of moves needed before discharge.

Staff did not discharge patients at night or very early in the morning. Staff planned discharges carefully with patients and other professionals to avoid this.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. We reviewed delayed discharge data for the forensic and secure and forensic CAMHS wards that we visited between October 2021 and September 2022. Cedar ward had the highest number of delayed discharge days at 710 days. Seventeen patients on this ward had been affected by delayed discharge during this period. However, despite these delays, Cedar ward had four successful discharges over the past 12 months and one patient was on trial leave to their discharge destination.

The forensic CAMHS wards had two delayed discharges but one patient had a planned discharge date and staff were in regular contact with the community teams involved with the other patient.

Patients sometimes had to stay in hospital when they were well enough to leave. Thirty out of 104 (29%) patients whose discharge was delayed between October 2021 and September 2022 were awaiting suitable accommodation. This was the reason for the delayed discharge for 12 out of 17 (71%) patients on Cedar ward.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff supported patients when they were referred or transferred between services. For example, one patient's discharge from the forensic CAMHS service had been delayed due to a COVID-19 outbreak at the identified placement. Managers had kept in regular contact with them throughout this period to minimise the delays to the patient's transition plan.

Forensic inpatient or secure wards

Staff invited external care coordinators to multidisciplinary team meetings and involved them in developing transition plans, to enable patients to visit their new placements prior to discharge. Patients were aware of their discharge plan and could tell us about this.

The forensic intensive recovery support team (FIRST) was a multidisciplinary team based at Reaside and had good links with other local providers. We saw that staff in this team supported patients on wards and regularly attended multidisciplinary meetings to support discharge planning.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. However, patients at Reaside did not have access to ensuite bathroom facilities. Senior leaders in the trust were aware of the limitations of the environment at Reaside and were considering how best to invest in the redevelopment of this site.

Each patient had their own bedroom, which they could personalise. For example, we saw that some patients had displayed artwork in their bedrooms. A patient on Coral ward had soft toys and some stationary in their bedroom, which had been agreed during multidisciplinary team discussions.

Patients had a secure place to store personal possessions. Patients had some storage in their bedrooms and staff stored excess toiletries and other belongings in locked storage rooms. Staff supported patients to access their belongings when they requested them.

Not all wards had a full range of rooms and equipment to support treatment and care that were accessible to staff and patients. We noted that wards at Reaside had limited therapy rooms, and staff told us that there was a lack of space for therapies and activities.

There were private telephone rooms on each ward where patients could make phone calls in private.

The service had quiet areas and a room where patients could meet with visitors in private. Patients met with visitors in designated visiting rooms on each site and staff supervised visits.

The service had an outside space that patients could access easily. Each ward had an outdoor space that patients could access. Some outdoor spaces were shared with other wards, and each ward had a rota system in place to allow patients to access these spaces safely.

Patients could make their own hot drinks and snacks. Most wards had facilities for patients to make hot drinks but patients on the intensive care wards had to be assisted by staff to use these safely.

The service offered a variety of good quality food. Most patients told us that food was of good quality, but two patients told us that sometimes menu options were not to their taste.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients on Myrtle ward had jobs allocated to them, such as keeping the drinks station clean, and they got paid for completing their jobs. This helped to prepare patients for discharge.

Staff helped patients to stay in contact with families and carers. Staff had supported a patient on Acacia ward to maintain contact with their relatives who lived abroad and ensured family were involved in their care and treatment. The service put on annual events for patients and carers. For example, the Tamarind Centre had recently organised an event where staff and patients had showcased their talents to family visitors.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. However, some wards at Reaside had narrow corridors and small bedrooms that would not be suitable for a wheelchair user and did not have accessible bathroom facilities. Managers on Severn and Trent wards told us that they worked with bed management to ensure that alternative beds were found for wheelchair users.

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us they had easy access to interpreters. We saw that staff had considered patients communication needs and used interpreters and communication aids to ensure they could be involved in community meetings on Coral and Sycamore wards.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Information about this was displayed in communal ward areas. Patients told us that they knew how to raise their concerns.

The service had information leaflets available in languages spoken by the patients and local community. Staff could request information to be provided in different languages via the trust intranet page.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Staff provided a range of meals to meet specific needs. We saw that occupational therapists supported patients to purchase ingredients and cook meals that reflected their cultural needs.

Patients had access to spiritual, religious and cultural support. Patients told us that staff respected their religious beliefs and they were able to access religious leaders. Patients could access multi-faith rooms to practice their religion.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Seventeen complaints were made by patients between April 2022 and October 2022, eight of these related to staff values and behaviours. Staff met with patients to to try and resolve complaints and provided patients with feedback. One patient told us that staff had apologised to them following a complaint they had made.

Forensic inpatient or secure wards

The service clearly displayed information about how to raise a concern in patient areas. Patients told us that they knew how to raise concerns. However, three patients told us that they did not feel able to raise concerns because they worried that this would affect their relationships with staff.

Staff understood the policy on complaints and knew how to handle them. Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers provided written feedback to patients following investigations into complaints and gave them the opportunity to discuss this.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care. Staff regularly nominated their colleagues for excellence rewards and displayed these. Managers discussed compliments they had received from patients and carers during community meetings.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff knew who the senior leaders in the service were, they told us that leaders were approachable, regularly visited the wards and engaged with patients. Ward managers told us that they felt well supported by the senior leadership team.

Staff told us that they had opportunities to develop in their leadership roles. Several staff members told us that they had been supported to progress to management positions.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

The trust's vision and values of committed, compassionate and inclusive, were displayed on the wards and staff knew what these were. The service had focused on how they could make the service more inclusive. Managers had recently appointed new clinical inequality leads and patient experience leads to improve patient engagement and reduce health inequalities.

We saw that staff in the forensic CAMHS service had developed their own ward values of loyalty, communication, respect and honesty at a team away day, to support a positive ward culture.

Forensic inpatient or secure wards

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us that they felt valued and were proud to work for the service. Staff told us that there was a positive culture and felt able to raise concerns to their managers or to freedom to speak up guardians within the trust. Some female staff members had raised concerns about sexual harassment, and we saw that senior leaders had responded appropriately to these concerns and had sent a letter to all staff to address this. The trust were also continuing to develop their strategy around addressing harassment and discrimination. Staff were aware of the initiative with the police to report patient assaults and were encouraged to do this. Staff had opportunities to develop, we saw that seven staff in the forensic CAMHS service were completing training to become nursing associates.

Ward teams worked well together and supported each other at difficult times. Staff celebrated success and good practice by nominating their colleagues for awards.

However, we were concerned that staff had not maintained appropriate boundaries with two patients on Citrine ward and had allowed them to display posters with inappropriate nicknames on them.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and performance and risk were not always managed well.

Managers attended regular governance meetings both within the service and the wider trust. They took part in regular clinical audits and acted when needed.

However, teams did not always meet to discuss learning from incidents as team meetings on most wards were irregular due to low staffing levels. Managers did ensure that staff received information about incidents in emails but the infrequency of team meetings meant that there was limited oversight and follow up of the actions discussed.

Although systems and processes were in place to monitor compliance with training and supervision, these were not always effective. We saw that compliance with training and supervision was low on some wards. There was not an effective system in place for ensuring that staff appropriately managed the ligature risk identified in the laundry room on Avon ward.

Whilst managers were aware of issues related to staffing, actions put in place to mitigate risks were ineffective as we found a number of shifts where there were not enough qualified nurses on duty.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Each building in the forensic and secure core service had its own risk register. The risks on these reflected the risks identified on the directorate risk register. The main concern raised by staff was about low staffing levels and high vacancies, this was recorded on the risk register as a high level risk.

Forensic inpatient or secure wards

The service had plans for emergencies. For example, it had a contingency plan which set out actions to be taken if staffing fell below 80%. Senior leaders reviewed issues relating to staffing and quality at monthly finance, planning and performance meetings. However, plans to mitigate these risks were not effective as staffing levels did not meet safer staffing guidelines on several occasions.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement initiatives. This included restrictive practice reduction, and projects to promote patient engagement and to reduce health inequalities.

Managers collected and reviewed data about performance, staffing and patient care.

Managers had access to dashboards that provided information about ward performance and staff made notification to external organisations, such as the police and CQC as needed.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff received information about the developments within the trust through the intranet and newsletters. Staff at Reaside had developed a trauma informed care newsletter to provide information and updates for patients.

Patients and carers had the opportunity to give feedback through annual surveys and engagement events. Staff also supported patients and carers to contribute to the service's podcast.

Learning, continuous improvement and innovation

Staff had opportunities to participate in research. For example, staff who worked in the women's service at Ardenleigh had completed a research project to evaluate the effectiveness of a ward-based occupational therapy model and staff at Reaside had completed an evaluation of a specific psychology group intervention.

Forensic and secure wards were accredited by the Quality Network for Forensic Mental Health Services. The forensic CAMHS service was accredited by the Quality Network for Inpatient CAMHS (QNIC) and the National Autistic Society.