Black Country Healthcare NHS Foundation Trust

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

Inspection report

Trafalgar House, 2nd Floor
47-49 King Street
Dudley
DY2 8PS
Tel: 01922607000
blackcountryhealthcare.nhs.uk

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

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

Requires Improvement 

Black Country Healthcare NHS Foundation Trust was formerly called Black Country Partnership NHS Foundation Trust. It changed its name in April 2020 when it acquired the mental health services previously run by Dudley and Walsall Mental Health Partnership NHS Trust, which is now Dudley Integrated Health and Care NHS Trust.

Since the merger we have completed one inspection in November 2021. This consisted of how well led the trust was and three mental health services: acute wards for adults of working age and psychiatric intensive care units, mental health crisis services and health-based places of safety and wards for older people with mental health problems. We rated the trust overall and all three mental health services as good. In rating the trust in November 2021, we took into account previous ratings for services not inspected.

Following the inspection in November 2021 we told the trust that it must take action to bring services into line with two legal requirements. This action related to this core service was:

Wards for adults of working age and psychiatric intensive care units

The trust must ensure that all ligatures in the acute wards are removed or mitigated effectively to protect patients from self-harm. (Regulation 12) (1)(d)

We told the trust action it should take to improve:

Wards for adults of working age and psychiatric intensive units: The trust should ensure that all patients are involved in their treatment and care and receive a copy of their care plan.

The trust should consider updating the seclusion room at Macarthur Centre to make the environment more comfortable for patients in seclusion.

At this inspection we inspected one core service: Acute wards for adults of working age and psychiatric intensive care units. We inspected this service following reports of safeguarding incidents to the local authority and police which were being investigated at time of inspection.

In November 2021 we rated this core service as Good overall, requires improvement for safe and Good for effective, caring, responsive and well led.

What people who use the service say

Patients said staff were good and had supported them.

Patients told us they could make drinks and snacks when they wanted to although the kitchen on Ambleside ward was locked. Patients said that when they complained about the lack of variety of food this had improved.

Our findings

Some patients did not have a copy of their care plan and one patient didn't know they should have one. Other patients said they were not involved in their care plan. Some patients told us they did not have one to one time with their named nurse.

Patients on Dale ward at Penn hospital and patients at Bushey Fields hospital said there were a lot of activities going on. However, on other wards patients said they were bored and there was nothing to do. Patients at Hallam Street hospital said they did not often get to the resource centre for activities so did not have a chance to meet patients from other wards.

Patients told us that staff were kind, caring and interested in them, they said staff knocked on their door before entering and treated them with respect.

One patient's relative said staff keep them updated on their family member. Another said that staff treated them and their relative with respect.

We rated this service as requires improvement at this inspection because:

The environment had not fully been adapted to ensure patients safety. However, the trust had undertaken significant work to assess ligature risks, undertake incident surveillance and provided funding to the wards where environmental risk was highest. Staff reduced the risks of blind spots by observing patients closely.

Patients said they did not always have one to one time with nurses, and leave was often cancelled. Doctors could not always attend the ward at night but were available by telephone. However, the wards had enough nurses and doctors to ensure patents were safe.

Staff did not always manage medicines safely and did not show they followed guidance from pharmacists.

The trust had not trained all staff in immediate life support.

Staff did not always develop holistic, recovery-oriented care plans informed by a comprehensive assessment.

Staff were not always able to provide a range of treatments suitable to the needs of the patients in line with national guidance about best practice. This was because there were vacancies for occupational therapists and psychologists on some wards. The ward teams did not always include or have access to the full range of specialists required to meet the needs of patients.

On Friar ward the staff did not always work well together as a multidisciplinary team or with community teams and external providers who would have a role in providing aftercare. Staff across the wards were not aware of the role of the newly formed Complex Care team within the trust.

The service did not always have a bed available locally to a person who would benefit from admission and patients were not always discharged promptly once their condition warranted this.

The governance processes did not always ensure that ward procedures ran smoothly.

However:

Our findings

Staff assessed and managed risk well and minimised the use of restrictive practices.

The ward environments were clean.

Staff followed good practice with respect to safeguarding.

The trust had reduced the staff turnover rates across the wards.

Managers ensured that staff received supervision and appraisal.

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 engaged in clinical audit to evaluate the quality of care they provided.

Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Is the service safe?

Requires Improvement 

Safe and clean care environments

All wards were clean, but the wards at Hallam Street Hospital and seclusion room at Macarthur centre were not safe. Some wards were not well equipped, well furnished, well maintained or fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. However, the environment of the wards on Hallam Street was not conducive to delivering safe care for acutely unwell patients. Hallam Street hospital was an old estate, with each acute ward spread over two floors within the hospital. Some work had been done to reduce risks following our previous inspection, however, windows and doors were still on order and had not yet been replaced. Staff told us that the doors had been delivered but were not anti – ligature so had been returned to the manufacturer to make them fit for purpose. At Bushey Fields hospital the trust had identified ligature risks on Wrekin ward however they were moving to a newly refurbished ward in May 2023. In the interim they had increased observations of patients based on individual risk assessments.

Staff could not observe patients in all parts of the wards. There were blind spots in some areas of the wards. On some wards these had been reduced by use of mirrors, however at Hallam Street there was a blind spot on the stairs that was not reduced by a mirror. Risk assessments stated where these were and where possible, patients at higher risk were in downstairs bedrooms and staff increased observations where needed to reduce risk.

Our findings

The wards complied with the NHS England guidance on delivering same sex accommodation and complied with this. At Hallam Street the wards were mixed sex. However, there were separate areas for male and female patients, they did not share bathroom or living facilities, and patients said they did not mix with each other.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. For each ward there was a ligature risk assessment that identified the action taken to reduce the risks. This included increased observation. The trust had a draft 'Ligature Harm Minimisation Strategy' as is best practice which included work on the buildings, therapeutic engagement with patients, risk assessments and management plans, and systems and processes to reduce the risks. The draft strategy was discussed in the trust Quality and Safety Committee in January 2023 but was still in draft form at the time of the inspection, but plans were in place to ensure this was progressed by the end of February 2023. The ratification of the strategy by the Trust board had not delayed the start of the building works. The ligature harm minimisation strategy was on the trust risk register.

Staff had easy access to alarms and patients had easy access to nurse call systems. The trust were updating the alarm system to ensure it was updated and worked well. At time of inspection all staff had an alarm and said they alerted other staff when needed.

Maintenance, cleanliness and infection control

Ward areas were clean, however they were not all well maintained, well furnished and fit for purpose. Ambleside ward at Dorothy Pattison hospital needed redecoration, we saw there was paint peeling off the ceiling and the decoration of the walls was tired and worn. One of the shower rooms was broken and not in use which meant for 21 patients there was one shower room and two bathrooms. On the male side of Friar ward at Hallam Street hospital the sofas were ripped, and staff said they had been ripped for a couple of months. The washing machine on Friar ward had not worked for eight weeks and needed replacing and the dishwasher in the male side kitchen had not worked for three weeks. Laundry facilities were provided on other wards at Hallam Street for patients use. The trust provided evidence post inspection to assure that they were aware of this before the inspection and replacements had been ordered. Since our inspection the washing machine and dishwasher were replaced.

Staff made sure cleaning records were up-to-date and the premises were clean. All wards were clean and cleaning records showed that regular cleaning was done.

Staff followed infection control policy, including handwashing. The trust had relaxed the requirement for staff to wear masks on the week of our inspection. Some staff continued to wear masks as their preference, and these were available, and bins were provided to safely dispose of them. On all wards there were hand washing facilities provided with soap and hand towels and we observed staff using these. Regular infection control audits were completed on each ward, and managers monitored the outcomes of these. Staff received e-learning training in infection prevention and control, and this met the trust target of 95% for level 1 training. However, for level 2 the trust target was 95% for e-learning but only 80% of staff had received this training.

Seclusion room

The seclusion room at the Macarthur Centre Psychiatric Intensive Care Unit (PICU) did not allow clear observation and two-way communication. A small wall had been placed between the toilet and wash hand basin which meant staff could not observe patients at all times. There was a clock that was visible from inside the room and was at the correct time on inspection. The seclusion area was poorly furnished and the toilet and washing facilities needed updating, we saw mould around the toilet and bare plaster on the walls. The trust showed us plans to update the Macarthur Centre which

are due to start in June 2023 and be completed by March 2024. In the interim, where the seclusion room needed to be used, staff tried to reduce risks by using the extra care area. This was an area outside the seclusion room itself but still part of the seclusion suite so was behind locked doors. Staff could observe the patient in all parts of the area or keep the seclusion room door open and enter to observe the patient where needed.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff told us that the 'crash bags' were heavy and that in a scenario training exercise it had been difficult to find the equipment needed. However, there had been no incidents where patients had been harmed. The trust had taken appropriate action to source and replace the crash bags which were lighter and more accessible. Following our inspection the trust confirmed that the new crash bags have been delivered and were now in use.

Staff checked, maintained, and cleaned equipment. In all clinic rooms we visited records showed that staff checked equipment regularly. Cleaning audits were completed regularly, and the clinic rooms were checked by a pharmacist on a weekly or twice-weekly basis.

Safe staffing

The service had enough nursing and medical staff, who knew the patients. However, they did not all receive basic training to keep people safe from avoidable harm.

Nursing staff

The service did not always have enough nursing and support staff on each shift. This meant that some staff sometimes did not get their full break, staff said they sometimes only had 30 minutes in the long day (12 hour) shift. Staff told us they should have 90 minutes break across the 12 hour shift.

The service had high vacancy rates. The vacancy rates in this core service ranged from 2.3% to 31% with an average of 22.4% in January 2023.

The service had reducing rates of bank and agency staff. Managers told us that they had recruited several regular bank and agency staff to permanent posts. When they did use bank and agency staff, these were mostly regular staff who worked on the ward often so knew the patients.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Most staff were block booked to work on specific wards, so they were familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Bank and agency staff said they had an induction before starting their shift on a different ward. Staff said they often worked on the same wards and were blocked booked by the trust to do this.

The service had reducing turnover rates. The trust target for turnover was between 10 to 13%. In December 2022 the turnover was 4% and 9% in January 2023 compared to 15% in February 2022.

Managers supported staff who needed time off for ill health. Staff said they were supported to take time off if they were unwell and not expected to come to work.

Our findings

Levels of sickness were low and / or reducing. The trust told us the sickness rate across the core service in January 2023 was 8% which had increased from 3% in December 2022 but decreased from 12% in February 2022.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. Ward managers could do this daily depending on patients' observation levels and needs.

Some patients said they did not have regular one to one sessions with their named nurse and staff said this was sometimes difficult to do depending on patients' needs and observation levels.

Patients sometimes had their escorted leave or activities cancelled. Staff said sometimes the doctor agreed that patients could have more leave than there were staff available to escort patients on this. This meant that patients expectations were not met, and patients did not receive the treatment they needed to support their discharge from hospital. On some wards there were not enough occupational therapists or activity staff. This meant that nurses and support workers did activities with patients, but they did not always have time to do these, and patients told us they were bored. .

The service had enough staff on each shift to carry out any physical interventions safely. Staff told us there were always enough staff to do this safely when needed.

Staff shared key information to keep patients safe when handing over their care to others. Staff told us and we observed that key information about patients was verbally handed over at the beginning of each shift. This was also recorded and available for staff to read.

Medical staff

The service had enough daytime medical cover but not always at night-time. Patients and staff told us there was always a doctor available for advice on call when needed. However, staff said at night it was sometimes difficult to get a doctor to come to the ward. They said that if a patient was admitted at night they may not be seen by a doctor until the morning. Doctors covered three sites at night, and it was dependent what was going on in other hospitals. During our inspection we saw staff calling doctors to see patients and the doctors responded quickly.

Managers could call locum doctors when they needed additional medical cover and made sure all locum doctors had a full induction and understood the service before starting their shift. Managers and doctors told us they could use locum doctors where needed and they had an induction.

Mandatory training

Staff had not completed and kept up-to-date with their mandatory training. The training figures provided by the trust showed that for face to face training the target was 75% and for e-learning was 95%. The information provided showed that for some face to face training the targets had not been met. For example, basic life support overall compliance was 59% with Dale ward at 25%, Abbey ward at 41%, Friar ward at 47%, Charlemont ward at 52%, Macarthur PICU at 55%, and Clent ward and Clee ward at 62%. For immediate life support training the overall compliance was 70% however on Ambleside ward this was 50%, Clent ward 54%, Friar ward 55%, Clee ward 66%, Dale ward 71%, Abbey ward 71% and Macarthur PICU 72%. We requested further information about this from the trust. They told us that due to the COVID-19 pandemic face to face training had paused, the merger of trusts where legacy trusts historically had different requirements and the ability to provide sufficient places with a historic provider had impacted on life support training.

Our findings

They said they completed a full tender and training needs analysis in July 2022 which streamlined their provision and ensured capacity to deliver so there was an improvement. They said that across the trust on 6 March 2023 e-learning for level 1 resuscitation was at 74%, adult basic life support was at 64%, basic life support for children at 74% and immediate life support was 77%. The trust had arranged further training sessions to increase the number of staff trained.

The mandatory training programme was comprehensive and met the needs of patients and staff. This included training in fire safety, moving and handling, violence and aggression, life support, equality and diversity, infection prevention and control, Mental Capacity Act, information governance, preventing radicalisation, safeguarding adults and children from abuse and dementia awareness.

Managers monitored mandatory training and alerted staff when they needed to update their training however this did not ensure all staff completed their training. The trust sent us reports of mandatory training compliance per ward that was colour coded to show when staff were due to update their training. Staff told us their ward manager and the electronic system alerted to them when updates were required. However, figures provided by the trust did not show that staff always completed their training when required.

Assessing and managing risk to patients and staff

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. The ward staff participated in the provider's restrictive interventions reduction programme.**

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. The trust used the 'Steve Morgan' risk assessment tool. Records showed that staff completed a risk assessment for each patient on admission. They updated these at least weekly and after any incident or changes in the patient's risk.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff also took appropriate actions to ensure patient items that could cause a risk to themselves or others were restricted. These were kept in a separate cupboard on each ward. There was no signing in or out process of these items, so it was unclear when patients had these and if they were returned to the cupboard. There was no evidence of any incidents that related to this.

Staff identified and responded to any changes in risks to, or posed by, patients. Records showed that staff reviewed and updated patients risk assessments at least weekly and more often where the patient's risks or needs had changed.

Staff followed procedures to minimise risks where they could not easily observe patients. In Hallam Street wards and Macarthur Centre seclusion room staff could not easily observe patients on all areas. They used observation based on each patient's risk assessment to minimise risks.

Our findings

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Records showed and patients said they were sometimes searched after unescorted leave from the ward which followed the trust search procedure and or policy. When needed and if staff believed there to be a risk, they searched a patient's bedroom and removed items that could put the patient or others at risk of harm.

Use of restrictive interventions

Levels of restrictive interventions were low. The trust told us they recorded each individual period of restraint in line with best practice. During a restraint, a patient may be involved in several different holds as the hold required to support the patient may change across the course of the incident. In the last six months across the 11 wards, there were 806 individual periods of restraint recorded across 631 incidents.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The trust was an accredited training centre with an external training provider. Its curricula meet Restraint Reduction Network Standards, focuses on prevention alongside teaching staff de-escalation skills as well as non-restrictive and restrictive interventions.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff told us they used restraint only as a last resort. Records showed that where restraint was needed this was a low-level hold to prevent patients from harming themselves and for the shortest amount of time needed.

Staff understood the Mental Capacity Act definition of restraint and worked within it. They said and records showed they used restraint only when it was proportionate and to prevent harm to the patient.

Staff did not always follow National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. One patient on Ambleside had required rapid tranquilisation four times in the week before our inspection. Their records showed that staff had not always completed their physical health observations following this. Staff had recorded that the patient was asleep or had refused these but had not observed their respirations. They omitted the observations four times after one administration and eight times after an administration. Physical health observations should have been recorded at least every four hours up to 48 hours after administration.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. There were 51 incidents of seclusion at Macarthur PICU in the six months before our inspection. Records reviewed showed that staff kept records of these, and nursing and medical reviews were completed on the patient.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. There were no patients in long-term segregation at time of inspection. The trust told us that in the last six months for this service there had been 14 incidences of long term segregation. This had involved nine patients, one on Brook ward and the other 13 at Macarthur PICU.

Safeguarding

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

Our findings

Staff received training on how to recognise and report abuse appropriate for their role. Staff kept up-to-date with their safeguarding training. Records showed that overall, 97% of staff had completed safeguarding adults level 1 and 94% of staff had completed safeguarding adults' level 2 training. The trust had trained 82% of staff who were eligible to receive safeguarding adults training level 3.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We saw examples of how staff had supported well patients who had a learning disability. Staff ensured that patients were not discriminated against due to their disability. We saw another example of where a patient had been supported to stop them being exploited by other patients on the wards.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Prior to our inspection there had been some incidents that staff had reported to their managers and the safeguarding team. Staff from the safeguarding team worked with the local authority safeguarding teams to protect patients.

Staff followed clear procedures to keep children visiting the ward safe. Staff told us that they risk assessed if a child was to visit the ward although children usually visited in a room off the ward which helped to keep them safe. Staff received training in safeguarding children

Staff knew how to make a safeguarding referral and who to inform if they had concerns. One patient's records showed they had been hit by another patient. Staff had completed an incident form and reported the incident to the safeguarding team as appropriate. There was an online tool in the incident form that went to the safeguarding team when needed. All staff including bank staff had access to this. There were safeguarding leads on each ward.

Staff access to essential information

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

Patient notes were comprehensive, and all staff could access them easily. There had been an outage of the patient electronic records system before our inspection. The trust had ensured that arrangements were in place to ensure this did not negatively impact on patients. Observation records were still in paper format, but the trust was putting in a system for staff to record these on an electronic tablet.

When patients transferred to a new team, there were no delays in staff accessing their records. The trust used the same electronic care records across all teams so when patients were discharged back to the community staff had access to their records.

Records were stored securely. Electronic records were password protected.

Medicines management

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Staff did not always show they followed pharmacists' advice. Staff did not always review the effects of medications on each patient’s mental and physical health.

Our findings

Staff did not always follow systems and processes to prescribe and administer medicines safely. All staff completed medicines competency on an annual basis and any concerns triggered a competency assessment. The pharmacist visited each ward at least twice a week to audit patient treatment cards and safe medicines management. However, most prescription records we reviewed did not show that staff took action to resolve the comments made by pharmacists in their audits.

One patient was prescribed medicine to be given by rapid tranquilisation. We saw that this patient was administered above the recommended dose of injections. We asked the trust for the rationale of this which they provided however, staff had given the injection off the manufacturer's licence, and this exceeded the maximum dosage. The trust sent us their draft rapid tranquilisation policy for this medicine which did not state this medicine should be given in a maximum of 4 doses. However, the rationale provided by the trust showed there was no harm to the patient and a positive outcome.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Records showed that staff reviewed patients' medicines at least weekly at their ward review meeting with their doctor. Patients said they were given advice and information about their medicines.

Staff completed medicines records accurately and kept them up-to-date. However, there were no photographs of the patients with their medicine record. This may mean that unfamiliar staff may not be able to identify the patient.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in locked cabinets in clinic rooms on each ward.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. When a patient was admitted staff checked their medicines and prescription to ensure they were receiving their prescribed medicines.

Staff did not always learn from safety alerts and incidents to improve practice. Patients medicine records had comments from the trust pharmacists which were written to improve staff practice. However, there was no indication on any of the wards that staff had made improvements as a a result of these.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. However, staff did not always have guidance as to which medicine to use for a patient when they were in distress. We saw in 16 of the prescription charts for as required medicines that they included two different medicines. They did not guide staff by stating which one to give first to the individual.

Staff did not always review the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence (NICE) guidance. Staff had administered medicine by injection to one patient. Staff had not followed the trust procedure for monitoring the patient's physical health observations after administration. They had recorded that the patient was asleep or had refused their observations however had not observed and recorded the patient's respirations.

Track record on safety

The service had a good track record on safety.

Our findings

We inspected this service following allegations that abuse had occurred and a multi- agency safeguarding meeting was convened to discuss the investigations of these. One of these attracted media interest following an incident where staff were reportedly sleeping in a patient's bed. The trust took appropriate action in response to these concerns and suspended the staff involved. The investigation was ongoing at time of inspection.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. All staff we spoke with said they knew how to report incidents and what to report.

Staff raised concerns and reported incidents and near misses in line with trust policy. All staff knew how to raise concerns in line with trust policy and said they would do so.

Staff reported serious incidents clearly and in line with trust policy. Staff had reported serious incidents and ensured that managers were aware of these.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff apologised to patients and their families and were honest about what had happened.

Managers debriefed and supported staff after any serious incident. All staff we spoke with said they had a debrief and were supported following incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers engaged with other professionals to investigate incidents. Patients and their relatives told us they were involved in investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. All staff received weekly emails with feedback about learning lessons in 'Mail on Monday'. However, some staff said they did not have time to read these. Throughout February the trust had focused on learning lessons with daily calls set up for staff to access but some staff said they did not have time to access these. This included incidents within the trust or in other services. Recent learning lessons had been about physical health care, transition from child to adult services and family involvement. There was a learning library on the trust intranet that all staff could access.

Is the service effective?

Requires Improvement 

Assessment of needs and planning of care

Our findings

Staff assessed the physical and mental health of all patients on admission. Staff reviewed patient care plans regularly through multidisciplinary discussion and updated as needed. However, they were not always personalised, holistic and recovery-orientated.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed 36 patients care records across the nine wards we visited. These showed that staff had completed a care plan for each patient of their mental health on admission.

Patients had their physical health assessed soon after admission. However, this was not regularly reviewed during their time on the ward for all patients. For one patient at Macarthur, we saw that staff had not monitored their physical health following an incident where the patient had harmed themselves. For a patient on Ambleside ward, we saw that staff had not monitored their physical health following administration of rapid tranquilisation. Another care plan for the patient's physical health needs did not refer to the detailed information about their physical health need on their risk assessment.

Staff did not always develop a comprehensive care plan for each patient that met their mental and physical health needs. For example, one patient who was admitted a week before our inspection only had care plans from the community and staff had not updated these on admission. In two patients' records there was no mention of how staff needed to support them to meet their physical health needs, but their records stated they had a physical health need.

Staff did not always regularly review and update care plans when patients' needs changed. For example, one patient care plan did not record their current prescribed medicines. Another had not been updated when the patient was no longer detained under the Mental Health Act and their observation levels had changed.

Care plans were not always personalised, holistic and recovery-orientated. Care plans we reviewed had standard statements in them that were sometimes contradictory. For example, a care plan stated, ‘patient has capacity’ and then stated ‘patient does not have capacity’ on the same page of the care plan. Other care plans stated, ‘copy of care plan declined’ and then said, ‘offered and accepted care plan’. Several care plans read the same for different people and did not show staff how the individual wanted to be supported. Another patient’s care plan had not been updated when their observation levels and Mental Health Act status had changed. Care plans did not record the patients' comments but were similar in content. One care plan did not include detailed information about the patient's individual needs that was in their risk assessment.

Best practice in treatment and care

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

Staff were not always able to provide a range of care and treatment suitable for the patients in the service. On some wards there were vacancies for occupational therapists and on others there were vacancies for psychologists. This reduced the therapies available to patients and meant that staff could not always deliver care in line with best practice and national guidance. On some wards where there were vacancies for psychologists' patients were referred to the community psychologist. Patients said they had to wait until they were discharged for this which meant they did not receive treatment in hospital. On wards where there were vacancies for occupational therapists or activity workers patients told us they were bored, and we observed patients sitting around with nothing to do. Nursing staff said they tried to do activities but often did not have time. At time of inspection these vacancies were being recruited to.

Our findings

Staff identified patients' physical health needs and recorded them in their care plans. Records showed that patients who were prescribed Clozapine (anti-psychotic medicine) attended clinics, had regular Electro Cardiograms (ECG's) and regular blood tests. However, in two patients' records there was no care plan for their physical health needs despite their records stating the patients had some needs.

Staff made sure patients had access to physical health care, including specialists as required. Most records showed that patients had access to physical health care and we saw referrals were made to specialists when required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Records showed that staff completed a malnutrition universal scale tool when patients were admitted which included their weight on admission. Staff regularly reviewed this by weighing the patient during their admission.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. On some wards patients told us they had regular opportunities to use the gym or have regular exercise. However, other patients told us that opportunities for exercise were limited, and they did not get off the ward. On all wards patients were offered smoking cessation programmes. The trust had relaxed it its smoke free programme during the COVID-19 pandemic but planned to reintroduce this during the summer months.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Records included rating scales for depression and anxiety. They also included an assessment of the patient's skin and risks of developing pressure ulcers and an assessment of their risks of falls.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. These included care planning, suicide prevention, learning lessons and reducing violence and aggression in the workplace.

Managers used results from audits to make improvements. Audits were discussed in board and quality committees. The infection control audits completed showed that improvements were needed in hand hygiene and the wearing of personal protective equipment. Further audits completed between September to December 2022 showed improvements had been made.

Skilled staff to deliver care

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

The service did not always have access to a full range of specialists to meet the needs of the patients on the ward. For example, at the Macarthur centre, there were vacancies for occupational therapists and activity workers although these posts were being recruited to. Some patients told us they were bored and there were no activities provided. At Hallam Street hospital, there were vacancies for psychologists. Some patients told us they had not seen a psychologist during their stay and had to go on the waiting list for psychology in the community when they were discharged. These posts were being recruited to. At Bushey Fields and Dorothy Pattison hospitals there was one physiotherapist who spent 50% of their time at each hospital. There was one speech and language therapist at Bushey Fields hospital.

Our findings

Managers did not always ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. For example, the number of staff who had received life support training was below the trust target. However, the trust had plans to increase the training provided so all staff could receive this.

Managers gave each new member of staff a full induction to the service before they started work. Staff said they received an induction when they first started working there. Agency and bank staff said they had an induction of the ward before they started their shift.

Managers supported staff through regular, constructive appraisals of their work. All staff we spoke with said they had an annual appraisal.

Managers supported staff through regular, constructive clinical supervision of their work. All staff we spoke with said they had monthly supervision.

Managers supported staff through regular, constructive clinical supervision of their work. Staff said they had opportunities for clinical supervision and were given time to do this.

Managers made sure permanent staff attended regular team meetings or gave information from those they could not attend. Permanent staff told us they had opportunities to attend monthly team meetings and if they were not at work, they had minutes of these. However, some bank staff told us they were not included in team meetings and did not feel part of the team.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Staff said they had received training in supporting people with a learning disability and said they had found this useful. Patients at Hallam Street said staff understood their sensory needs and we saw compliments that showed that staff had supported well patients who had a learning disability and those who had additional sensory needs.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multidisciplinary and interagency teamwork

Staff from different disciplines were not always available to work together as a team to benefit patients which meant there were gaps in some patients care. The ward teams had started to work with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. However, we observed a patients ward review at Hallam Street where there was a nurse and three doctors. They discussed the needs of the patient and the need for occupational therapy assessments but there was not an occupational therapist involved or present at the meeting. The patient's social worker was also not involved. Staff spoke about a new complex care team within the trust, but they were not involved with this patient yet. However, we did see in other patient records that where needed staff referred patients to other teams and professionals, for example, eating disorder teams. Some patient's records showed that staff had referred the patient to physiotherapists where appropriate.

Our findings

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. All staff said they had the information they needed during handover meetings at the beginning of each shift so they could support the patients.

Ward teams had effective working relationships with other teams in the organisation. Staff said that they worked with staff from home treatment teams to prepare patients for discharge. However, doctors had only recently found out about the 'Complex care team' within the trust and had not started working with them yet.

Some ward teams had effective working relationships with external teams and organisations. Patients who had a learning disability had care and treatment reviews. We saw that for patients at Hallam Street who had a learning disability that staff worked well with the patient's community teams. The commissioning manager were complimentary about staff at Friar ward and how they worked with staff from the Intensive Support Team to meet the patient's needs.

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

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

Staff said they received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. However, we asked the trust for figures to show that staff had received this, but they did not provide these.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. The trust provided support through Mental Health Act administrators and staff also had support through the trust intranet.

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Information was displayed about advocacy on the patient boards on each ward. We saw that patients had appealed against their detention and records showed that Mental Health Act Tribunals took place.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand but did not always repeat these as necessary. For example, one patient's records showed they didn't appear to understand their rights but there was no evidence these were repeated. Another patient was detained under Section 2 of the Mental Health Act so staff should have repeated their rights to them weekly. However, their records showed these were given twice in four weeks, on admission and four weeks after.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Patients and staff told us patients had section 17 leave and this was supported by staff escorting the patient where needed.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Records showed that SOAD were requested and reviewed patients' detention where needed.

Our findings

Staff did not always store copies of patients' detention papers and associated records correctly. For example, on Friar ward three patients had a T2 form (completed by the Responsible Clinician when it is believed the patient has the mental capacity to consent to their medication and consents to receiving it). However, only one patient had this printed off and in their prescription folder. Another patient was prescribed as required medication but there was not a T2 form completed to authorise this. This was discussed with the doctor during the inspection.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. All patients we spoke with were aware if they were detained under the Mental Health Act or informal and were aware of their rights about leaving the ward.

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The trust told us 82% of staff had received training in the Mental Capacity Act.

There were 72 deprivations of liberty safeguards applications made between 1st January to 31st December 2022 and managers knew which wards made the highest and monitored staff, so they did them correctly. Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. The trust had trained 90% of staff in the Deprivation of Liberty Safeguards.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Staff told us there was information available on the trust intranet that they could easily access.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. All staff we spoke with understood that they needed to assess patients' capacity for each decision they needed to make.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Records showed that staff assessed patients' capacity to make specific decisions and provided detail about this. However, one patient's care plan for capacity stated, 'does have capacity' and then stated, 'does not appear to have capacity'. Staff had reviewed this five times but had not shown that they were aware of the conflicting information that was written.

Our findings

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Records showed that decisions were made by the multidisciplinary team of staff and included input from an advocate and the patient's family or a social worker. They considered the patient's wishes and what was in their best interests.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. Managers completed audits on the Mental Capacity Act and made improvements where needed.

Is the service caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. Staff were observed interacting with patients throughout the day.

Patients said staff treated them well and behaved kindly. Patients gave positive feedback about staff, they said they were treated well and found staff supportive.

Patients' experience on the ward meant they did not always get one to one sessions with nurses and staff were often too busy to speak with them. Staff were not always available to give patients help, emotional support and advice when they needed it. Patients said there was not enough staff to talk to during the day, and that nurses were often too busy to speak to. Patients did not always know who their named nurse was. One to one sessions did not always take place and patients had raised this in community meeting as a concern. Patients saw a wide range of professionals to support their recovery, however there was no psychology available at Hallam Street Hospital.

Staff directed patients to other services and supported them to access those services if they needed help. Patient boards displayed community projects and groups to support patients once they had been discharged from hospital.

Staff understood and respected the individual needs of each patient. Staff showed good knowledge of patients and understood what they needed from their care. Carers said the same. Staff were able to describe reasonable adjustments that had been made for patients and why they had been made.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff said they could raise problems or concerns with managers if they needed to, that they would be listened to, and managers would take action to address these concerns.

Staff followed policy to keep patient information confidential. All staff we spoke with understood when information had to be shared to safeguard patients.

Our findings

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients had a tour of the ward on admission and were introduced to staff and other patients. Some patients said they were given information on their care and treatment, and the visiting policy was explained.

Staff did not always involve patients and give them access to their care planning and risk assessments. Most patients told us they had not been offered a copy of their care plan. One patient said they had seen a poster in reception about care plans, when they asked staff, it took 5 days to receive a copy of their care plan. Care plans were not routinely written and discussed with patients as a meaningful way to support recovery.

Staff mostly made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff involved patients in their weekly ward reviews to understand their care and treatment needs. However, one carer said they were not routinely invited to ward review, this meant they were not always up to date with care and treatment. Most patients said care plans were not made jointly with them.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Patients gave feedback through community meetings. Actions were taken from those meeting and followed up on. These were displayed on 'You said, we did' boards in ward areas. For example, staff had been using their phones whilst on the ward, this was raised in community meeting and staff were asked to not bring phones on to the unit. Patient saw this as a useful meeting between themselves and staff.

Staff made sure patients could access advocacy services. The patient board displayed details of how to contact advocacy services. Staff said advocates came on the unit weekly and would speak with all new patients to explain their role and how they can support.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Staff regularly informed families and carers with changes and updates. However, some carers said they were not included in ward reviews. Staff on Friar ward told us reasonable adjustments were made to the visiting policy when needed to ensure patients could keep in regular contact with family members.

Staff helped families give feedback on the service. Wards displayed information to support families giving feedback.

Staff gave carers information on how to find the carer's assessment. A carers service ran a weekly carers peer support group at Hallam Street Hospital, and this was advertised on the wards.

Our findings

Is the service responsive?

Requires Improvement 

Access and discharge

Staff were not able to manage beds well because of the pressure on the system. A bed was not always available when a patient needed one. Due to housing and social needs patients did sometimes have to stay in hospital when they were well enough to leave. However, patients were not moved between wards except for their benefit.

Bed management

At time of inspection the bed occupancy was at 100%. Staff said that as soon as a patient was discharged another patient was admitted.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. However, some patients had housing or social needs which meant their discharge was delayed. Some patients at Macarthur PICU were ready to step down to an acute mental health ward but there was not always a bed available for them to do so. This meant they were not able to progress in their recovery and discharge from the hospital.

The service had out-of-area placements as there was not a psychiatric intensive care unit within the trust for female patients. If a female patient needed this care the trust used beds in the independent sector.

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

When patients went on leave there was not always a bed available when they returned. Staff said they could not guarantee that a bed would be available when a patient went on leave. One patient said they did not want to go on leave because of this. This meant there could be a delay in their recovery and have a negative impact on their mental health.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. During the inspection we saw a patient moved from Macarthur to Brook ward and a patient was transferred from there to Macarthur. This was a clinical decision to meet their needs.

Staff did move patients in the evenings however they did not discharge patients at night or very early in the morning. On the day of inspection to Macarthur ward a patient was due to be transferred to Brook ward and a patient was to move from there to Macarthur. Staff told the patient at Macarthur that they would move before lunchtime. The patient had packed their belongings and spent the day walking around the ward at times agitated because staff were unable to tell them when they were leaving. When we visited Brook ward the following day, we found that the patient had not arrived there until late evening.

The trust had one psychiatric intensive care unit for men based at Macarthur in Sandwell. At time of inspection Macarthur ward had no beds available. The trust does not have a female psychiatric intensive care unit.

Discharge and transfers of care

Our findings

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. However, there were patients at MacArthur ward who were ready for step down to an acute ward but there were no beds to transfer the patients to. Some patients were ready to be discharged but did not have housing or appropriate placements to move to.

Due to housing or social needs, patients did sometimes have to stay in hospital when they were well enough to leave. At time of inspection there were two patients at MacArthur ward who were well enough to step down to an acute ward but there were no beds available. Across the wards we saw in patient records that the patient was ready to be discharged but their housing was not ready for them to move to. Patients said that staff helped them with their housing and their social workers visited the ward.

Staff often carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Patients' records showed that staff worked with patient's social workers, housing services and community mental health teams to plan the patients discharge from hospital well. However, we observed a patients review meeting on Friar ward where their community mental health team were not invited. This meant that the patients discharge was not well planned and there were not the professionals present at the meeting to make decisions about the patient's future. There was a new complex care team within the trust to help facilitate patients discharge and ensure communication with community teams however some staff were not aware of this.

Staff supported patients when they were referred or transferred between services. Staff spent time speaking with the patient who was transferred to Brook ward and reassuring them.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support patients' treatment, privacy and dignity. Each patient had their own bedroom. However, at Bushey Fields, Hallam Street and Dorothy Pattison hospitals patients had to share toilet, bath and shower rooms. Patients could keep their personal belongings safe. There were quiet areas for privacy on most wards but at Hallam Street patients only had their bedroom as a quiet area. The food was of good quality and most patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. However, one patient at Bushey Fields did not have curtains in their bedroom. Staff said these had been ordered. The patient said this had affected their sleep as it was too light in their bedroom. We observed on Ambleside ward that the décor was worn, and paint was peeling off the ceiling and walls.

The wards were being refurbished at time of inspection at Bushey Fields hospital which would increase patients access to bathroom and toilet facilities.

Patients had a secure place to store personal possessions. Each patient had their own locker and staff supported patients to access these when needed.

Staff on some wards used a full range of rooms and equipment to support treatment and care. At Bushey Fields Hospital patients had access to the activity hub five days a week. This was staffed by occupational therapists and assistants who worked with the activity workers on each ward. However, at Hallam Street Hospital patients did not regularly use the resource centre. This meant they used their living area (a lounge/dining area) for activities which meant that patients who did not want to participate in activities did not have access to the lounge at this time. Patients also did not have opportunities to meet patients from other wards.

Our findings

The service had quiet areas and a room where patients could meet with visitors in private. At Abbey ward there was a visitor's room that patients could use. However, on other wards at Hallam Street patients only had access to a dining room and lounge area apart from their bedroom and this was also where activities took place.

Patients could make phone calls in private. Most patients had their own mobile phones with them and went into their bedrooms to make phone calls. Patients could access the ward telephone where needed and arrangements were made for them to make calls in private.

The service had an outside space that patients could access easily. On all wards there was an outside space that had an allocated staff member so that patients could access the space. On MacArthur ward staff could not always open the door to this however this was repaired at time of inspection. There was an outdoor gym that patients could use although staff said this had not been used much and patients generally used the internal courtyard. On all wards the gardens were bare and on Brook ward there was no green area in the garden and no greenery could be seen from there. Ward managers spoke about plans to improve the outside space but there were no fixed timescales for this. On all wards we observed cigarette butts in the gardens and most patients that used the garden only went out to smoke. The trust planned to implement smoke free environments on all wards later in 2023.

Patients on most wards could make their own hot drinks and snacks and were not dependent on staff. However, on Ambleside ward the kitchen was locked due to the risks of one patient.

The service offered a variety of good quality food. Some patients said they had commented on the lack of variety of food, and this had improved their choices. Some patients said they did not have food that met their cultural background, but they had not requested this and when they went on leave, they visited supermarkets to purchase these.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients. We observed at patients' multidisciplinary review meetings that their employment and education was discussed. Staff could refer patients to the employment support team in the trust when needed. There was evidence that staff had supported patients to do voluntary work within the local community.

Staff helped patients to stay in contact with families and carers. Most patients had their own mobile phones but if not, staff ensured patients could use the ward phone. Relatives told us that even if their relative was unable to keep in contact, staff always ensured that relatives were contacted and updated.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. At Bushey Fields patients could go to the activity hub five days a week where they could meet patients from other wards. At Hallam Street there was a resource centre, but this was not often used by patients from the wards. Patients told us they did use the resource centre regularly. Space on the wards was limited and activities took place in the lounge/dining areas.

Meeting the needs of all people who use the service

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

Our findings

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. On all wards except at Bushey Fields there were specific bedrooms and a bathroom that were accessible for people with mobility needs to use and where possible patients with mobility needs used these rooms. Staff said at Bushey Fields if a patient needed disabled access they would be admitted to another ward in the trust. However, these wards were being refurbished to accommodate people with mobility needs. We saw in some patients records there were specific care plans to meet the patient's sensory needs. For example, in one patient's care plan there was clear information as to how to support the patient with activities and to finish one activity before going on to the next. For patients who had a learning disability or were autistic their records included a positive behaviour support plan. This showed staff how to support the person as an individual to help reduce their distress and anxiety. For a patient who was pregnant we saw staff supported them with regular midwife visits. Staff received training on how to use restraint on the patient if needed.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Patients told us they had this information and we saw it was provided in reception areas. On Friar ward we saw staff gave each patient a welcome booklet that provided a range of information for patients.

The service had information leaflets available in languages spoken by the patients and local community. We saw these in reception areas and staff said they could request further leaflets to meet patients' individual needs.

Managers made sure staff and patients could get help from interpreters or signers when needed. We saw that an interpreter was booked for one patient for an hour each day so they could speak about their experience at the hospital with them. One record showed a communication plan for patient whose first language was not English and included use of an interpreter.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. One patient said they did not have food that met their cultural needs but had not asked for this. One relative had brought food in for a patient that reflected their cultural background.

Patients had access to spiritual, religious and cultural support. We saw chaplains visiting individual patients during our inspection. There were multi faith rooms in each hospital for patient use and staff showed us that items for patients to pray and read books and information to meet their religious needs were available.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Patients and carers told us they knew how to complain if they needed to. Patients showed us a trust comment card where they could record compliments, concerns or complaints.

The service clearly displayed information about how to raise a concern in patient areas. Information was displayed in reception areas and on patient boards on the wards. Each patient on admission to Friar ward was given a booklet about the ward, this included information about feedback and how to give a compliment or make a complaint.

Staff understood the policy on complaints and knew how to handle them. All staff knew how to handle complaints by patients and said they would treat them seriously.

Our findings

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Information submitted by the trust showed that patients received feedback from managers. Where appropriate staff had apologised to the patient.

Managers investigated complaints and identified themes. The trust told us that across the service they had received 26 complaints and 122 informal concerns in the previous 12 months before our inspection. These had been dealt with at ward level and resolved so did not progress to a formal complaint.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Complaints information submitted by the trust showed that staff reassured patients they would not be discriminated against for raising complaints.

Managers shared feedback from complaints with staff and learning was used to improve the service. Information submitted by the trust showed that following investigation feedback was given to staff and improvements were made as a result.

The service used compliments to learn, celebrate success and improve the quality of care. The trust told us that across the service they had received 45 compliments in the previous 12 months before our inspection.

Is the service well-led?

Requires Improvement 

Leadership

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

Leaders had the skills, knowledge and experience to perform their roles. Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Ward managers and matrons showed they understood the services they managed.

Leaders were visible in the service and approachable for patients and staff. All staff told us that ward managers and matrons were approachable and were visible in the service. Patients knew who the ward managers were and said they were available to talk to. However, most staff said they had not seen managers above matron level on the wards.

Leadership development opportunities were available, including opportunities for staff below team manager level. Nursing staff had opportunities for leadership training and were given opportunities to take on leadership roles on the wards. On all wards there were 'Champions' such as for infection control, equipment testing and carers involvement.

Vision and strategy

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

Our findings

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. All staff told us they understood the trust vision and values and how they reflected these in their day-to-day work with patients and as a team.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff said they had been able to contribute to discussions in team meetings and things had changed. For example, staff discussed how stressful it was to be on constant observations of patients and this had been listened to.

Culture

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

Staff felt respected, supported and valued. Staff felt positive and proud about working for the provider and their team. All staff told us they felt valued and supported in their role. The trust had an established wellbeing strategy that included areas of staff support, recognition of staff burnout and impact of the cost-of-living crisis. This included a £50 shopping e-voucher to all staff in December to help with financial difficulties. Some staff told us they thought the wellbeing strategy was to be discontinued. However, minutes from the People Committee 23 January 2023 showed that the trust were committed to continuing the wellbeing plan, its initiatives and projects to support staff across the trust.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. All staff said they knew how to raise concerns and would do so if they needed to without fear of retribution.

Managers dealt with poor staff performance when needed. Where safeguarding allegations had been made, managers responded promptly and ensured all staff who were alleged were suspended pending investigation. Where appropriate managers contacted the agencies of the staff members to inform them.

Teams worked well together and where there were difficulties managers dealt with them appropriately. Staff from both previous trusts before the merger said they were supported and there was good teamwork.

Staff appraisals included conversations about career development and how it could be supported. Staff said there were lots of opportunities for career development within the trust.

Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. Staff said the trust supported flexible working which helped them to manage their childcare and those with long-term health conditions.

The service's staff sickness and absence were above the provider target. The trust target for sickness was 4.5%. This service exceeded that target for eight of the previous 12 months and at its highest was 7% in March 2022.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff told us they could access the wellbeing team which also included 24-hour support and a counselling service. Where needed managers referred staff to the occupational health service for support and reasonable adjustment plans were put in place.

Our findings

The provider recognised staff success within the service – for example, through staff awards. Managers shared compliments with staff. Staff told us that there were staff awards and they felt recognised when they had worked well.

Governance

Our findings from the other key questions, such as staff not completing physical health checks when needed, care plans not updated when patients needs changed and sufficient staff not receiving life support training demonstrated that team level managers had not always used the governance processes effectively to identify all risks. This meant that senior managers could not assure themselves that risk was managed well all the time.

There was not a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. We saw that learning from incidents and complaints was shared through emails and bulletins. However, staff told us they did not always get their breaks so may not have time to read emails and bulletins. It was not clear how managers could be assured that all staff including bank and agency staff had read and understood the learning to ensure this was embedded in their day-to-day work with patients.

Staff undertook or participated in local clinical audits. However, the audits were not sufficient to provide assurance and staff did not always act on the results when needed. For example, on all wards we saw that pharmacists visited the ward a few times a week. They made comments on patients' medicine records about improvements needed. However, these had not been addressed by nursing staff, so it was not clear if action was taken to make improvements. Audits of care plans had not identified that patients were not always involved in these. They had also not identified that standard statements used sometimes contradicted whether the patient had capacity to make a decision.

Staff did not always understand the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. However, some staff had not heard about the complex care team within the trust and did not know how to contact them. We saw that a patient's community team had not been invited to their review, so they were not involved in planning the patient's discharge from hospital.

Management of risk, issues and performance

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

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required. Staff said they were able to add items to the risk register.

Staff concerns matched those on the risk register. Staff told us their concerns were about staffing and the ward environments in some of the hospitals.

The service had plans for emergencies – for example, adverse weather or a flu outbreak. Staff were aware of these plans and responded where needed.

Information management

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

Our findings

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff said they had access to equipment on the wards to help them do their work. There were laptops and computers provided on each ward for staff use. The trust was to move towards completing patient observations on tablets rather than using paper which staff said would be useful. However, there were some difficulties with connections at Hallam Street hospital due to the lack of Wi-Fi signal.

Information governance systems included confidentiality of patient records. Staff had training on information governance, however only 81% of staff had received e-learning training at time of inspection in information governance. This was below the trust target for e-learning of 95%.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed. Staff reported incidents to the Care Quality Commission as needed and to the local authority safeguarding teams.

Engagement

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

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters and so on.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Patients said they were supported by staff to give feedback where needed.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. Staff told us that feedback from patients was shared so they could improve the service.

Directorate leaders engaged with external stakeholders including commissioners and Healthwatch. We saw that staff from this service worked well with the teams for people with a learning disability within the trust to provide a service to patients that met their needs. Patients with a learning disability had Care and Treatment reviews and staff ensured the patient was able to be involved in these.

Learning, continuous improvement and innovation

The trust has developed their ligature harm minimisation strategy in accordance with the latest best practice guidance co-produced by providers, the Royal College of Psychiatrists and the Care Quality Commission.

Our findings

Staff said they did not have the time to consider opportunities for improvements and innovation which could lead to changes. They said they did not have time to participate in research. However, student nurses from Wolverhampton University had placements on the wards. Nursing staff said this helped them to learn also and make improvements.

Staff used quality improvement methods and knew how to apply them but some of these had not progressed due to staffing vacancies. The trust told us of the quality improvement projects for this service. This included violence and aggression reduction in the workplace, suicide prevention and care planning. The violence and aggression reduction project showed that the trust aimed to increase the use of the 'Safewards' model. However, we did not see evidence of the use of this on the wards during our inspection.

Our findings

Areas for improvement

Action the service MUST take to improve:

The trust must ensure that patients have an opportunity to be involved in their care plans and are offered a copy of this. (Regulation 9)

The trust must ensure that all works to the environment to reduce ligature risks are completed. (Regulation 12)

The trust must ensure the seclusion room at Macarthur Centre is updated to make the environment more comfortable for patients in seclusion. (Regulation 15)

The trust must ensure that sofas and flooring on Friar ward at Hallam Street are replaced to make the environment suitable and comfortable for patients. (Regulation 15)

The trust must ensure that staff complete patients physical health observations following administration of rapid tranquilisation. (Regulation 12)

The trust must ensure that all staff receive training in basic life support and those eligible in immediate life support. (Regulation 12)

The trust must ensure that the rapid tranquilisation policy informs staff clearly of the maximum dose of anti-psychotic medicines to be administered and what action to take if administering medicines off the manufacturer's licence. (Regulation 17)

The trust must ensure that there are systems and processes in place to manage patients' restricted items. (Regulation 17)

The trust must ensure that there are sufficient staff so that patients have their escorted leave, regular one to one sessions with their named nurse and have access to psychology during their stay in hospital. (Regulation 18)

The trust must ensure that all staff are aware of the teams available within the trust and the community to facilitate safe discharge from hospital for patients. (Regulation 17)

Action the service SHOULD take to improve:

The trust should ensure that the environment at Ambleside ward is redecorated and comfortable for patients. (Regulation 15)

The trust should consider investing in the outside spaces and gardens on all wards to enable patients to enjoy time outside of the ward. (Regulation 15)

The trust should consider having photographs on patients' medicine administration records so that all staff can easily identify patients. (Regulation 12)

Our findings

The trust should consider how they manage daily rotas to ensure staff get sufficient breaks each shift. (Regulation 18)

The trust should ensure that all staff have an opportunity to know about learning from complaints and incidents and the trust are assured that staff understand these. (Regulation 17)

Our inspection team

The team that inspected comprised of three CQC inspectors and three CQC specialist advisors who were registered mental health nurses. An expert by experience was booked for this inspection but unfortunately was unwell.

We visited all five sites in this core service:

Macarthur Centre psychiatric intensive care unit

Penn Hospital – Brook and Dale wards

Bushey Fields Hospital – Wrekin, Clee and Clent wards

Dorothy Pattison Hospital – Ambleside and Langdale wards

Hallam Street Hospital – Friar ward

We did not visit Abbey and Charlemont wards at Hallam Street Hospital as there was an outbreak of COVID -19 there at time of inspection.

During the inspection the inspection team:

Looked at 36 care records of patients

Spoke with 27 patients on the wards

Spoke with 22 staff members including nurses, support workers, doctors and occupational therapists

Spoke with three carers of patients who were visiting

Looked at 51 prescription charts of patients

Attended four patients ward review meetings with their permission

Spent time observing staff caring for patients and the activities on the ward.

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing