Good

Birmingham and Solihull Mental Health NHS Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Specialist services	Dan Mooney House	RXT96
	Hertford House	RXT54
	Eden Unit Northcroft site	RXT27
	Reaside	RXT 64
Services for older people	Reaside	RXT64
	Juniper Centre	RXTD5
	Ashcroft	RXT06
	Little Bromwich Centre	RXT37
Long stay forensic and secure services	Ardenleigh	RXT05
	Reaside	RXT64
	Little Bromwich Centre	RXT37
Neuropsychiatry	The Barberry	RXTD3
Specialist eating disorders services	The Barberry	RXTD3
Adult community services	Trust Headquarters	RXTC1
Adult community-based crisis service	Trust Headquarters	RXTC1
Acute admission services	Eden Unit Northcroft site	RXT27
	The Barberry	RXTD3
	Mary Seacole	RXT47
	Solihull Hospital	RXT76
	Newbridge House	RXT37

Summary of findings

Perinatal services	**The Barberry** **Trust Headquarters**	**RXTD3** **RXTC1**
Psychiatric intensive care unit and health based places of safety	**The Barberry** **Eden Unit Northcroft site** **Mary Seacole House**	**RXTD3** **RXT27** **RXT47**

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

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 mental health services at this provider	Good 
Are mental health services safe?	**Requires Improvement** 
Are mental health services caring?	**Good** 
Are mental health services effective?	**Good** 
Are mental health services responsive?	**Good** 
Are mental health services well-led?	**Good** 

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

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health services in Birmingham and Solihull to over a million adults aged 18 years and older. It does not provide any children's mental health services.

We found that the trust was providing a good service overall to the population that it served. Within the core services inspected, we saw evidence of innovative and good practice. This was being delivered by caring and professional staff who were working together.

Improvements were required by the trust to ensure that the safety concerns identified in some of the core services inspected were addressed. We saw robust systems in place for managing most of the risks within the trust. There were clear trust protocols for identifying and investigating safeguarding concerns. Most staff were aware of their role in proactively identifying and reporting risks.

Overall the trust provided an effective service. We found that it provided evidence-based treatments that were in line with best practice guidelines. People were supported to make choices and, where possible, gave informed consent. Evidence that effective outcome measures were being used. The trust employed appropriately qualified and trained staff. On some of the units we visited, records of when people were detained for treatment under the Mental Health Act 1983 were inconsistently completed.

Overall the trust provided a caring service. We saw examples of staff treating people with kindness dignity and compassion. Feedback from people and their visitors was generally positive about their experiences of the care and treatment provided by the trust. Individual concerns about care being provided to some people were brought this to the attention of senior staff who responded appropriately.

Overall the trust provided a responsive service. We noted that the trust organised services to meet the needs of people in the local area. People's individual needs and wishes were met when their care and treatment was being assessed, planned and delivered. There was an emphasis on avoiding unnecessary admissions wherever possible.

We concluded that the trust was well-led, with proactive and responsive trust-wide leadership. Staff felt engaged and were well supported by their local managers. There were clear clinical governance systems in place to monitor and improve the trust's performance.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Improvements were required by the trust to ensure that the safety concerns identified in some of the core services inspected were addressed. We saw robust systems in place for managing most of the risks within the trust. There were clear trust protocols for identifying and investigating safeguarding concerns. Most staff were aware of their role in proactively identifying and reporting risks.

Requires Improvement

Are services effective?

Overall the trust provided an effective service. We found that it provided evidence-based treatments that were in line with best practice guidelines. People were supported to make choices and, where possible, gave informed consent. Evidence that effective outcome measures were being used. The trust employed appropriately qualified and trained staff. We found some inconsistencies in compliance with the requirements of the legislative requirements of the Mental Health Act 1983 on Bruce Burns unit, Magnolia, Newbridge and George units when people were detained for treatment. This could have an impact on people's legal detention under the Act.

Good

Are services caring?

Overall the trust provided a caring service. We saw examples of staff treating people with kindness dignity and compassion. Feedback from people and their visitors was generally positive about their experiences of the care and treatment provided by the trust. Individual concerns about the care being provided to some people were brought this to the attention of senior staff who responded appropriately.

Good

Are services responsive to people's needs?

Overall the trust provided a responsive service. Throughout the inspection we noted that the trust organised services to meet the needs of people in the local area. We found examples of innovative and collaborative working across the trust to meet the local assessed needs of people.

People's individual needs and wishes were met when their care and treatment was being assessed, planned and delivered. We found that staff had access to appropriate specialist services where required. However, we found that having older people with functional and organic mental health problems on the ward may have compromised the quality of care that both groups received.

Good

Summary of findings

The religious and cultural needs of people were being met. People spoken with told us they knew how to make a complaint and they would be listened to. Staff spoken with told us that they knew how to support people who used the service and their care or relatives to make a complaint.

Are services well-led?

Good

Most of the staff spoken with were aware of the trust's vision and strategy. We found that the trust was well-led, with proactive and responsive trust-wide leadership. Staff felt engaged and were well supported by their local managers. Most front line staff were committed to ensuring that they provided a good and effective service for people.

There were clear clinical governance systems in place to monitor and improve the trust's performance. For example, there was a trust wide risk register in place and this was linked to those local risk registers seen. We saw that actions had been taken to address the concerns identified.

Most of the staff we spoke with felt they were able to provide feedback about how it felt to work for the organisation and knew about the trust's whistleblowing policy and procedures. Staff felt that the organisation was reasonably responsive when concerns were identified.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett, Consultant Psychiatrist, Oxleas NHS Mental Health Foundation Trust

Team Leader: Julie Meikle, Head of Inspection (Mental Health), Care Quality Commission (CQC)

The team that inspected the trust included: CQC inspectors, consultant psychiatrists, Mental Health Act commissioners, senior psychiatric nurses, social workers, psychologists and experts by experience who were people that had previously used mental health services or were carers of someone using a service.

Why we carried out this inspection

We inspected this trust as part of our comprehensive Wave 2 pilot mental health inspection programme.

How we carried out this inspection

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

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

We carried out an announced visit to the trust between 12 and 16 May 2014. Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. During the visit, we held focus groups with a range of staff who worked within the service, including nurses, doctors, support staff and therapists. We talked with people who used the services their carers and/or family members.

We observed how people were being cared for and reviewed their care and treatment records. We carried out an unannounced visit to the specialist services being provided at Ross House on 16 May 2014.

Information about the provider

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health services in Birmingham and Solihull to over a million adults aged 18 years and older. It does not provide any children's mental health services.

The following core services it provides are:

- Specialist services.
- Older people's services.
- Specialist eating disorder services.
- Neuropsychiatry services.
- Perinatal services.
- Acute admission services.
- Psychiatric intensive care units and health-based places of safety.
- Adult community services.
- Adult community-based crisis services.
- Long-stay forensic and secure services.

Birmingham and Solihull Mental Health NHS Foundation Trust has 17 registered locations providing mental health care. This includes three hospitals sites: Northcote, Juniper and Raeside. It also provides community health services, which were registered as being managed from the trust's headquarters.

The trust was established as Birmingham and Solihull Mental Health NHS Foundation Trust on 01July 2008. Before becoming a foundation trust, the organisation was created on 01 April 2003 through the merger of the former North and South Birmingham Mental Health NHS Trusts,

Summary of findings

which included mental health services for Solihull. The trust now provides services from more than 50 sites, with an income of approximately £230 million, and employs more than 4,000 staff.

The trust provides inpatient services, community services and day clinics, as well as specialist services to a population of about one million people living within Birmingham and Solihull. Some of the specialist services are provided to a wider area outside Birmingham and Solihull.

The Care Quality Commission has inspected 17 locations registered by Birmingham and Solihull Mental Health NHS Foundation Trust since it first registered. This does not include visits by Mental Health Act Commissioners. We had previously visited eight of the services we inspected in May 2014 over twelve months ago. We issued twelve compliance actions against four of these locations. These were addressed fully by the trust at that time and subsequently followed up by the Commission. The trust was subsequently assessed as being fully compliant with the regulations.

What people who use the provider's services say

The community mental health patient experience survey for people aged 18 and above asked about the experiences of people who receive specialist care and treatment for a mental health problem. The last survey was conducted between 01 July 2013 and 30 September 2013. We reviewed the results of the survey for this trust before our inspection. The results showed us that the trust was performing well for most of the questions asked and had improved their overall results since the previous survey.

During our visit, we spoke with people who used the inpatient and community services. Most of the feedback we received was positive. People were often complimentary about the kindness and support shown by individual members of staff. People said that they felt listened to and that they were able to provide feedback to the service. They knew how to make a complaint and were listened to by the trust when they did this.

We reviewed the feedback systems used by the trust to gather the views of people who had used the service. We noted that the trust responded appropriately when any concerns were identified.

Some people told us that there were too many bank or agency staff and that they did not know the staff that supported them. Several people told us that they would like a wider range of activities provided and that they sometimes got bored.

Good practice

Innovative and good examples of best practice we identified at trust-wide level

The trust worked with the West Midlands Police and local ambulance trust to operate a 'street triage' service, which started in January 2014. The purpose of this scheme was to provide people with services they needed when they were in crisis and the police were called. Between January 2014 and May 2014 there was a 40% reduction in the number of people attending the health-based place of safety. Through this scheme, the trust's partners were engaged to make sure that people were provided with responsive and appropriate care. The care and dignity people received improved as they were attended to by skilled and trained staff. In addition, we saw evidence that people were avoiding police custody and being admitted to hospital admission through accident and emergency (A&E) departments. A&E staff were committed to joint working across agencies to help the people who used the service.

The trust used the Rapid, Assessment, Interface and Discharge (RAID) model of care in all of the local acute NHS trust hospitals. This made sure that people received the responsive psychiatric care and treatment they needed when they were admitted to hospital. People also had access to a responsive, multidisciplinary team that was provided immediate assessment and short-term interventions. The teams covered the needs of everyone aged 16 and above , including older people and people who had substance misuse problems. The model developed by the trust was effective as it provided a

Summary of findings

single point of contact for people in acute hospitals. It also ensured that people's needs were met, that hospital admissions were kept as short as possible and that discharges were better facilitated. The RAID team also worked with bed management if a person needed to be admitted to psychiatric services.

The trust had recently started a pilot project with The British Transport Police, which operated from the British Transport Police offices in Birmingham. The project identified people who displayed behaviour that was risky close to railway lines or train stations. This was a national project which covered most of England and aided the sharing of information between the police and local health services to protect people who may be at risk. While this was in the early stages of development, it indicated strong joint working between agencies.

The trust had effective and widespread process for consultations. These included the 'Dear John' initiative to the chief executive and 'listening into action', which made sure that people's opinions and views were heard by senior trust leadership.

We saw that the number of staff across the trust had increased since January 2014 to give people the care and treatment they needed and to safeguard them from harm.

Innovative and good examples of best practice we identified at core service level

The neuropsychiatry core service had a strong research focus.

We saw high standards of person-centred and innovative care practices on Rosemary ward and Ashcroft unit within the services provided for older people.

We saw good practice in community mental health services for older people. Services were integrated to provide a swift and effective response to people's needs.

The trust had provided specialist wards in the acute admission service, for example a service for deaf people and a service for young women under 18 years old.

The trust's specialised resettlement team located at Dan Mooney House supported people transferring from rehabilitation services to their new home.

Non-medical prescribing leads were in place in community services for prompt assessment and treatment.

The perinatal services had established excellent links with local acute hospitals to identify the needs of women in maternity units quickly.

The perinatal services had established an annual review of its performance this service which gave the people who used the service an opportunity to provide feedback.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must ensure that all people who used the acute admission services on the Barberry location, Mary Seacole house Newbridge house and the Bruce Burns unit are protected against the risks associated with the monitoring of safe temperatures for the storage of medicines and that people who require their physical health care medication receive this in a timely manner.
- The trust must ensure that the ligature risks identified at Mary Seacole House are risk assessed and addressed.
- The trust must ensure that all records for people who use the acute admission service on the Northcroft site are accurate and fit for purpose.
- The trust must ensure that sufficient numbers of suitably qualified, skilled and experienced staff are employed to ensure that the physical health care needs of people at Mary Seacole House and Newbridge House are being met.
- The trust must ensure that all the people who use the specialist rehabilitation services at Ross House are protected from the potential risk of abuse.
- The trust must ensure that all the people who use the specialist rehabilitation services at Ross House are treated with dignity and respect.

Summary of findings

- The trust must work with the commissioners of this service to address the length of waiting times for people to be assessed and treated by the neuropsychiatry service.
- The trust must make suitable arrangements to protect people on the Hollyhill unit who may be at risk from the use of unsafe equipment by ensuring that the equipment provided is properly maintained and suitable for its purpose.
- The trust must take proper steps to ensure that each person on the Hollyhill unit is protected against the risks of receiving care or treatment that is inappropriate or unsafe.
- The trust should work with their commissioners to determine whether older people with functional and organic mental health needs should be accommodated on the same ward.
- The trust should ensure that the examples seen of good practice on the Ashcroft unit and Rosemary ward are disseminated throughout the rest of the older peoples service.
- The trust should review the referral pathways into the specialist eating disorder service to ensure that care and treatment needs are being met in a responsive manner.
- The trust should ensure that the environment of Ross House is updated to provide care in a safe and rehabilitative environment.
- The trust should recruit to staff vacancies in the specialist core rehabilitation services.
- The trust should ensure that the community teams and the trust pharmacy carry out regular audits of the medication stocks held by the community teams, and that any identified concerns are addressed.
- The trust should work closely with commissioners to ensure that shared care arrangements with general practitioners are established within the youth clinical support team.
- The trust should provide specific training for all staff who work with people who have a diagnosis of a personality disorder.

Birmingham and Solihull Mental Health NHS Trust

Detailed findings

Requires Improvement

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

Summary of findings

Improvements were required by the trust to ensure that the safety concerns identified in some of the core services inspected were addressed. We found that the previously identified ligature risks at Mary Seacole House had not been addressed by the trust.

We saw robust systems in place for managing most of the risks within the trust. There were clear trust protocols for identifying and investigating safeguarding concerns. Most staff were aware of their role in proactively identifying and reporting risks.

Some of the records we saw on the acute admission services on the Barberry location, Mary Seacole house Newbridge house and the Bruce Burns unit did not provide strong evidence that people's medicines were stored according to the manufacturers' guidelines. We found that there were some delays in people receiving some of their prescribed medicines out of normal working hours. We were concerned about the management of risks and the promotion of safe practices on Ross House.

Our findings

Track record on safety

Senior managers spoken with had a good understanding of where the current risks were for the trust. We saw that the trust carried out regular safety and equipment audits. However we identified concerns with one suction machine on the Hollyhill unit within the older people's service. This was addressed by the trust during the inspection.

Most staff displayed a good knowledge about how incidents were reported and escalated within the trust. Staff confirmed that they received information about incidents when they were reported. All reported incidents were screened by the clinical lead and incidents,

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

complaints and feedback were discussed in the minuted directorate business meetings which were held monthly. We noted that clinical governance was a standing agenda item on all trust business meetings.

This meant that the trust was taking action to ensure that staff were aware of current issues in their directorate and across the wider trust which related to patient safety and feedback from people who used the service.

Learning from incidents and improving safety standards

We noted that monthly clinical governance meetings were held within each directorate. These were attended by the relevant clinical lead from each core service. These meetings ensured that issues, including incidents, from each of the services were discussed and shared across the services. The meetings also discussed the findings from clinical audits. The clinical lead then ensured that this information was shared at a local level through regular team meetings. This meant that the local core service had an understanding of local incidents but also promoted learning from incidents that happened across the trust. Staff were able to give examples of where incidents had been highlighted and when practices had changed as a result of the learning from incidents that had happened in the wider trust.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Most staff spoken with displayed a good understanding of safeguarding policies and procedures throughout the trust. This included knowledge of when to report safeguarding concerns and who to inform. We saw that most trust staff had received training related to safeguarding and that non-attendance at training was monitored through individual line managers. Trust staff throughout those services inspected told us that they felt they would be able to report concerns to their immediate managers or more senior management when appropriate.

However in Ross House we found that improvements were required by the trust to ensure that all the people who used the service were protected from potential abuse and were treated with respect and dignity. This was brought to the attention of senior trust staff during our inspection.

The trust had a whistleblowing policy and allowed members of staff to contact the chief executive with concerns about unsafe practice that front line staff were aware of. This meant that staff had the means to alert the trust to unsafe practice if identified.

Most of the core services inspected were being provided from premises that were clean and well maintained. Where individual concerns had been identified at Ross House. These had been brought to the attention of staff during the inspection. We found that the trust wide infection control policy and procedures were being effectively followed.

Assessing and monitoring safety and risk

Staff explained how they used risk assessments to ensure that the services they were providing were safe. Staff levels met the required complement. We noted that trust employed bank staff were used regularly. These staff were familiar with the service and had access to the same training and development opportunities as the permanent staff.

However in some specialist rehabilitation services inspected, we found that improvements were required by the trust to ensure that clear environmental risk audits were consistently and systematically carried out.

Within the George unit at Northcroft we noted clinical risks were not always fully assessed and recorded to ensure that all staff knew how to safely support each person who used the service.

Some of the records we saw on the acute admission services on the Barberry location, Mary Seacole house Newbridge house and the Bruce Burns unit did not provide strong evidence that people's medicines were stored according to the manufacturers' guidelines. We found that there were some delays in people receiving some of their prescribed medicines out of normal working hours.

Understanding and management of foreseeable risks

Most staff were aware of the trust's emergency and contingency policies. Staff told us that they knew what to do in an emergency within their core service. The trust used risk registers to record and assesses potential risks to the service. We noted that risk registers were reviewed monthly in order to reflect new and updated risks to the trust.

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

We saw an example of where the chief executive officer (CEO) had met with staff to review risks as identified by staff. Actions from that meeting were put in place to address these concerns.

Good

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.

Summary of findings

Overall the trust provided an effective service. We found that it provided evidence-based treatments that were in line with best practice guidelines.

Some core services within the trust had achieved accreditation through the College Centre for Quality Improvement (CCQI) which was part of the Royal College of Psychiatrists.

People were supported to make choices and, where possible, gave informed consent. Evidence that effective outcome measures were being used. The trust employed appropriately qualified and trained staff. Staff told us that they received monthly supervision and annual appraisals and this was evidenced by those records inspected. Senior staff told us that individual care practices would be observed as part of supervision where required.

We found some inconsistencies in compliance with the requirements of the legislative requirements of the Mental Health Act 1983 on Bruce Burns unit, Magnolia, Newbridge and George units when people were detained for treatment. This could have an impact on people's legal detention under the Act.

Our findings

Assessment and delivery of care and treatment

We found that most staff across the core services inspected had a good understanding of best clinical practice as it related to their own specific service. This included clinical guidelines as established by the National Institute for Health and Care Excellence (NICE). Most staff had attended training related to the use of the Mental Capacity Act (2005) and the Mental Health Act (1983) and was able to demonstrate their knowledge of relevant legislation and codes of practice. We found that the trust had good systems for assessing and meeting the physical health care needs of people who used its services. We saw that trust staff completed the relevant care and treatment documentation for people. We found that newly admitted people had been assessed promptly by staff and most people had a 72 hour care plan to enable staff to meet their assessed needs.

Outcomes for people using services

Evidence was seen of effective outcome measures being used throughout the trust. We noted that the Health of the Nation Outcome Scales (HoNOS) was being used throughout the trust to record outcomes for people who used the service. Examples were seen of other specific outcome measures being used. For example the Hospital Anxiety and Depression Scale (HADS) and the star recovery model in longer term services.

This showed us that outcomes related to the specialist needs of people using the service were being considered.

Some core services within the trust had achieved accreditation through the College Centre for Quality Improvement (CCQI) which was part of the Royal College of Psychiatrists. This meant they had been reviewed through a peer network and found to be providing good quality care. Staff in these services told us that they had benefited from being part of the peer network and had accessed support, training and information which enabled them to keep up to date with current best practice.

Staff, equipment and facilities

We noted that new staff had received both trust and local induction to the service. The records seen demonstrated that staff received mandatory and other training across the trust. Most staff told us that they had access to additional training and specialist continuing professional development (CPD) provided or supported by the trust. Some concerns were identified regarding the lack of dementia awareness and other specific training opportunities on some of the older peoples' services visited.

Staff told us that they received monthly supervision and annual appraisals and this was evidenced by those records inspected. Senior staff told us that individual care practices would be observed as part of supervision where required.

Good

Are services effective?

We saw that staffing levels had been increased across the trust since January 2014 to ensure that people had the care and treatment they needed and were safeguarded from harm. This was confirmed by most of the front line staff who reported that they were enough staff on duty to meet the needs of the people who used the service. Staffing noticeboards were on display in ward based areas showing the numbers and grade of staff on duty. We saw examples of additional staff being deployed by ward managers to meet the increased assessed needs of some people who used the service. For example when a person needed enhanced staff support.

Generally the trust's core services were being provided in clean and well maintained environments. Arrangements were in place for the servicing and maintenance of trust equipment. The trust met the requirement to provide single sex accommodation. We saw that activities were being provided. However some people on some acute admission and specialist rehabilitation services complained of feeling bored and of a lack of structured activities.

Multidisciplinary working

We found evidence of good multi-disciplinary working across the trust. We saw the involvement of a number of health care professionals in the provision of care and treatment. Those care and treatment records seen confirmed this. However concerns were expressed by some stand-alone units about out of hours medical cover from the trust's on call psychiatrists and from physical health care medical support.

The trust provided good examples of joint working with other health care providers. For example when people were being assessed for admission or discharge from inpatient units. Clear care plans were in place to meet the needs of people with complex and challenging needs.

Evidence was seen of pro-active discharge planning with local social services and other providers of health and social care. Evidence was seen that

Mental Health Act (MHA)

We found that most trust staff had received training regarding the use of the Mental Health Act (1983) and the Mental Capacity Act (2005). Non-attendance at training was being monitored by ward managers and we saw that steps were being taken to address this. Staff spoken with had an understanding of both Acts and how they impacted on their professional practice.

Generally those records seen across the trust relating to detention under the Act were well completed. For example we saw that people were being granted Section 17 leave and were having their rights under the Act explained to them under Section 132. We found some inconsistencies in compliance with the requirements of the legislative requirements of the Mental Health Act 1983 on Bruce Burns unit, Magnolia, Newbridge and George units when people were detained for treatment. This could have an impact on people's legal detention under the Act.

Good

Are services caring?

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

Summary of findings

Overall the trust provided a caring service. We saw examples of staff treating people with kindness dignity and compassion. Feedback from people and their visitors was generally positive about their experiences of the care and treatment provided by the trust. Individual concerns about the care being provided to some people were brought this to the attention of senior staff who responded appropriately.

Our findings

Kindness, dignity and respect

We found good examples of person centred care throughout the trust. Staff treated people with respect and kindness. Most people who used the core services provided spoke highly of the care and attention shown by staff. This was confirmed by most of those visiting relatives and carers that we spoke with. Individual concerns were brought to the attention of senior trust staff during our inspection. We noted that these were promptly addressed.

Examples were seen within the older peoples' services that people could choose what they would like to eat and drink and were then supported by staff where required. We saw that generally the privacy and dignity of people was being maintained by staff.

Involvement of people who use services

We saw front line staff actively involving people in their care throughout the core services inspected. For example seeking permission from the person before providing assistance. We found good examples of the active involvement of carers and relatives where appropriate. This was supported by most of the carers and relatives. We saw examples of formal and informal feedback received by the trust. The latter included a number of 'thank you 'letters and cards.

Most trust staff spoken with had a good understanding of the Mental Capacity Act. We were given some examples of recent capacity assessments carried out by the trust where applicable. Staff confirmed that they had received training on this Act. However we found concerns about the use of deprivation of liberty safeguarding applications on the Hollyhill unit within the older peoples' mental health service.

Trust staff were clear about how to secure advocacy services for people. Information was available around the trust about how to access advocacy services. Appropriate literature and information about advocacy services were available throughout the trust. In some of the services visited we saw examples of ward based meetings involving the people who used the service and these were being facilitated by people themselves or by staff.

Emotional support for care and treatment

When we reviewed individual care and treatment records and talked with people who used this service and their carers we found good examples of emotional support being provided by front line staff.

The front line staff had a good understanding of the needs of people who used their service. For example, we were told that if someone was admitted to a service who did not speak English fluently the trust would arrange for an interpreter to be present.

We found that the trust made effective use of noticeboards. These were used to signpost people to local self-help groups, charities, health promotion advice and provided condition specific information.

Good

Are services responsive to people's needs?

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

Summary of findings

The trust provided a responsive service. Throughout the inspection we noted that the trust organised services to meet the needs of people in the local area. We found examples of innovative and collaborative working across the trust to meet the local assessed needs of people. For example, the street triage service and the Birmingham Rapid, Assessment, Interface and Discharge (RAID) model of care within local acute NHS trust hospitals.

People's individual needs and wishes were met when their care and treatment was being assessed, planned and delivered. There was an emphasis on avoiding admission wherever possible.

We found that staff had access to appropriate specialist services where required. However, we found that having older people with functional and organic mental health problems on the ward may have compromised the quality of care that both groups received.

The religious and cultural needs of people were being met. People spoken with told us they knew how to make a complaint and they would be listened to. Staff spoken with told us that they knew how to support people who used the service and their care or relatives to make a complaint.

Our findings

Planning and delivering services

Throughout the trust we found that there was pressure on the availability of inpatient beds. The trust was addressing this through their bed management service. Staff from this service informed us that beds were prioritised based on assessed need and risk. During our inspection we saw that nine people were being accommodated out of the trust area. Staff reported that this number varied from week to week.

Senior trust staff confirmed that they were working with commissioners regarding developing urgent care pathways to ensure that the provision of community based care and inpatient bed provision met the assessed needs of the local population..

Right care at the right time

In every care setting visited we observed that when a person who used services required assistance staff responded appropriately. Although staff were busy, they always responded promptly to meet the needs of the people who used the service. Senior staff ensured that additional staff were on duty to provide enhanced support for people who required this.

We saw that people had information provided to them when they were admitted. However, we saw that there were significant delays in the times between referral and subsequent assessment to some specialist services being provided by the trust. For example within the neuro psychiatry and the eating disorders service. Senior staff confirmed that these issues were discussed at the regular meetings held with the commissioners of services. We found that front line staff were working hard to minimise any delays to accessing services where this was possible.

Care pathway

We saw that comprehensive assessments of people's needs were in place . This meant that the care plans reviewed reflected the specific care and treatment needs of people who used services. We saw that these were reviewed regularly by the multi-disciplinary team. Evidence was seen of clear admission assessment and discharge procedures.

We found that the trust worked closely with other professionals involved in the care and treatment of people, such as social services, when they were involved. When people were discharged back to primary care, sufficient discharge information was provided.

Throughout the services inspected we saw that multi- faith rooms were available for people to use and that spiritual care and chaplaincy was provided when requested. We saw that there was a range of choices provided in the menu that catered for people's dietary, religious and cultural needs.

Good

Are services responsive to people's needs?

Learning from concerns and complaints

We found that the trust had an effective complaint policy in place. Staff were aware of this. People who used the service told us they knew how to make a complaint and they would be listened to. Staff spoken with told us that they knew how to support people who used the service and their carer or relatives to make a complaint.

We found examples of where learning from complaints had been used to change front line practices and training for some staff. For example within the community services for older people we that the trust had initiated a care home liaison service to address this with the aim of minimising inappropriate care home placements, particularly for those with rare or complex forms of dementia.

Senior staff throughout the trust confirmed that informal concerns were addressed promptly and this was confirmed by most of those people spoken with and those care and treatment records reviewed.

Good

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.

Summary of findings

Most of the staff spoken with were aware of the trust's vision and strategy. We found that the trust was well-led, with proactive and responsive trust-wide leadership. Staff felt engaged and were well supported by their local managers. Most front line staff were committed to ensuring that they provided a good and effective service for people.

There were clear clinical governance systems in place to monitor and improve the trust's performance. For example, there was a trust wide risk register in place and this was linked to those local risk registers seen. We saw that actions had been taken to address the concerns identified.

Most of the staff we spoke with felt they were able to provide feedback about how it felt to work for the organisation and knew about the trust's whistleblowing policy and procedures. Staff felt that the organisation was reasonably responsive when concerns were identified.

Our findings

Vision and strategy

Most of the staff spoken with felt that different services within the trust worked well together. They told us that they felt proud to work for the trust. Some staff were concerned about the unsettling effect of proposed changes within some core services. However they confirmed that these changes remained under consultation with trust management.

Most staff were aware of the trust's vision and strategy and received regular updates from senior trust leadership. Staff were kept aware of this and other developments within the trust at regular staff meetings and via the trust's intranet site.

Senior staff were aware of the weaknesses and strengths of the trust and were committed to ensuring that the trust's vision and strategy were disseminated throughout the service. We found that staff were committed to ensuring that they provided a good and effective service for people who used the trust services.

Responsible governance

Throughout the trust there were clear governance and risk management structures in place. We saw that local governance structures were in place in all the core services inspected. Staff were aware of their role in monitoring concerns and assessing risks. They knew how to report these to their line manager.

Staff had an understanding of trust leads to contact for information if necessary regarding safeguarding and specific areas around use of the Mental Health Act (1983) and the Mental Capacity Act (2005). There was a trust wide risk register in place and this was linked to those local risk registers seen. We saw that actions had been taken to address the concerns identified by the trust risk register.

Leadership and culture

Staff spoke highly of their local managers and were aware of the trust's wider based quality initiatives such as 'Dear John' and 'learning into action'. Most of the core service inspected confirmed that they had been visited by senior trust managers and non-executive directors. We saw that some senior trust leaders took the opportunity to work alongside front line staff. For example the executive director of nursing worked a shift a month in front line services. Examples were seen of effective collaborative working within the trust and between the trust and other stakeholders. For example with the British Transport Police, West Midlands Police and local NHS acute hospital providers.

Engagement

We saw that there was information available throughout the trust about how to provide feedback on the specific services received by people. Evidence was seen of the availability and accessibility of independent advocacy throughout those services visited. Staff were able to attend local clinical governance meetings and had regular meetings with their managers to ensure that their concerns were captured. Most of the staff we spoke with felt they

Good

Are services well-led?

were able to provide feedback about how it felt to work for the organisation and knew about the trust's whistleblowing policy and procedures. Staff felt that the organisation was reasonably responsive when concerns were identified.

Performance improvement

We saw that the trust had robust systems in place to ensure that staff received regular supervision and annual appraisals from their line manager. We saw that staff appraisals identified training needs. We saw examples of where the trust had responded to specific identified concerns with their services. For example, we saw that actions had been taken to address concerns regarding waiting times for treatment by the neuro-psychiatry service. We found that there had been a case shared at board level to look at increasing the capacity of the service and this had been progressed by senior managers.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust must ensure that people on the Bruce Burns unit are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user. Regulation 20 (1) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust must protect people on the Oleaster Centre, Mary Seacole house, Newbridge House and the Bruce Burns units against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording and safe keeping of medicines. Regulation 13

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust must take proper steps to ensure people in the Ross House service are protected against the risks of receiving care or treatment that is inappropriate or unsafe. Regulation 9 (1) (b) (i) (ii)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	The trust must make suitable arrangements to ensure that each person in the Ross House service is safeguarded against the risk of abuse by means of

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury	• Taking steps to identify the possibility of abuse and prevent it before it occurs and • Responding appropriately to any allegation of abuse. Regulation 11 (1)(a) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust must make suitable arrangements to protect people on the Hollyhill unit who may be at risk from the use of unsafe equipment by ensuring that the equipment provided is properly maintained and suitable for its purpose. Regulation 16 (1) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust must take proper steps to ensure that each person on the Hollyhill unit is protected against the risks of receiving care or treatment that is inappropriate or unsafe. Regulation 9 (1) (b) (i) (ii)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust must ensure that people on Mary Seacole House are protected against the risks associated with unsafe or unsuitable premises; by means of suitable design and layout. Regulation 15 (1) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust must ensure that sufficient numbers of suitably qualified, skilled and experienced staff are employed to ensure that the physical health care needs of people at Mary Seacole House and Newbridge House are being met.

This section is primarily information for the provider

Compliance actions

Regulation 22

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust must take proper steps to work with the commissioners of this service to address the length of waiting times for people to be assessed and treated by the neuropsychiatry service. Regulation 9 (1) (b)(i)