Birmingham and Solihull Mental Health NHS Foundation Trust

Inspection report

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Date of inspection visit: 5/11/2018
Date of publication: 05/04/2019

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.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	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**

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.

Summary of findings

Background to the 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. Community mental health services for children and young people in Birmingham is provided by another NHS trust.

The trust has 17 locations registered with the CQC with 702 inpatient beds across 53 wards. The trust had 139 community clinics a week to support people and families with mental health problems.

The trust has an annual budget of £230 million and a workforce of around 4,000 staff.

Three clinical commissioning groups (CCGs), Birmingham Cross City, Birmingham South Central, and Solihull, work with the trust to commission mental health services. NHS England commission specialised mental health services and the trust works in partnership with a NHS Trust and an independent mental health provider to deliver secure care services regionally across the West Midlands.

The trust delivers the following mental health services:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Wards for older people with mental health problems
- Child and adolescent mental health wards
- Forensic inpatient/secure wards.

The trust delivers specialist mental health services including:

- Perinatal mental health services
- Eating disorder services
- Deaf mental health services
- Neuropsychiatry services
- Homeless primary care and mental health services.

The previous comprehensive inspection of this trust was in March 2017 and we rated the provider as requires improvement overall. At the time of our previous comprehensive inspection, there were 93 areas for improvement for the trust to take.

Summary of findings

There were eight breaches of regulation across the following core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Community-based mental health services for older people
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Wards for older people with mental health problems
- Child and adolescent mental health wards
- Forensic inpatient/secure wards.

These breaches related to the following regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations:

- Regulation 9 – Person-centred care
- Regulation 10 – Dignity and respect
- Regulation 11 – Need for consent
- Regulation 12 – Safe care and treatment
- Regulation 13 – Safeguarding service users from abuse and improper treatment
- Regulation 15 – Premises and equipment
- Regulation 17 – Good governance
- Regulation 18 – Safe staffing.

Following the inspection in March 2017, we monitored the trust action plans addressing the regulatory breaches, carried out focused inspections of some services and looked at documentary evidence to support that the breaches were met.

We carried out a focused inspection of specialist community mental health services for children and young people in January 2018, to see if the trust had carried out the necessary actions they were required to take. We found that the trust had made a number of improvements to address the issues contained in the regulatory breaches and the report was published in March 2018.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement

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What this trust does

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health services for people from the age of 16 years upwards in Birmingham and for all ages in Solihull

Summary of findings

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected five of the mental health services provided by the trust as part of our continual checks on the safety and quality of healthcare services.

We inspected the following core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Mental health crisis services and health-based places of safety
- Wards for older people with mental health problems
- Child and adolescent mental health wards
- Forensic inpatient/secure wards

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we also inspected the well-led key question for the trust overall. We summarise what we found in the section headed Is this organisation well-led?

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- The trust had made insufficient improvements since our last comprehensive inspection in March 2017. This is reflected in the ratings of the core services that we inspected at this most recent inspection. The ratings for two of these five core services have changed from good to requires improvement. This means that four of the trust's nine core services are now rated as requires improvement overall. We have also once again rated the safe and effective key questions as requires improvement for the trust overall.
- There were continued concerns raised by some staff from diverse backgrounds about the support they received and whether they were listened to. This was shown in the staff survey results from 2017.
- Many of the wards that we visited during this inspection had a shortage of permanent nursing staff. They relied heavily on agency and bank staff. This had an impact on the quality of patient care; including the adequacy of risk assessments of patients.

Summary of findings

- Staff consistently told us about a lack of consultation when the trust implemented a new model of working on acute mental health wards. The model integrated occupational therapists into the nursing teams on these wards. As a result, both disciplines could not carry out their basic duties. For example, occupational therapists had less time to carry out therapeutic activities with patients and there were delays in patients receiving medicines from nurses. This had an impact on the morale of staff.
- Managers did not ensure staff received appropriate professional support and supervision to carry out their duties effectively. Staff had difficulty accessing clinical supervision and there were problems in how managerial supervision was recorded.
- Some wards did not have fixed nurse call buttons in patients' bedrooms. Staff did not mitigate the risk this posed by assessing whether individual patients, who might be at risk or otherwise be vulnerable, should be provided with a portable alarm to request assistance if needed.
- Care plans were not always personalised, holistic or updated.
- Feedback from carers was not always positive regarding staff engagement and a response from concerns.
- Patients could not always access a mental health bed in a timely manner when in crisis. There were blocks in the wider health and social care system in accessing mental health assessments for patients in crisis.
- There continued to be problems with medicines management across the trust. Staff did not always follow best practice when storing, dispensing, and recording medication. Staff did not regularly review the effects of medications on each patient's physical health following the use of rapid tranquilisation.

However:

- The trust had improved the board assurance framework and risk register. It was now robust and clear. The trust leadership team had improved its cohesion. A plan for quality improvement to improve patient care and safety had started but required further work to embed across the trust. The trust leadership team had the necessary skills and experience to provide innovation and change. The trust had a good understanding of the wider health and social care economy, and were active in shaping local transformation plans.
- The trust had improved the way it searched patients across services. There was improved individual risk assessments of patients and staff rather than a blanket restriction for search. The trust has also removed blanket restrictions relating to takeaway food providers
- The trust had improved staff knowledge and application of the Mental Capacity Act across its services. 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 treated patients with compassion and kindness. They almost always respected patients' privacy and dignity, and supported their individual needs.

Are services safe?

Our rating of safe stayed the same. We took into account the previous ratings of services not inspected at this time. We rated it as requires improvement because:

- There were insufficient permanent registered nursing staff to meet the needs of patients. There was high use of bank and agency staff. We found that patients had to wait for treatment and activities. There was variation in the frequency and quality of risk assessments across the service.

Summary of findings

- Medicines management across trust services remained a problem. Staff did not always follow best practice when storing, dispensing, and recording medication. There were many recorded errors in practice. Staff did not carry out physical health checks consistently after administering rapid tranquilisation. Staff did not always record a discussion of the side effects of valproic acid/valproate with female patients to whom it had been prescribed.
- Not all staff felt safe across its services. Staff did not always have access to an alarm system or personal alarms to alert others in the case of an emergency.
- The Building Note relating to acute mental health wards states that 'Service user to staff system call points should be provided in spaces where a service user or attendee may be left alone temporarily, for example within service user bedrooms, en-suite WCs, disabled WCs and therapy or education areas'. Some wards did not have fixed nurse call buttons in patients' bedrooms. Staff did not mitigate the risk this posed by assessing whether individual patients, who might be at risk or otherwise be vulnerable, should be provided with a portable alarm to request assistance if needed.

However:

- The board, senior leaders and clinical staff had a shared understanding of the main risks to the trust.
- Since the previous inspection in March 2017, the trust had reviewed it policy and processes when searching patients. The trust had introduced systems that meant blanket restrictions in searching individual patients did not occur.
- Although figures for prone restraint were similar to the previous inspection in 2017, they were lower than comparable trusts. The use of restrictive interventions, such as restraint, was well managed and reviewed across trust services. Staff participated in the trust restrictive interventions reduction programme. Staff recognised incidents and knew when to report them.
- Staff understood how to protect patients from abuse and the trust worked well with external organisations when Reporting safeguard incidents.
- Wards and the team bases for community services were clean, well equipped, furnished and well maintained. There were environmental risk assessments in place and patients were kept safe. Staff followed infection control practice evident across all services.

Are services effective?

Our rating of effective stayed the same. We took into account the previous ratings of services not inspected at this time. We rated it as requires improvement because:

- Care plans across the trust were not always personalised, holistic or involved the patient. This is what we also found at the previous inspection in March 2017. They did not always meet the needs of the patient and were not always reviewed or updated in line with trust guidance.
- Staff did not have access to regular managerial and clinical supervision. The recording and reporting system for management and supervision and clinical supervision required improvement. Appraisal rates in some services did not meet the trust target. This meant that staff did not have the necessary time to reflect on their practice and career development.
- Following the introduction of a new model of working in mental health acute wards, staff raised concerns about the integration of occupational therapists into the ward staffing complement. This meant that occupational therapists had reduced capacity to effectively carry out their roles including undertaking activities with patients.
- Section 62 Mental Health Act paperwork was not always reviewed and referrals for a second opinion appointed doctor were not always completed on time.

Summary of findings

However:

- Staff across the trust had improved their knowledge and skills in the Mental Capacity Act and Gillick competence since the previous inspection in March 2017. Most services were compliant with the Mental Health Act and the Code of Practice. Patients' were read their rights when detained and were regularly updated.
- Physical health monitoring for patients with mental health problems was co-ordinated well across the trust. Patients were regularly reviewed by multidisciplinary teams and they were supported to live healthier lives. Care and treatment interventions were aligned to national best practice and guidance, and staff participated in regular audit.
- Staff had access to induction and training that supported their roles. Compliance across the trust was above 75% and regularly achieved the trust target of 90%.

Are services caring?

Our rating of caring stayed the same. We took into account the previous ratings of services not inspected at this time. We rated it as good because:

- Staff treated patients with compassion and kindness. Staff were caring and passionate about their roles. They respected patients and worked hard to ensure patients' needs came first. Staff ensured that patients had easy access to independent advocates.
- Staff across most services involved patients in care planning and risk assessments but this was not always reflected in the electronic healthcare records.
- The trust had embedded the 'See Me' programme and had improved patient involvement in planning trust services.

However:

- Staff had not ensured the confidentiality of confidential information in one older people's mental health ward.

Are services responsive?

Our rating of responsive stayed the same. We took into account the previous ratings of services not inspected at this time. We rated it as good because:

- The design, layout, and furnishings of the wards and most services supported patients' treatment, privacy and dignity. Patients had their own rooms where they could keep personal belongings safe. There were quiet areas for privacy and where patients could be independent of staff when risk allowed.
- Staff supported patients with activities outside the service, such as work, education and family relationships. This included access to the recovery college that was valued by patients. The service was accessible to all who needed it and took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support. The trust worked positively with ethnically diverse communities.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- When there was high demand for crisis services and beds in acute mental health awards, the trust could not always meet the needs of patients. There were delays in mental health assessments for people in the emergency departments at local acute hospitals and in health-based places of safety because of a lack of access to approved

mental health professionals. Some patients in the PDU were on occasion waiting over 24 hours for treatment. Bed occupancy rates in adult mental health wards were regularly over 100% and patients did not always have a bed to return to following leave. There was not always a bed available when patients required a psychiatric intensive care bed.

Are services well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

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

- The trust had made insufficient improvements since our last comprehensive inspection in March 2017. This is reflected in the ratings of the core services that we inspected at this most recent inspection. The ratings for two of these five core services have changed from good to requires improvement. We have also once again rated safe and effective as requires improvement for the trust overall.
- There were local governance issues in some core services linked to the quality of care plans, medicines management and risk assessments.
- There was a shortage of staff across key clinical services and a reliance on bank and agency staff. There were not effective systems in place for staff to receive supervision and for managers to collect the information. This impacted on the morale of staff.
- We heard from staff about bullying and discrimination within parts of the organisation. This appeared to be a cultural problem that had existed for a number of years. We recognised that the trust was working hard to address these issues but further work was required.

However:

- In the months preceding this inspection, the trust had improved collective leadership and the board and senior leaders were confident about plans to improve the quality of care. The trust was working with a number of organisations and stakeholders to improve services. They had learnt from other organisations to develop a culture of quality improvement and we saw signs of achievement.
- The board and senior leadership team had set a clear vision and values that were at the heart of all the work within the organisation. Clinical managers we spoke to shared the same values and the majority thought that the trust was well-led. Senior leaders were visible and well connected with services. They had a shared understanding with clinical staff of the risks the trust face.
- The trust had improved the skills and knowledge of staff in the Mental Capacity Act since the previous inspection in March 2017. Safeguarding structures and processes are clearly defined and were working effectively.
- The trust was working positively with a range of partners in the wider health and social care economy. This ranged from influencing local sustainability and transformation plans, working with three NHS trusts locally as part of an innovative MERIT Vanguard, and within an accountable care organisation with one other NHS trust and independent healthcare charity to commission and deliver secure care services.

Summary of findings

- The trust had developed and was working positively with patient and carer groups. The 'See Me' service user involvement scheme was valued by patients and carers. The trust ran a number of groups and courses for patients and carers in local communities, often reflecting the diverse communities it served, that included the recovery college and mindfulness awareness.
- The trust was committed to improve services by promoting research, innovation and training. There was strong links with universities that underpinned collaborative working around workforce and clinical practice. Staff were encouraged to work on ideas to improve practice and leadership courses were available for staff to attend.
- The trust collected, analysed, managed and used information well to support its activities, using secure electronic systems with security safeguards. The trust treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services, and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in the following core services:

- Wards for older people with mental health problems
- Forensic inpatient or secure wards

Areas for improvement

We found areas for improvement including 24 breaches of legal requirements that the trust must put right. We found 18 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report

Action we have taken

We issued six requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches in the Trust and four core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

We found the following outstanding practice:

Summary of findings

Trust wide

- The trust had developed a business model to train its own domestic staff and widen the provision to train external providers. This generated income to the trust to support the services it provided.
- The trust had planned recruitment of approved mental health professionals to improve access to Mental Health Act assessments for patients in crisis. This would mean that patients had earlier access to treatment for their conditions.
- The 'See Me' user involvement project promoted patient involvement in planning and delivering mental health services across Birmingham and Solihull. The trust customer relations team assisted patients and carers to stay actively involved with the trust.
- Information systems ensured that incident data, including safeguarding, was saved into the electronic patient record system every five minutes. This enabled front line clinicians to have access to up to date risk information to inform decision making for patients at risk.
- The trust was part of the MERIT Vanguard programme with three local mental health NHS trusts. As part of this work of shared learning, the trust was able to share bed vacancies with the other trusts to identify a bed for patients urgently in need of support.

Wards for older people with mental health problems

- The service was committed to continuous improvement and innovation. Staff gave examples of projects and quality improvement projects they had undertaken at ward level to improve efficiency, patient care and save money for the trust. We saw a project conducted by leaders on Bergamot Ward that had resulted in cost saving for the ward and this had extended to other wards within the service with projected further savings over time.
- We saw the implementation of an occupational therapist in a ward manager's role offering a diverse perspective on patient care and visible changes to the ward.
- The trust employed a tissue viability lead and continence nurse in 2017 and their role has made a visible impact on the levels of pressure ulcers.

Forensic inpatient or secure wards

- Hillis Lodge had developed a range of outstanding practice related to healthy lifestyles and patient engagement. New outdoor exercise equipment had been installed in the communal garden area and there had been a very high uptake from patients at sessions using these. Pedometers had been purchased and patients were encouraged to wear these out when going into the community. Information about steps taken communally was then being used to create events and sessions for patients.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust **must** take to improve

We told the trust that it must take action to bring services into line with 22 legal requirements. This action related to the trust and four services.

Trust wide

Summary of findings

- The trust must ensure that on wards that did not have fixed nurse call buttons in patients' bedrooms, staff mitigate the risk this posed by assessing whether individual patients, who might be at risk or otherwise be vulnerable, should be provided with a portable alarm to request assistance if needed. Regulation 12 (1)(2)

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

- The trust must ensure that on wards that did not have fixed nurse call buttons in patients' bedrooms, staff mitigate the risk this posed by assessing whether individual patients, who might be at risk or otherwise be vulnerable, should be provided with a portable alarm to request assistance if needed. Regulation 12 (1)(2)
- The trust must ensure that the prescribing, administration, and monitoring of physical health of patients are completed as detailed in trust policy and NICE guidelines [NG10] on-Violence and aggression: short term management in mental health, health and community settings. Regulations 12(1)(2)
- The trust must ensure that there are sufficient numbers of suitably qualified, competent and skilled staff on each ward. Regulation 18(1)
- The trust must ensure that staff have appropriate supervision and appraisal to enable them to carry out the duties they are employed to perform. Regulation 18 (2)
- The trust must ensure section 62 paperwork is reviewed and that referrals are made to a SOAD in a timely manner. Regulation 17 (2)
- The trust must ensure that governance systems and processes at ward level assess, monitor and improve the quality and safety of services provided in the carrying on of regulated activity. Regulation 17(2)

Mental health crisis services and health-based places of safety

- The trust must ensure that systems and processes are in place to identify where quality and safety are being compromised and to respond appropriately and without delay. This includes the quality of the experience that patients receive in those services. Regulation 17 (2)(a)
- The trust must ensure staff follow the trust medicines policies. There was no system in place to accurately monitor medicine stocks within the home treatment teams. Staff were not transporting medicines in a secure container to patient’s homes and they did not always record and dispose of controlled drugs appropriately. The fridges in the psychiatric decision unit were not secured appropriately. Regulation 12 (1)(2)(b)
- The trust must ensure all staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2)(a)
- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled staff to make sure that they can meet patient’s care and treatment needs. Staff must respond in a timely manner when patients contact the service. Regulation 18(1)
- The trust must ensure that staff have access to an alarm system or personal alarms to alert others in the case of an emergency in the Psychiatric Liaison Team (previously known as the Rapid Assessment interface and discharge teams (RAID). Regulation 12 (1)(2)
- The trust must ensure they have enough facilities such as appropriate rooms to speak to patients at the Oleaster unit when they are seen on trust premises. Regulation 15 (1)(c)

Wards for older people with mental health problems

- The trust must ensure that on wards that did not have fixed nurse call buttons in patients' bedrooms, staff mitigate the risk this posed by assessing whether individual patients, who might be at risk or otherwise be vulnerable, should be provided with a portable alarm to request assistance if needed. Regulation 12 (1)(2)

Summary of findings

- The trust must ensure environmental risk assessments at Ashcroft and Reservoir Court are up to date and actions completed. Regulation 17(1)(2)
- The trust must ensure that staff have access to an alarm system or personal alarms to alert others in the case of an emergency at Ashcroft. Regulation 12(1)(2)
- The trust must ensure that patient identifiable information is secure and cannot be accessed by unauthorised people. Regulation 17(1)(2)
- The trust must ensure staff always follow best practice when storing, dispensing, and recording the use of medicines. Regulation 12(1)(2)

Forensic inpatient or secure wards

- The trust must ensure that all risk assessments are complete and up to date. The information contained within must be personised and specific to the individual. Regulation 12(1)(2)(a)
- The trust must ensure that care plans are personalised, specific and recovery focused. Regulation 9(1)(2)(3)
- The trust must ensure that there are no unnecessary blanket restrictions in place at the Tamarind Centre. Regulation 13(1)(4)

Action the trust **should** take to improve

This action related to four services.

Trust wide

- The trust should ensure that the board assurance framework and risk assessments documents are kept together.

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

- The trust should ensure that the prescribing of valproate/ valproic acid to females of childbearing age is undertaken following national guidance and staff ensure they record this activity in patients care records. Regulation 12 (1)(2)
- The trust should ensure that all staff at Mary Seacole House adhere to the trust no smoking policy.
- The trust should ensure that staff record seclusion reviews as per trust policy.
- The trust should ensure that care plans are holistic, recovery orientated and personalised, and that patients are offered a copy of their care plan.

Mental health crisis services and health-based places of safety

Wards for older people with mental health problems

- The trust should ensure staff received both managerial and clinical supervision and this is recorded effectively.
- The trust should ensure they know where visitors are on the ward and give them access to a nurse call alarm.
- The trust should ensure staff establishment levels are accurate for the service.
- The trust should ensure adequate medical cover is in place across all wards.
- The trust should ensure all staff are appropriately supported and debriefed following all instances of abuse or incidents.
- The trust should ensure there are development opportunities for all staff and staff are aware how to access these.

Summary of findings

- The trust should ensure carers are appropriately involved in patient's care and given the opportunity to engage and feedback.
- The trust should ensure care records reflect where carers have been contacted and actions taken by staff.
- The trust should ensure complaints are managed effectively and resolved with all parties and any actions followed up.

Forensic inpatient or secure wards

- The trust should ensure that staff record information on their electronic database in a consistent way.
- The trust should ensure that all staff receive regular management and clinical supervision.
- The trust should ensure that governance processes operate effectively at Reaside Hospital and The Tamarind Centre. Regulation 17(2)(a).

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

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

- The trust had made insufficient improvements since our last comprehensive inspection in March 2017. This is reflected in the ratings of the core services that we inspected at this most recent inspection. The ratings for two of these five core services have changed from good to requires improvement. We have also once again rated safe and effective as requires improvement for the trust overall.
- There were local governance issues in some core services linked to the quality of care plans, medicines management and risk assessments.
- There was a shortage of staff across key clinical services and a reliance on bank and agency staff. There were not effective systems in place for staff to receive supervision and for managers to collect the information. This impacted on the morale of staff.
- We heard from staff about bullying and discrimination within parts of the organisation. This appeared to be a cultural problem that had existed for a number of years. We recognised that the trust was working hard to address these issues but further work was required.

However:

- In the months preceding this inspection, the trust had improved collective leadership and the board and senior leaders were confident about plans to improve the quality of care. The trust was working with a number of organisations and stakeholders to improve services. They had learnt from other organisations to develop a culture of quality improvement and we saw signs of achievement.
- The board and senior leadership team had set a clear vision and values that were at the heart of all the work within the organisation. Clinical managers we spoke to shared the same values and the majority thought that the trust was well-led. Senior leaders were visible and well connected with services. They had a shared understanding with clinical staff of the risks the trust face.

Summary of findings

- The trust had improved the skills and knowledge of staff in the Mental Capacity Act since the previous inspection in March 2017. Safeguarding structures and processes are clearly defined and were working effectively.
- The trust was working positively with a range of partners in the wider health and social care economy. This ranged from influencing local sustainability and transformation plans, working with three NHS trusts locally as part of an innovative MERIT Vanguard, and within an accountable care organisation with one other NHS trust and independent healthcare charity to commission and deliver secure care services.
- The trust had developed and was working positively with patient and carer groups. The 'See Me' service user involvement scheme was valued by patients and carers. The trust ran a number of groups and courses for patients and carers in local communities, often reflecting the diverse communities it served, that included the recovery college and mindfulness awareness.
- The trust was committed to improve services by promoting research, innovation and training. There was strong links with universities that underpinned collaborative working around workforce and clinical practice. Staff were encouraged to work on ideas to improve practice and leadership courses were available for staff to attend.
- The trust collected, analysed, managed and used information well to support its activities, using secure electronic systems with security safeguards. The trust treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Ratings tables

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 2019	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Requires improvement →← Apr 2019	Requires improvement →← Apr 2019

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 mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement →← Apr 2019	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Requires improvement ↓ Apr 2019	Requires improvement →← Apr 2019
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement →← Aug 2017	Good →← Aug 2017	Good →← Aug 2017	Good →← Aug 2017	Good →← Aug 2017	Good →← Aug 2017
Forensic inpatient or secure wards	Requires improvement →← Apr 2019	Requires improvement ↓ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Requires improvement ↓ Apr 2019
Child and adolescent mental health wards	Good ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019
Wards for older people with mental health problems	Requires improvement →← Apr 2019	Good ↑ Apr 2019	Requires improvement ↓ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Requires improvement ↓ Apr 2019
Community-based mental health services for adults of working age	Good →← 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 2019	Requires improvement ↓ Apr 2019	Good ↑ Apr 2019	Requires improvement →← Apr 2019	Requires improvement ↓ Apr 2019	Requires improvement →← Apr 2019
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

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.

Mental health crisis services and health-based places of safety

See guidance note ICS 1 – then delete this text when you have finished with it.

Key facts and figures

The trust provides crisis services and health based places of safety across Birmingham and Solihull through crisis resolution home treatment teams (CRHT), Psychiatric Liaison Team previously known as rapid assessment interface and discharge (RAID) mental health teams and urgent care services. Urgent care services include the health-based place of safety, psychiatric decisions unit, bed management, street triage, and British Transport Police.

The trust provides crisis resolution home treatment services from six teams. The teams are Solihull Team, North Team, South-West Team, South-East Team, Zinnia Team and Handsworth & Ladywood Team. At night, the service is provided centrally from the Oleaster Centre.

The trust provides rapid assessment interface and discharge teams from City Hospital, Good Hope Hospital, Heartlands Hospital and University Hospital Birmingham. The service is also provided from Solihull Hospital but only between 8am and 8pm, 7 days a week.

The trust provides a health-based place of safety at the Oleaster Centre with capacity for two patients. It is staffed by one senior nurse and one nursing assistant at all times who also act to provide a bed management service for the trust.

The trust provides a psychiatric decisions unit at the Oleaster centre with capacity for up to eight patients. The unit has its own staff team. It offers a place for patients to receive an extended assessment and decision-making service for up to 24-hours as an alternative to remaining in an emergency department or being taken into custody.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

We inspected the health-based place of safety base and the psychiatric decision unit at the Oleaster centre, three home treatment teams – South East, South West and North, and one Psychiatric Liaison (PL) service at the University Hospital Birmingham.

During our inspection we: -

•visited and toured the health-based place of safety and the psychiatric decision unit, three home treatment teams one Psychiatric Liaison (PL) team.

•spoke with 19 members of staff including doctors, nurses, health care support workers, occupational therapist, including seven managers and senior managers

•spoke with nine patients and two carers

•observed six meetings including one handover, two medical reviews and three allocation meetings.

•looked at 20 care records.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The services did not have enough staff to keep people safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams was high.

Mental health crisis services and health-based places of safety

- Staff did not always follow trust guidelines in relation to medicines management.
- Staff did not always respond in a timely manner when patients contacted the service and at times had to wait to be seen by staff.
- Governance processes did not operate effectively. The systems and processes did not always support staff to carry out their roles, for example managers did not ensure that staff had regular supervision and annual appraisals. Staff said morale was low.
- The mental health crisis teams did not always have access to the full range of specialists required to meet the needs of the patients. Senior management were aware of this and a business case had been developed to address this issue.

However:

- Staff working for the mental health crisis teams developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients.
- Staff worked well together as a multi-disciplinary team and with relevant services outside the organisation.
- Clinical premises where patients were seen were safe and clean and the physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients, families, and carers in care decisions.

Is the service safe?

Requires improvement 

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

- The services did not have enough staff, to keep people safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams was high.
- Staff in the rapid assessment, interface and discharge team did not have access to personal alarms to maintain their safety.
- Not all staff were up to date with their mandatory safeguarding training, however, staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff did not always follow best practice when storing, dispensing, and recording the use of medicines. They had not always followed the trust's medicines policies and procedures. However, staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's physical health.

However:

- All clinical premises where patients received care were safe, clean, well equipped, well furnished and well maintained. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

Mental health crisis services and health-based places of safety

- Staff assessed and managed risks to patients and themselves. Staff working for the mental health crisis teams developed crisis plans when this was necessary and responded promptly to sudden deterioration in a patient's health. Staff followed good personal safety protocols.
- Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The services 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.

Is the service effective?

Requires improvement 

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

- Managers did not ensure that all staff had an annual appraisal or regular supervision, which meant they missed opportunities to update and further develop their skill.
- The mental health crisis teams consisted of nurses, doctors and support workers. Access to other specialists such as psychologists was limited, which meant there was not a full range of specialists required to meet the needs of patients under their care.

However:

- Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams developed individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented and staff updated them when appropriate. They ensured that patients had good access to physical healthcare.
- Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes.
- Staff supported each other to make sure that patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- 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.

Is the service caring?

Good 

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

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

Mental health crisis services and health-based places of safety

- Staff in the mental health crisis teams involved patients in care planning and risk assessment and sought their feedback on the quality of care provided.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Staff did not respond in a timely manner when patients contacted the service and at times patients had to wait to be seen by staff.
- There were not always enough rooms to see patients when they came for appointments at the Oleaster centre and the room that was available did not ensure patients privacy and dignity was maintained.

However:

- The mental health crisis service was available 24-hours a day. The referral criteria for the mental health crisis teams did not exclude people who would have benefitted from care. Staff followed up people who missed appointments.
- The health-based places of safety were available when needed and there was an effective local arrangement in place for young people who were detained under Section 136 of the Mental Health Act. Section 12 approved doctors and approved mental health professionals attended promptly when required.
- The services met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The services treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Requires improvement 

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

- Our findings from the other key questions demonstrated that governance processes did not always operate effectively. The systems and processes did not always support staff to carry out their roles, for example staffing levels remained low and medicines management was not robust across all teams, also managers did not ensure that staff had regular supervision and annual appraisals.
- Staff in the home treatment teams said morale was low, and they did not have enough resources to do their job effectively.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- They felt able to raise concerns without fear of retribution.

Mental health crisis services and health-based places of safety

- There were effective, multi-agency arrangements in place to agree and monitor the governance of the health-based places of safety.

Areas for improvement

We found areas for improvement in this service. See Areas for improvement section above.

Wards for older people with mental health problems

Requires improvement 

Key facts and figures

The trust's wards for older people with mental health problems care for people with both organic and functional mental health disorders.

Organic mental illness is usually caused by disease affecting the brain, such as Alzheimer's. Functional mental illness has predominantly a psychological cause. It may include conditions such as depression, schizophrenia, mood disorders or anxiety.

We inspected five wards spread over three sites:

- Reservoir Court, Erdington, has 24 beds and admits both male and female patients.
- Ashcroft Complex Care Unit, Lozells, has 16 beds and admits both male and female patients.
- At Juniper Centre, Moseley: Sage Suite has 18 beds and admits only male patients, Rosemary Suite has 18 beds and admits only female patients and Bergamot Suite has 18 beds and admits only female patients.

At the last inspection, the service was rated good in key questions: safe, caring, responsive and well-led and requires improvement in effective.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- spoke with nine patients who were using the service and four carers
- spoke with five ward managers and three matrons for each of the wards
- spoke with 19 other staff members; including doctors, nurses, health care assistants, occupational therapists and housekeeping staff
- observed four handover meetings
- reviewed 21 patient records, 44 prescription medication charts and Mental Health Act paperwork.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Staff had not updated environmental risk assessments appropriately on Ashcroft Ward and Reservoir Court. This meant that staff working on the wards were not working within the most up to date document and may not identify accurately where potential risks such as ligatures were and how these should be managed to keep patients safe. Staff on Ashcroft Ward did not always have access to personal alarms and reported that they could not be heard in all areas of the ward when activated which added to the potential risk for patients.
- Staff on Ashcroft Ward did not always follow best practice when storing, dispensing, and recording the use of medicines. For example, we found medication was not always stored at the correct temperature and staff did not record how this was managed. Staff could not be sure that medication was safe to administer to patients.

Wards for older people with mental health problems

- The trust had high use of agency and bank use across all wards. There had been delays in accessing a medic quickly on Reservoir Court. Staff we spoke with had concerns about the impact on patient care.
- On Ashcroft Ward we found that not all patient information was stored appropriately in locked storage. This meant that people other than staff could access a patient's information without their consent.
- Feedback from carers was not always positive regarding staff engagement and response to concerns raised at ward level. Carer involvement was not routinely recorded in care records.

However:

- The ward environments were safe and clean. Staff assessed and managed risk well on most wards. They minimised the use of restrictive practices, and followed good practice with respect to safeguarding.
- Staff developed care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance and best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training and appraisal. The ward staff worked well together as a multidisciplinary team and with external agencies who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients.
- Managers followed governance process set out by the trust that ensured the wards ran smoothly. Staff had a clear framework for sharing information from ward to executive team level.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- The trust had high use of agency and bank use across all wards. The trust were aware of the concerns.
- Staff had not assessed and managed environmental risks appropriately on Ashcroft Ward and Reservoir Court. Staff and patients on Ashcroft Ward did not always have access to nurse call alarms.
- Staff had experienced abuse and assaults from patients and some staff told us they did not always feel adequately supported following incidents.
- Staff on Ashcroft Ward did not always follow best practice when storing, dispensing, and recording the use of medicines. Medicines were out of date, labelled incorrectly and one medicine had been administered to a patient who it was not prescribed for. Staff did not ensure medicines were properly secured.

However:

- Wards were clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff showed good knowledge of managing physical health risks, including falls and pressure ulcers.

Wards for older people with mental health problems

- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the trust's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The wards had a good track record on safety. 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.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- 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 the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance and best practice. They ensured that patients had good access to physical healthcare and supported patients 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.
- The ward had access to the full range of specialists required to meet the needs of patients. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- 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 wards had effective working relationships with other teams within the organisation and with relevant services outside the organisation.
- 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 supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- The trust did not provide data on compliance with managerial supervision.
- Some staff reported that they did not have sufficient opportunities to progress within the trust.

Wards for older people with mental health problems

Is the service caring?

Requires improvement  

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

- Staff had not ensured the confidentiality of confidential information in one older peoples mental health ward.

However:

- 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 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.

Is the service responsive?

Good  

Our rating of responsive stayed the same. We rated it as good because:

- Staff managed admission and discharge well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity, including implementation of dementia friendly environments. 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 a good quality and patients had access to hot drinks and snacks at any time.
- The wards met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Carers told us that when the raised a complaint they had not seen any changes on the ward as a result.

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

Wards for older people with mental health problems

- Staff felt respected, supported and valued. They reported that the provider promoted opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well on most wards.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However:

- On Reservoir Court and Ashcroft Ward environment risk assessments were not always updated and actions completed.
- Staff in all wards expressed challenges in relation to staffing and constant use of agency and bank staff.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

The service was committed to continuous improvement and innovation. Staff gave examples of projects and quality improvement projects they had undertaken at ward level to improve efficiency, patient care and save money for the trust. We saw a project to reduce medication waste on wards at the Juniper Centre by implementing a different style of medication trolley. Leaders on Bergamot Ward that had identified areas for cost improvement by surveying ward staff, estates teams and the pharmacy department and put forward a cost-effective solution that resulted in cost and time saving for the ward, estates team and pharmacy teams within the trust. Following implementation on the ward, staff gathered feedback from staff and patients and found that staff could complete tasks more efficiently and patients preferred the new system. Following its success, this had extended to other wards within the service with projected further savings over time.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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

Requires improvement 

Key facts and figures

The acute wards and psychiatric intensive care units for adults of working age were provided over

six sites in Birmingham. The trust had a total of 16 acute wards and three psychiatric intensive care units. For this inspection we visited the following 12 wards:

The Oleaster had two acute admissions wards, two assertive outreach wards (with four acute beds each) and one a psychiatric intensive care unit:

- Caffra suite -10 bed male psychiatric intensive care unit
- Tazetta suite- 16 bed male acute ward
- Melissa suite – 16 bed female acute ward

Mary Seacole House had:

- Meadowcroft – 10 bed male psychiatric intensive care unit
- Ward 1 – 16 bed male acute ward
- Ward 2 – 14 bed female acute ward

The Zinnia centre:

- Lavender – 16 bed female acute ward

The Northcroft site

- Eden psychiatric intensive care unit – 8 bed female ward
- Eden Acute – 16 bed male acute ward
- Endeavour House – 12 bed male ward

Newbridge House is a standalone unit with one ward. It is a 16-bed ward for females. This ward had strict referral criteria and only accepted patients who were lower risk to selves or others, due to the fact it is was stand alone.

Ardenleigh Site

- Larrimar ward – 8 bed female acute ward

At the last comprehensive inspection in March 2017, we rated the acute wards for adults of working age and psychiatric intensive care units as requires improvement overall. We rated the safe and effective domains as requires improvement and caring, responsive and well led domains as good. We found that the trust had breached regulations under the Health and Social Care act (regulated Activities) Regulations 2014. We issued the trust with four requirement notices for acute wards for adults of working age and psychiatric intensive care units. These related to the following regulations under the Health and Social Care act (regulated Activities) Regulations 2014:

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 11 HSCA (RA) Regulations 2014 Need for Consent

Regulation 17 HSCA (RA) Regulations 2014 Good Governance

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

Regulation 18 HSCA (RA) Regulations 2014 Safe Staffing

We also carried out an unannounced focussed inspection on Caffra Psychiatric intensive care unit 6 September 2018. We issued the trust with one requirement notice. This related to regulation 18 HSCA (RA) Regulations 2014 Safe Staffing. We told the trust that they must ensure that there are adequate staffing levels to meet the needs of patients and ensure staff have access to breaks during their shifts. We also told the trust:

- The provider should ensure that patients are not admitted above the ward bed numbers.
- The provider should ensure that patients privacy and dignity are maintained and are only nursed in seclusion when clinically needed.
- The provider should ensure that staff are aware of systems in place to ensure adequate provision of personal alarms for staff and visitors to the ward.

The trust was in the process of addressing these issues raised in this report during this inspection and have returned an action plan to address the issues.

The current inspection was unannounced (staff did not know we were coming). During the inspection we carried out the following activities:

- looked at the quality of the ward environment and observed how staff were caring for patients
- interviewed the ward manager for each ward and the clinical nurse matron for two sites
- attended and observed two multi-disciplinary team meetings
- reviewed six comment cards
- spoke with 41 staff including nurses, healthcare assistants, occupational therapists, psychologists and psychiatrists
- spoke with 28 patients
- reviewed 50 care records
- reviewed 78 electronic medicine administration records.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not always follow National Institute of Health and Care Excellence and trust guidance following rapid tranquilisation and seclusion reviews. Records showed gaps in monitoring patients' physical health following administration of intra muscular medicines for rapid tranquilisation and in the records of the reviews required for secluded patients in line with the Mental Health Act, Code of Practice and the trusts policy.
- Staff did not always record the fact that that they had undertaken a discussion with females of childbearing age regarding the risk of valproate medicines.
- Most wards had a high number of vacancies and high use of agency and bank staff. This led to some shifts being unfilled. This placed increased pressure on staff and also impacted upon their ability to access supervision. The staffing model did not always ensure an appropriate skill mix was in place on wards to provide safe and effective care and treatment.

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

- Despite the trust implementing a smoke free environment in April 2017, some staff at Mary Seacole House continued to tolerate smoking within the ward gardens on wards 1 and 2. This meant patients had access to cigarette lighters on the wards, which they concealed from staff. This may put themselves or others at risk. Staff at other locations enforced the no smoking policy offering suitable alternatives to the patients.
- Staff did not always write holistic, personalised or recovery focussed care plans and did not always record if they had offered patients a copy of their care plan.
- Staff did not always have the appropriate Mental Health Act paperwork to authorise administration of medicines. We found that section 62 paperwork was not always reviewed and staff were sometimes unable to tell us if a referral to a second opinion approved doctor had been made. We had found that this was an issue for some wards during the 2017 core service inspection.
- The service experienced bed pressures. Most wards had bed occupancy rates above 100%. Beds were not always available to patients on return from leave.
- Our findings from the other key questions demonstrated that governance processes did not always operate effectively at ward level. There were variations across sites and amongst wards. This had led to lapses in medicines management, observations following rapid tranquilization and seclusion reviews, issues with staffing levels and skill mix, lapses in implementing the non-smoking policy and supervision rates were poor.
- The Building Note relating to acute mental health wards states that 'Service user to staff system call points should be provided in spaces where a service user or attendee may be left alone temporarily, for example within service user bedrooms, en-suite WCs, disabled WCs and therapy or education areas'. These wards did not have fixed nurse call buttons in patients' bedrooms. Staff did not mitigate the risk this posed by assessing whether individual patients, who might be at risk or otherwise be vulnerable, should be provided with a portable alarm to request assistance if needed.
- Although staff supported each other, morale was poor and they felt under pressure. Some staff told us that they did not feel heard or listened to by senior management within the trust.

However:

- The trust had implemented six out of the seven actions we told them they must make to improve since the last inspection in March 2017. Staff engaged actively in local and national quality improvement activities. Staff knew and understood the provider’s vision and values and how they were applied in the work of their team.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The ward environments were safe and clean. Staff minimised the use of restrictive practices, completed a risk assessed in a timely manner and staff assessed the physical and mental health of all patients on admission.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- The wards had a good track record on safety. 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 demonstrated duty of candour; staff apologised and gave patients honest information and suitable support.

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

Is the service safe?

Requires improvement ➔➔

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

- Staff did not always carry out physical health checks after administering intra-muscular medicines for rapid tranquilisation. Patients receiving rapid tranquilisation are at risk of seizures, airway obstruction, excessive sedation and cardiac arrest. The failure to carry out checks in line with national guidelines and trust policy put patients at risk of avoidable harm.
- Staff did not always record a discussion of the side effects of valproic acid/ valproate with female patients to whom it had been prescribed.
- Most wards had high numbers of vacancies for registered nursing staff and the acute wards had some difficulties in filling shifts with the appropriate skill mix.
- Staff at Mary Seacole House did not always follow best practice in implementing a smoke free environment. Staff either did not carry out observations of the garden area adequately or they tolerated patients smoking in the garden.
- Wards did not have fixed nurse call buttons in patients' bedrooms. Staff did not mitigate the risk this posed by assessing whether individual patients, who might be at risk or otherwise be vulnerable, should be provided with a portable alarm to request assistance if needed.
- Staff did not always record if nursing reviews, following seclusion always took place. Records showed gaps in the monitoring of seclusion on some wards.

However:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff assessed and managed most risks to patients and others. 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. Staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- The wards had a good track record on safety. 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 demonstrated a duty of candour; staff apologised and gave patients honest information and suitable support.

Is the service effective?

Requires improvement ➔➔

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

- Staff did not receive regular supervision and compliance rates for appraisals was low. Staff did not always have time to attend business meetings due to staffing issues. This meant there was a risk that some staff were not receiving appropriate professional support to enable them to carry out their duties safely and effectively.
- Most care plans were generic, they did not contain information that was holistic, personalised or recovery based.
- Staff did not always have correct Mental Health Act paperwork to authorise administration of medicines. We found that section 62 paperwork was not always reviewed and staff were sometimes unable to tell us if a referral to a second opinion approved doctor had been made.

However:

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients 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 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 team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Good 

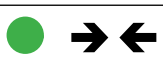
Our rating of caring stayed the same. We rated it as good because:

- 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 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.
- Staff informed and involved families and carers appropriately.

However:

- Staff told us they always offered patients a copy of their care plan, however, they did not record this in care records.
- We found little recorded evidence of patients' involvement in their care planning, and few patients had crisis or advanced care plans.

Is the service responsive?

Good 

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

Our rating of responsive stayed the same. We rated it as good because:

- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support. New BP patients had access to gym equipment at all sites.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- The trust experienced bed pressures in this core service due to bed capacity compared to demand. The average bed occupancy rates for the core service was 105%.
- There was not always a bed available for patients returning from leave. This meant patients were sometimes admitted into other wards, disrupting continuity of care. There was not always a bed available for patients who needed a transfer to a psychiatric intensive care unit.
- Patients admitted to Endeavour House did not have a suitable area to see visitors.

Is the service well-led?

Requires improvement 

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

- Our findings from the other key questions demonstrated that governance processes did always operate effectively at ward level. There were variations across sites and amongst wards. This had led to lapses in medicines management, observations following rapid tranquilization and seclusion reviews, issues with staffing levels and skill mix, supervision rates were poor and in some areas staff did not always implement the smoke free environment.

However:

- The trust had implemented six out of the seven actions we told them they must make to improve since the last inspection in March 2017.
- Staff engaged actively in local and national quality improvement activities
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Child and adolescent mental health wards

Good ➔➔

Key facts and figures

The child and adolescent mental health wards (CAMHS) provided by Birmingham and Solihull Mental Health NHS Foundation Trust are located at the Ardenleigh site.

Atlantic and Pacific wards form the forensic children's and adolescent mental health services (FCAMHS) within this trust. The wards admit children and young people, up to the age of 18 years. The wards currently operate as a single service. The wards provide care and treatment to children and adolescents up to the age of 18 who require detention under the Mental Health Act (MHA) and who have engaged in, or are at risk of engaging in, offending behaviour. Patients admitted to Atlantic and Pacific wards need a high level of supervision in a medium secure environment. They are a nationally commissioned service. Children and young people on FCAMHS have access to education within Ardenleigh, from the centre for learning.

At the time of inspection there were eight patients, all of whom were detained under the Mental Health Act.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During our inspection we: -

•visited and toured the Atlantic and Pacific wards

•visited the seclusion unit

•visited the education centre

•spoke with 10 members of staff including team managers, nurses, health care assistants, psychiatrists and therapists

•spoke with two patients

•observed a weekly planning meeting

•looked at three prescription charts and eight care records

•attended two handover meetings.

Summary of this service

We rated this service as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.

Child and adolescent mental health wards

- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They followed good practice with respect to young people's competency and capacity to consent to or refuse treatment.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

Is the service safe?

Good 

Are services safe?

We rated safe as good because:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it. There was an identified named nurse and doctor for child protection.
- Staff had easy access to clinical information and it was easy for them to maintain high quality electronic clinical records.
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. 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.

Is the service effective?

Good 

Are services effective?

We rated effective as good because:

Child and adolescent mental health wards

- 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 the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients 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.
- 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 a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new and agency or bank staff.
- 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 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 supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under the age of 16. Staff assessed and recorded capacity or competence clearly for patients who might have impaired mental capacity or competence.

Is the service caring?

Good 

Is the service caring?

We rated caring as good because:

- Staff treated patients with sensitivity, 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 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 and to child helplines.
- Staff informed and involved families and carers appropriately. They offered support to patient's families and carers.

Is the service responsive?

Good 

Child and adolescent mental health wards

Is the service responsive?

We rated responsive as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- Staff facilitated young people's access to high quality education throughout their time on the ward.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Is the service well-led?

Good 

Is the service well-led?

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged in local and national quality improvement activities.

Forensic inpatient or secure wards

Requires improvement 

Key facts and figures

The forensic service pathway for adults at Birmingham and Solihull Mental Health Foundation NHS Trust is spread across four different locations.

Ardenleigh consists of three wards delivering care to female service users. Coral Ward is an acute ward with eight beds, Citrine Ward is an acute ward with eight beds and Tourmaline Ward is a rehab ward with 14 beds.

Hillis Lodge is a 14-bedded unit providing a low secure rehabilitation service for men.

The Tamarind Centre has seven wards providing care to men. All were medium secure wards sat within a boundary as laid out in the medium secure unit standards. It is made up of Sycamore Ward which is an intensive care ward with eight beds, Hibiscus Ward which is a 12-bedded acute ward, Laurel Ward which is a specialist personality disorder ward with 12 beds, Cedar Ward which is a complex long term mental health ward with 15 beds, Myrtle Ward which is a 15-bedded complex long term mental health ward, Acacia Ward which is a 15 bedded rehabilitation ward, and Lobelia Ward which is a 15 bedded rehabilitation ward.

Reaside Hospital provides care to men across seven wards. All were medium secure wards sat within a boundary as laid out in the medium secure unit standards. Severn Ward is the intensive care ward and has eight beds, Avon Ward is an acute ward with 14 beds, Blythe Ward is an acute ward with 13 beds, Dove Ward is a rehabilitation ward with 14 beds, Trent Ward is a rehabilitation ward with 14 beds, Swift Ward is a rehabilitation ward with 15 beds and Kennet Ward is a rehabilitation ward with 14 beds.

The last comprehensive inspection of the trust took place from the 27th to the 31st March 2017 and the forensic service was rated as good overall.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During our inspection we: -

- visited 14 out of the 18 wards across the service we did not inspect Cedar or Acacia wards at the Tamarind Centre. We did not inspect Dove or Kennet wards at Reaside Hospital
- undertook 14 ward tours and checked 14 clinic rooms
- interviewed 23 patients and three carers
- interviewed 14 ward managers, 25 qualified nurses, 18 health care assistants, six doctors, and occupational therapist and a modern matron
- reviewed 54 care records and 43 medication cards
- looked at a range of risk assessments and other documentation including seclusion policies, documentation relating to the safe use of equipment around the wards, ligature risk assessments and fire risk assessments
- attended three ward rounds, two multidisciplinary team meetings, a staffing review, 2 patients' community meetings and observed six patient sessions

undertook a specific review of seclusion practice at Reaside Hospital and Ardenleigh where we reviewed 14 records and read a range of policies and risk assessments linked to the use of seclusion.

Forensic inpatient or secure wards

Summary of this service

We rated this service as requires improvement because:

- All patients had risk assessments and care plans in place but they were not consistently of a good quality. At the Tamarind Centre and Reaside Hospital we saw examples of risk assessments that were incomplete or did not have up to date information. The information contained within some care plans was not personalised and specific to the individual.
- Staff at the Tamarind Centre and Reaside Hospital used the electronic recording system in such a way that it could be difficult for new starters or bank and agency staff to find the information they were looking for.
- The service did not minimise the use of restrictive practices on all wards. We found blanket restriction in place at The Tamarind Centre relating to choice at mealtimes.
- Staff supervision levels on some wards at the Tamarind Centre and Ardenleigh were below 75% due to staff shortages over the twelve months prior to our inspection though there were action plans in place to address this.

However:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They managed medicines safely and followed good practice with respect to safeguarding.
- They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason

Is the service safe?

Requires improvement 

We rated safe as requires improvement because:

- All patients had risk assessments in place but these were not always complete or up to date. We found some examples, at Reaside Hospital and the Tamarind Centre where risk assessments that had been started were not completed. We also found some that were vague or had information missing. In some cases, statements about risk were generic across a number of records and there had been no input from the patient.

Forensic inpatient or secure wards

- Staff at the Tamarind Centre and Reaside Hospital used the electronic recording system in such a way that it may be difficult for new starters or bank and agency staff to find the information they were looking for. We found that all information was present but there was a lack of consistency of information being stored in the same place across all records.
- There were blanket restrictions in place at the Tamarind Centre. Patients were unable to make reasonable choices at meals times due to restrictions placed upon them.

However:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff had the skills required 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.
- 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 followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. 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.

Is the service effective?

Requires improvement 

We rated effective as Requires improvement because:

- Staff had undertaken mental health assessments in all records we checked. At Hillis Lodge and Ardenleigh these were complete and contained all relevant information. At the Tamarind Centre and Reaside Hospital we found that records were sometimes incomplete or had not been updated. Care plans did not always meet the needs of the patients, were not personalised, holistic and recovery orientated and we saw some that had not been reviewed or updated in the trusts specified time frame. Some were generic and had not considered the views of the patient.
- Staff supervision and appraisal levels on some wards were below 75% compliance. This was due to staff shortages over the twelve months prior to our inspection and there were action plans in place to address this shortfall.

However:

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.

Forensic inpatient or secure wards

- The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with a range of skills needed to provide high quality care. Managers provided an induction programme for new staff. Multi-disciplinary team meetings were inclusive, recovery focussed and timely.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- 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 team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.
- 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 supported patients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Good 

We rated caring as good because:

- We observed staff working with patients throughout our inspection and found them to be caring supportive and respectful at all times. They had developed positive working relationships with patients and had good knowledge of patient's individual needs.
- Staff supported patients to understand their care and treatment. They were also able to support patients when they received care from outside the service, for example, when receiving treatment at another hospital for physical health conditions.
- All staff we spoke with had good knowledge of issues around patient confidentiality.
- There was a clear admission process that orientated new patients to the wards. Care records showed that, in most cases, patients were involved in planning their own care. Staff communicated with patients in a way that they could understand when discussing their care.
- There were regular ward meetings where patients were encouraged to give feedback about the service.
- Patients carers and relatives were actively involved in care planning by staff if this was appropriate. They were able to give feedback about the service and were provided with information to help them understand treatment options and service delivery.

Is the service responsive?

Good 

We rated responsive as good because:

Forensic inpatient or secure wards

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Is the service well-led?

Good  

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff engaged actively in local and national quality improvement activities.

However:

- Governance processes did not operate effectively at Reaside Hospital and The Tamarind Centre. Audits had not identified issues with care records and risk assessments at ward level. There was no consistent process to ensure that information was stored on the electronic recording system in the same way by all staff.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Our inspection team

Kathryn Mason, Head of Hospitals Inspection, led the well-led inspection. The well-led inspection team included two inspection managers, three inspectors, one mental health act reviewer, one assistant inspector, three specialist advisers, and two representatives from NHS Digital.

Kenrick Jackson, Inspection Manager, led the core service inspections. The inspection team across five core services included eight mental health inspectors, two assistant inspectors, one CQC pharmacist and 14 specialist advisers.

Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for someone who uses mental health services that we regulate.