Good

Black Country Partnership NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAJ20	Hallam Street Hospital	Charlemont Ward Abbey Ward Friar Ward	B71 4NH
TAJ52	Penn Hospital	Brook Ward Dale Ward	WV4 5HN
TAJ11	The MacArthur Centre	The MacArthur Centre	B71 2BG

This report describes our judgement of the quality of care provided within this core service by Black Country Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by Black Country Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Black Country Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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

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

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

Summary of findings

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Summary of findings

Overall summary

We changed the rating for safe from requires improvement to good because:

- At the last inspection, we found that the ward environments at hallam street hospital, abbey ward, charlemont ward and friar ward, did not have clear lines of sight that allowed staff to observe all areas. We found that improvements had been undertaken and that all blind spots had been mitigated with mirrors. The stairwells had been decorated and new lighting had been installed to improve visibility.
- At the previous inspection, we found a large amount of ligature risks on the wards at hallam street. We spoke with the managers of these wards and were informed that these had been identified in ligature audits. Upon re-inspection, we found that the trust had considered a number of solutions to this issue. They were unable to make changes to the environment due to the nature of their agreement with the owners of the building. This meant that these risks could not be fully eliminated. In order to address this, the trust had developed a document that identified all ligature risks and gave staff clear guidance on how each should be managed. This document included photographs of each risk and clear step by step directions.
- At the last inspection, we found that the wards at hallam street were not well presented. The walls and carpets were stained and there was an unpleasant odour throughout the ward areas. Some of the furniture in the day rooms was ripped and was in poor condition. During the follow up inspection, we found that all three wards were clean and well presented. Carpets had been changed and there was evidence that these were regularly cleaned. Decorating had been undertaken, doors had been replaced and new splash guards had been fitted in all bathroom, W.C. and kitchen areas. New furniture had been purchased and was in good condition. Overall the environment felt clean and well presented.
- At the inspection in 2015, there were staff vacancies in all wards across the service. We found that this had been addressed and several rounds of recruitment had been undertaken. We found that staff vacancies had been reduced in the 12 months since the previous inspection and were now at reasonable levels. The service had also developed links with agency staff and have developed a preferred staff list. This meant that there was a list of people who worked at the units regularly, had undertaken trust training programmes and were very familiar with the wards and patients.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- The service had made considerable improvements to the ward areas at both hallam street hospital and to the psychiatric intensive care unit at the macarthur centre. Friar, abbey and charlemont wards had all been refurbished with new furniture and had been decorated.
- Since our last inspection, the trust had undertaken several rounds of recruitment and staffing levels were high across all acute wards and the PICU. Vacancy levels were low with no ward carrying more than five vacant posts across any of the five acute wards and the PICU.
- Appropriate risk assessment processes had been introduced across the services. These documents were reviewed and updated regularly.
- The service had developed new documentation to safely mitigate the risks presented by the environment at hallam street hospital. A complete ligature risk document had been developed which gave staff all of the information they needed to safely manage all ligature risks. Since its introduction, abbey, friar and charlemont wards had not reported any incidents related to any of the ligature risks identified.

However

Safeguarding training levels were low across the service. None of the wards were above 70% compliance target in this area.

Are services effective?

Are services caring?

Are services responsive to people's needs?

Are services well-led?

Summary of findings

Information about the service

The acute wards for adults of working age and psychiatric intensive care units (acute wards or PICU) service at Black Country Partnership Foundation NHS Trust consist of five acute wards and one psychiatric intensive care ward. They provide support and treatment for adults of working age that require inpatient care relating to their mental health

Abbey ward, Charlemont ward and Friar ward are located at Hallam Street Hospital and were mixed gender services with nine beds for women and nine for men. All three wards are laid out in the same way and are serviced by a resource centre in relation to delivering sessions and serving meals. The resource centre was located externally of the main ward areas across a car park. There was no covered walkway to access this.

Brook and Dale wards were located at Penn Hospital. Brook was a 20-bed ward for men; Dale, an 18-bed ward for women. They were located in the same building and shared therapy rooms that were situated in a corridor just off the main ward areas

The MacArthur Centre is an 11-bed psychiatric intensive care (PICU) unit for males that is located at Heath Lane Hospital. It has two outside areas, therapy rooms, a dining area, a practice kitchen and two day areas located in the ward area. Any women that require PICU services have to go out of county, as the trust has no provision for a female PICU ward.

Our inspection team

Our inspection team was led by:

Head of Inspection: James Mullins, Head of Hospital Inspection (Mental Health), Care Quality Commission.

The sub-team which inspected this core services was comprised of one CQC inspector, two mental health specialist nurses, and an expert by experience.

Why we carried out this inspection

We inspected the acute wards for adults of working age and psychiatric intensive care units as a focussed follow up to the trusts comprehensive inspection in November 2015. We found a number of breaches in regulation at the time and told the trust to address these. These included:

- addressing the environmental risks associated with Abbey, Friar and Charlemont wards at Hallam Street Hospital.
- proper storage of patient information across all wards.
- the delivery of Mental Health Act and Mental Capacity Act training
- raising mandatory training levels to those stipulated in trust targets.

The provider had not assessed the risk to health and safety of service users in failing to identify and mitigate blind spots on Abbey ward, Charlemont ward and Friar ward at Hallam Street Hospital.

The provider had not taken steps that were reasonably practicable in failing to address the ligature risks that were identified in ligature risk audits at Abbey ward, Charlemont ward and Friar ward at Hallam Street Hospital.

The provider had not ensured that the premises used were safe to use for its intended purpose and used in a safe way at Abbey ward, Charlemont ward and Friar ward at Hallam Street Hospital.

All of the breaches in regulation 12, sections 2 (a), (b) and (d), occurred within the safe domain of the CQC inspection criteria and as such, we returned to undertake a focussed inspection of only the safe domain in October 2016.

The CQC had received a whistleblowing report between our inspection in 2015 and our most recent inspection. This related to The Macarthur centre. Claims were made

Summary of findings

that related to staff behaviour and falsification of records. We undertook a responsive inspection at the time of the whistleblowing and found no evidence to support the claim. We also found no evidence to corroborate the claim during our most recent inspection.

We found that the trust had addressed all of the concerns and we found no breaches in any regulations at the time of our most recent inspection.

How we carried out this inspection

To fully understand the experience of people who use services, we always asked the following question of this service and provider:

- Is it safe?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- Visited all five of the wards and the psychiatric intensive care unit (PICU) at three hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- Spoke with 18 patients who were using the service
- Spoke with one service managers, two modern matrons and six ward managers, one for each of the wards
- Spoke with 4 carers of patients currently using the service
- Spoke with 16 qualified nurses, six health care support workers, two occupational therapists and one social worker.
- Checked six clinic areas and in the process reviewed all medication charts.
- Reviewed 23 treatment records
- Reviewed two seclusion records
- Looked at training records for all six ward areas
- Reviewed six ligature audits for five wards and the PICU.

What people who use the provider's services say

All of the people we interviewed were complimentary of the staff. They stated that they felt safe and well cared for and were treated with dignity and respect. One patient stated that they felt that agency staff did not know them as well as full time staff but they felt this had not had a negative impact on the care they received.

The carers we spoke to during our inspection were extremely complimentary of the staff. They stated they felt included in the development of care for their relatives and were confident that the care that was delivered was of a high standard. We undertook a focus group prior to our inspection taking place that collected information from carers from across the trust. Concerns were raised about the level of carer involvement and carer safety whilst visiting ward areas. It was unclear if this related specifically to any one service.

Good practice

Friar, abbey and charlemont wards at Hallam Street Hospital had found an innovative solution to the problem of ligature points in the ward areas. As the trust did not own the building, they were unable to address some of the risks in more conventional ways. The service had developed a risk assessment document that contained photographs of the individual ligature points with a complete commentary of how each risk should be managed. This gave staff clear direction of how to mitigate each risk.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that the service meets its own targets in relation to mandatory training, in particular safeguarding level one, two and three.
- The provider should ensure clear information is provided in relation to training in the Mental Health Act and the Mental Capacity Act. This should include information relating to refresher training and responding to changes to the acts.

The provider should develop a system to ensure that staff undertake training. This should include a process of assessment to ensure that staff have the knowledge that they require to undertake the role for which they are employed.

Black Country Partnership NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Charlemont Ward Abbey Ward Friar Ward	Hallam Street Hospital
Brook Ward Dale Ward	Penn Hospital
The Macarthur Centre	Heath Lane Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- The use of the Mental Health Act was consistently good across all five acute wards and the PICU. The documentation we reviewed that related to detained patients was up to date, complete and stored effectively. All documentation relating to detainment was in place and completed correctly.
- Patients that we spoke to informed us that they had been made aware of their rights. There was evidence that processes were in place to repeat this as and when required. All T2 and T3 forms relating to medication and the use of a second opinion doctor were in place and complete.

Staff had undertaken Mental Health Act training. This consisted of an information leaflet and a video learning session. This had been backed up with some locally delivered sessions at Friar, Abbey and Charlemont wards at

Detailed findings

Hallam Street Hospital. All staff we interviewed had good knowledge of the code of practice. Some staff were not aware of the guiding principles but those that were, were able to talk about them in detail.

Mental Capacity Act and Deprivation of Liberty Safeguards

There was a policy available to staff relating to both the MCA and DoLS. Staff were aware of this and knew how to access it. Capacity to consent was assessed and recorded appropriately. This was done on a decision specific basis and reviewed weekly. People who had impaired capacity were given every assistance to make specific decisions for themselves before they were assumed to lack the capacity to make them. Staff told us how they would make an application for Deprivation of Liberty Safeguards. However, there were no patients on any of the wards that we inspected where this applied.

Staff had undertaken Mental Capacity Act training. This consisted of an information leaflet and a video learning session. This had been backed up with some locally delivered sessions at Friar, Abbey and Charlemont wards at Hallam Hospital. We also saw information leaflets at Brooke and Dale wards at Penn Hospital and Abbey, Friar and Charlemont wards at Hallam Street Hospital. These were designed to give staff information relating to the act and how it was applied.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- The environments at the MacArthur Centre, Brook ward and Dale ward were all unchanged from the last inspection. They offered good lines of sight and staff were able to observe all parts of the ward area. There were some ligature risks but these had been mitigated by assessment, process or observation. At Abbey, Friar and Charlemont wards, there had been considerable work undertaken to improve the environments because of last years inspection. Blind spot mirrors had been fitted. There was also improved lighting in corridor areas and a complete ligature risk assessment had been undertaken. This document contained photographs of all ligature risks with individualised action plans telling staff how each risk should be managed.
- The psychiatric intensive care unit (PICU) at the MacArthur centre is a male only service and as such, there were no same sex accommodation issues to explore. Brook and dale wards at Penn hospital were also gender specific with dale ward only admitting female patients and brook only admitting males. These wards did have some shared environments which included a number of group rooms and a gym area but these were managed with risk assessments and gender specific sessions. Friar, abbey and Charlemont wards were all mixed sex wards. This was managed well and all three were compliant with guidance on single sex accommodation. The wards were split in two with the right side of the ward being set aside for women and the left side for men. Each side had its own group room, lounge, kitchenette area and bathrooms. The only shared room on each ward was the laundry area, which was situated on the male side of each unit. This was only ever used under staff supervision.
- We checked the clinic areas in all of the six wards that we visited. We found them to be clean, fully equipped and well laid out. All equipment in the clinic areas were checked regularly and had documentation attached. Any equipment that required regular servicing or calibration had a sticker attached that stated the date that these checks should be undertaken and they were all in date.
- Only the PICU at the MacArthur centre had a seclusion room. This room was laid out in such a way that staff could observe all areas from the viewing window. It contained a toilet area and view of a clock.
- Brook and dale wards at Penn hospital are still relatively new wards and as such, the furnishings and décor were in very good condition. There were cleaning rotas available for both wards and we observed cleaning being undertaken during our visit. The MacArthur centre had removed all carpeting from communal areas and replaced with rubberised flooring. They had also redecorated and purchased new furniture for communal lounges. The ward was clean and well presented. Abbey, friar and Charlemont wards had purchased new furniture for communal lounges and had redecorated. They had fitted panels to the external doors and new splashguards in all of the bathroom areas.
- All staff that we observed adhered to good infection control protocols. We saw staff using hand sanitiser upon entering and leaving clinical areas.
- All equipment that we saw was in good condition, and where required, had relevant check stickers attached.
- We saw cleaning records for all of the wards that we visited. They were complete and in date and indicated that regular cleaning and deep cleaning were taking place.
- All wards we visited had in date and complete environmental risk assessments including comprehensive ligature risk assessments. They were reviewed regularly.
- All wards we visited had access to personal alarms with enough for all visitors and members of staff available.

Safe staffing

- Dale ward had 17 qualified nurses and 11 health care support workers (HCSW) as establishment figures. They had one qualified nurse vacancy and two HCSW vacancies at the time of our visit. Brook ward had 17 qualified nurses and 11 HCSWs as establishment figures with five qualified nurse vacancies. The MacArthur centre had 21 qualified nurses and 12 HCSWs as establishment figures and at the time of our visit had five vacancies for qualified nurses. Abbey ward had establishment figures of 14 qualified nurses and five HCSWs with three qualified nurse vacancies. Friar had

Good

Are services safe?

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establishment figures of 15 qualified nurses and nine HCSWs. They had a vacancy for one qualified nurse. Charlemont ward had establishment figures of 15 qualified nurses and 8 HCSWs and had two vacancies for qualified nurses at the time of our visit.

- The number of staff had been estimated as a result of a benchmarking exercise. Staff numbers had been increased since our last inspection and there had been a recruitment drive to address any shortfall.
- All bank and agency staff used were selected from a list of preferred staff and as such knew the service and patients well.
- All ward managers told us that they could manage their staff mix and make adjustments as required independently.
- The mix of qualified staff to HCSWs is such that there is always a qualified nurse available in communal areas of the ward.
- There was evidence in patients notes that there is enough staff to allow patients to have regular 1:1 time with their named nurse.
- We found no evidence that sessions were cancelled for anything other than emergencies. This is also what we were told by staff and patients we spoke to.
- Staffing levels for staff trained in physical holding techniques were sufficient that there was always enough staff to carry out physical interventions.
- We found that each ward had access to a psychiatrist and medical cover was available both day and night.
- We viewed the most current information available on the trusts training dashboard for all the wards that we visited. We found that all wards exceeded the trusts targets in most areas and were above 90% compliance with trust key performance indicators for mandatory training in most areas. We did find, however, that there were some deficits in Mental Health Act, Mental Capacity Act and Safeguarding levels one, two and three training. This training had been recently introduced and there were plans in place on all wards to ensure 100% compliance by the end of 2016

Assessing and managing risk to patients and staff

- Between November 2015 and October 2016 there had been 253 episodes of restraint at the MacArthur centre. Forty-three of these had resulted in the prone position being used. At dale ward, there had been 51 episodes of restraint with 10 of these being in the prone position. At brook ward, there had been 36 episodes of restraint with 11 of these requiring the prone position. At abbey ward, there had been 33 episodes of restraint with five of these requiring the prone position. At Charlemont ward, there had been 54 episodes of restraint with seven of these being in the prone position. Friar ward had 104 episodes of restraint with 14 of these being in the prone position. It was unclear from the figures if the data from friar ward included data gathered from the 136 suite which was attached to the ward.
- At the time of our inspection, the acute wards for adults of working age and psychiatric intensive care unit were using paper recording systems. We reviewed 23 treatment records and found them all to be in good order. We also attempted to review records held on the electronic recording system being trialled on abbey ward. We were unable to view any information using this system at the time of our visit as it was not working. Abbey ward also maintain treatment records in paper at this time as the electronic system was a trial version. We were able to view these and found them all to be complete and in good order.
- Staff had undertaken a risk assessment of every patient upon admission and these were updated regularly.
- We did not find any evidence of any blanket restrictions at any of the services we visited.
- Informal patients were free to leave at will. At Hallam street hospital and Penn hospital, the ward doors were locked but there were signs that informed informal patients that they could approach staff and request that they open the door. These signs were written in plain English and were backed up by staff members who would re-enforce this if approached.
- There were policies and procedures in place for the use of observations, searching patients and minimising risks from ligature points. The documents on abbey, friar and Charlemont wards relating to existing ligature points were particularly thorough. They had reviewed there ligature risk assessment and management processes as a result of our last inspection and developed robust documentation and assessments as part of their risk mitigation.
- There was evidence in patients notes that other strategies were attempted before restraint was used and it was only used as a last resort.
- We found that the use of rapid tranquilisation had been used in line with national institute of health and care excellence (NICE) guidelines.

Good

Are services safe?

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

- There were four patients in residence at the MacArthur Centre at the time of our inspection. As such there were only a limited number of seclusion records to view. We reviewed two seclusion records and found that it was being used appropriately. The seclusion records were kept appropriately. They were stored in a separate folder in a locked cupboard in the nursing office. They were available to be viewed by all staff if required.
- There was a deficit in safeguarding training across all six wards we visited. None of the wards were above 80% compliance with trust targets. Friar, Charlemont and abbey wards were all below 60% compliance. Staff that we interviewed did appear to have good knowledge of the safeguarding process though. We were told that this was due to the support of safeguarding leads on each of the wards that we visited.
- There were appropriate medications management systems in place. We checked all medication records across all six wards and found no errors in recording.
- There were safe procedures in place for children to visit the wards. Rooms set aside for child visits were separate from communal patient areas and could be accessed without going onto the main ward.
- Only the MacArthur Centre had seclusion facilities. There had been 190 episodes of seclusion between November 2015 and October 2016.

Track record on safety

- There had been 18 serious incidents in the acute wards for adults of working age and psychiatric intensive care units in the period between July 2015 and June 2016. There had been five on abbey ward, four on dale ward, four on friar ward, one on Charlemont ward, one on the MacArthur centre and two on brook ward. One other was not attributed to any particular ward in this service. The serious incidents related mainly to incidents of violence, aggression or serious self-harm or slips trips and falls.
- There was evidence that a lot of work had occurred to improve safety at both the MacArthur centre and wards at Hallam street hospital following our last inspection. The environment had been greatly improved in both areas. This included the introduction of equipment such as blind spot mirrors to improve visibility and reduce risk. New lighting to give better sightlines in corridors and coatings of doors to remove sharp edges. Ligature risk assessments and individual patient risk assessment processes had been improved across the whole service.

Reporting incidents and learning from when things go wrong

- All staff we spoke to knew what constituted an incident and how to report it.
- All of the incidents that we reviewed had been reported correctly and it appeared that all incidents that required reporting had been.
- Staff received feedback from investigations and complaints in a number of ways. Staff had regular staff meetings where information was fed back. There was also information posted on notice boards in staff areas and information was available electronically.
- There was evidence of change occurring as a result of improvements and investigations. This service had addressed all areas of concern that had arisen as a result of our last inspection and, where the environment made change difficult, innovative methods of improvement had been developed.
- There was a system of staff debrief in place. The service was trialling a new system of debrief that was facilitated by specially trained staff from across all staff grades including HCSWs. Staff stated that they felt that this system felt like a more comfortable process and there was less pressure to provide reasons for incidents and it was easier to focus on learning from the incident.

Are services effective?

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

Our findings

Assessment of needs and planning of care
<Enter findings here>

Best practice in treatment and care
<Enter findings here>

Skilled staff to deliver care
<Enter findings here>

Multi-disciplinary and inter-agency team work
<Enter findings here>

Adherence to the Mental Health Act and the Mental Health Act Code of Practice
<Enter findings here>

Good practice in applying the Mental Capacity Act
<Enter findings here>

Are services caring?

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

Our findings

Kindness, dignity, respect and support

<Enter findings here>

The involvement of people in the care that they receive

<Enter findings here>

Are services responsive to people's needs?

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

Our findings

Access and discharge

<Enter findings here>

The facilities promote recovery, comfort, dignity and confidentiality

<Enter findings here>

Meeting the needs of all people who use the service

<Enter findings here>

Listening to and learning from concerns and complaints

<Enter findings here>

Are services well-led?

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

Our findings

Vision and values
<Enter findings here>

Good governance
<Enter findings here>

Leadership, morale and staff engagement
<Enter findings here>

Commitment to quality improvement and innovation
<Enter findings here>

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.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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