

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Inspection report

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2023, 19 October 2023
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Ratings

Overall rating for this service

Inspected but not rated ●

Are services safe?

Inspected but not rated ●

Are services effective?

Inspected but not rated ●

Are services well-led?

Inspected but not rated ●

Our findings

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

Inspected but not rated



Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health services for people of Birmingham and Solihull, and to communities in the West Midlands and beyond. Birmingham and Solihull Mental Health NHS Foundation Trust was established on 1 July 2008. Before becoming a foundation trust, the organisation was created on 1 April 2003 following the merger of the former North and South Birmingham Mental Health NHS Trusts. The trust provides a range of inpatient, community and specialist mental health services for people from the age of 16 years upwards in Birmingham and for all ages in Solihull. However, the trust provides services to children younger than 16 in forensic child and adolescent mental health services and Solar services. Other community mental health services for children and young people in Birmingham is provided by another NHS trust. The trust provides services to 73,000 service users, with 700 inpatient beds across over 40 sites. The Trust has an annual income of £429 million.

We carried out this unannounced inspection on the three core services of acute wards for adults of working age and psychiatric intensive care units, long stay/ rehabilitation mental health wards for working age adults and forensic inpatient secure wards. This was an unannounced focused inspection to review progress against the conditions we imposed on the trust's acute wards for adults of working age and psychiatric intensive care units on 16 December 2020. This required the trust to take steps to address the ligature risks on all acute wards and implement an effective system to improve risk assessments and care planning. We also reviewed progress following the S29a warning notice we issued the trust with on 3 January 2023 on all three core services. This required the trust to make significant improvements regarding the trust deploying sufficient numbers of staff to work on the wards with patients and those staff receive the right training, professional development and have access to supervision and appraisal.

We also used the mental health observation tool across the wards observing staff interactions with patients and speaking with patients. This was to inform our work on Observing, Understanding and Improving Cultures on mental health wards.

We inspected some of the key lines of enquiry relating to Safe, Effective and Well led at this inspection. We did not rate at this inspection.

Following our previous inspection, we rated the core services of acute wards for adults of working age and psychiatric intensive care units as Requires improvement overall, Inadequate for Safe and Requires Improvement for effective, Caring, Responsive and well Led.

At this inspection we found:

Work had been completed to reduce the risk of ligature points on the acute and PICU wards which meant the conditions imposed on the trust on 16 December 2020 had been met. The trust had plans to reduce these risks on the forensic and secure wards also. The trust had prioritised the acute and PICU wards due to the increased risks of people using these services. However, in the interim they reduced risks on the forensic and secure wards. This included locking the ensuite doors back and increasing patient observation levels where needed.

The patients' care planning and risk assessment system had improved since we imposed the condition on 16 December 2020. The trust had implemented a system where the patient's care plan was reviewed and discussed in their

Our findings

multidisciplinary team meeting. In some care plans and risk assessments this review was not updated into the patient's care plan or risk assessment so that all staff working with the patient may not know of changes. However, this information could be found elsewhere on the system for staff to access. Whilst further improvements were still needed to embed, the system had been implemented to improve care planning, therefore overall, this condition had been met.

We found that not all patients had been offered a copy of their care plan and there was not a record that the patient or their family or carers were involved in their care plan.

Following the warning notice we served on 3 January 2023 we found at this inspection that staffing had improved across the wards however further improvements were needed. The trust was using a safer staffing tool which assessed the staffing levels needed for each ward based on the patients' needs. However, staff told us that sometimes they were moved to other wards to work which meant there may be only one qualified nurse remaining on a ward. Qualified nurses said they did not always get their breaks. Patients and staff told us that their authorised leave was sometimes delayed because of staffing. Some patients told us they did not have support from an occupational therapist which meant they had not been assessed for their rehabilitation skills.

Improvements had been made to staff appraisal rates since our inspections in October 2022. Staff said improvements had been made to them receiving supervision and data showed this had improved. However, the system to electronically record these was still difficult for staff to use and some staff still did not have access to this system. Therefore, the data received from the trust did not show that all staff had received regular supervision or an annual appraisal.

Some staff had not completed their mandatory training. These included training in emergency and immediate life support.

On George ward there was litter in the courtyard which did not make it a pleasant environment for patients to spend time off the ward and have fresh air.

What people who use the service say:

We spoke with 46 patients across the three core services we visited.

Most patients told us that the staff were good and supported them to feel safe.

Patients who were ward representatives on the 'Residents Council' were proud of this role. They said they had the opportunity to improve all wards and that staff listened to their suggestions and acted to improve the wards.

Patients said their physical health needs were monitored and they always saw a doctor if they needed to.

Some patients were not aware what an advocate was. However, on all wards we saw that there was information displayed about the advocate with contact details. Staff told us the advocate visited at least weekly and was available by telephone if needed.

Patients had mixed views about the food and some patients said it lacked taste. However, all patients said they had a choice of food and where appropriate met their cultural and dietary needs.

Our findings

Is the service safe?

Inspected but not rated



Safe and clean care environments

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

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. We reviewed these assessments and found these were regularly updated.

The ward complied with guidance and there was no mixed sex accommodation. All wards were single gender so there was no mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. At our previous inspections in November 2020 and October 2022 we found the trust had identified a ligature risk over bedroom and bathroom doors following a series of serious incidents and were in the process of fitting door alarms to both bedroom and bathroom doors. We visited each acute ward and psychiatric intensive care unit during this inspection to check these alarms had been fitted. We found that the trust had fitted these alarms on each bedroom and bathroom door to reduce the risks of patients harming themselves.

Maintenance, cleanliness and infection control

Ward areas were not all clean and well maintained.

We saw that there was a pile of litter in the courtyard of George ward at Northcroft. This included several discarded disposable e-cigarettes and was not a pleasant environment for patients to spend time in off the ward.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. However, staff expressed concerns on all wards that when there were enough staff on a shift, they were often moved to cover other wards where there were shortages. Qualified nurses said they were often the only qualified nurse on a shift when there should be 2. They said this was stressful, and they often did not get a break during their shift.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff on all wards told us that they had a dedicated core group of bank staff that they could use to fulfil short notice staffing deficits and advance off duty rotas. This meant that these staff were familiar with the trust and wards.

Our findings

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Staff told us that bank and agency staff had an induction and knew the wards before starting their shift.

The service had reducing turnover rates. Data provided by the trust showed that in September 2023 across this core service staff turnover rates had reduced from 9.28% in April 2023 to 7.85%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The trust used the Mental Health Optimal Staffing tool (MHOST) to review and calculate nurse staffing requirements based on acuity, dependency, and workload of patients on a ward. Matrons at Oleaster told us that there were 10 staff each day that were 'floaters' who were on a separate rota. This meant that they could be allocated to assist where higher observations were needed and if a patient was in the general hospital and needed to be escorted by staff. Matrons said staffing was discussed at the daily 'huddle' meeting where it was agreed which staff would be allocated where to ensure patients' needs were met that day. However, they acknowledged the difficulties of moving staff around wards and said this affected staff morale.

Staff told us that staffing had improved in the last 12 months and that the trust was taking this seriously. All ward managers and matrons spoken with referred to the review of safe staffing levels and said this indicated a willingness of senior leaders to listen to and address staffing issues. However, staff across all locations told us that wards were short staffed. They said this was due to establishment figures not being high enough and the impact of staff moved across wards and locations. Staff on all wards told us that when they had a full establishment for a shift, staff were often moved to alternative wards across sites and locations. Staff told us that they found this frustrating. Some staff told us that they often worried more about coming into work and being moved rather than being short staffed. Newly qualified staff nurses also told us that they had some anxiety about working shifts alone if the more experienced qualified nurse was moved to another site or ward. Newly qualified nurses said they often felt vulnerable if the other qualified was moved to another ward. Ward managers on ward 1 at Mary Seacole House and Melissa ward at Oleaster were used in the established numbers to support. Staff also shared the impact of reduced numbers of qualified nursing staff on shift. They said that the ward could be left vulnerable, or staff were unable to go on breaks if the qualified staff had to attend ward rounds or tribunals. We observed this on George ward.

The ward manager could adjust staffing levels according to the needs of the patients. Ward managers were able to increase staffing for incidents or where patients needed increased observations from staff. Staff told us that ward managers could increase staffing numbers for safe staffing if there was an incident or concern on the ward that justified additional staff. Staff rotas reviewed on George ward and Melissa ward showed managers had requested 2 additional bank health care assistants following incidents and due to increased observations for patient safety.

Patients rarely had their escorted leave or activities cancelled but their escorted leave was often delayed until later that day or sometimes the next day. All staff told us that patients had been impacted by the staff shortages. They said although it was rare for scheduled section 17 leave to be cancelled, planned leave was often delayed. On some wards staff told us that this was more frequent if there was a patient on increased observations. Staff also said this impacted on patients' well-being and they thought it increased incidents on the wards. We observed on Melissa ward a patient repeatedly asked to go out on leave who became increasingly frustrated at being told they needed to wait. On Eden PICU the activity worker post was vacant which meant patients did not get many planned activities. However, we found that where there were activity workers and occupational therapists, they were not used to cover nursing staff doing patient observations. They had time to specifically concentrate on activities and therapies with patients.

Mandatory training

Our findings

Staff had not all completed and were not all up-to-date with their mandatory training. Data provided by the trust showed that for emergency life support (ELS) training only 44% of staff on Eden PICU, 57% of staff on Eden acute ward and only 29% of staff on George ward had completed this. For intermediate life support (ILS) only 29% of staff on Eden acute ward, 56% of staff on George ward and 64% of staff on Eden PICU had completed this.

At The Oleaster on Melissa ward only 55% of staff and on Tazetta ward only 62% of staff had completed ELS training. Only 62% of staff on Melissa ward had completed ILS training.

At Mary Seacole House on ward 1 only 58% of staff and on ward 2 only 67% of staff had completed ELS training. On ward 2 only 64% of staff and at Meadowcroft only 62% of staff had completed ILS training.

However, across the trust 84% of staff had completed safeguarding adults training at level 3 and 86% of staff had completed safeguarding children training at level 3.

Managers monitored mandatory training and alerted staff when they needed to update their training. All staff said they were alerted on the computer system when their training needed to be updated and managers also monitored this. However, some staff said their training was sometimes delayed due to staffing.

Assessing and managing risk to patients and staff

Staff assessed but did not always manage risks to patients and themselves well.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 25 patient records in this core service. Most patient's records showed their risks had been assessed and updated when needed with a clear formulation of their risk.

Management of patient risk

Staff did not always know about all risks to each patient so they could act to prevent or reduce risks. For example, one patient record showed they had a history of offending, but the risks of this were not assessed in their risk assessment. Another patient records stated they were racially abusive but there was no management plan to manage this risk. Another patient's records at Meadowcroft showed the patient had 2 risks but only 1 of these was included in their risk management plan. It was not clear how staff were to manage the patient when they behaved in an aggressive way.

The audit completed on Larimar ward showed that in several risk management plans included the old plans which had not been deleted so could cause confusion when assessing current risk.

On Meadowcroft PICU the audit completed showed that in 2 of 10 risk assessments reviewed that old formulations and risk management plans were still present on the risk screening tool, which could lead to confusion on the current management plan of the patient.

Our findings

Is the service effective?

Inspected but not rated



Assessment of needs and planning of care

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

We reviewed 25 patient records in this core service. Each record contained a care plan for the patient.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We saw in one patient care plan that their choking risk had been assessed by the speech and language therapist and a plan in place with thickened drinks to reduce the risk.

Staff developed a care plan for each patient, but we found these were task focused. Matrons had recognised this in their audits and reported this to the clinical governance group. There was an action plan in place to resolve this.

Staff regularly reviewed and updated care plans when patients' needs changed. These were discussed and updated at patient's multidisciplinary team meetings. However, this information was not always transferred to the patients care plan, so it was not easy for staff to access this information.

Care plans were not always personalised, holistic and recovery orientated. Some care plans lacked personalised information. It was not clear to see how the patient had been involved in their plan and if they had received a copy. However, at Eden PICU we saw a care plan that was personalised and written in a way the patient could understand. Staff also told us that patients were offered a copy of their care plan weekly and in some records, this had been documented. One patient's care plan on Meadowcroft was holistic and included details as to how staff could meet their physical health and spiritual needs.

Care plan audits completed by Matrons on Larimar ward, Newbridge House and Japonica ward in October 2023 showed that patients and their carers views were not always included, and the patient had not always been offered a copy of their care plan. The audit on George ward in July 2023 showed that 64% of patient's relatives had not been contacted with no explanation given. The matrons said this was partly due to the computer system used. They said when the care plans were printed off all the information on the system pulled through onto this copy which included more detail such as the patient's views.

Staff had not always updated patients records each day to record their current mental state, their progress or if their needs had been met that day. For example, one patient record at Tazetta ward was not updated on 4 of the days we reviewed. One patient on Melissa ward had no record completed on 4 days and another patient had no record completed for 2 days to record their progress. Another patient on Ward 1 did not have an entry in their progress notes for 4 days at the time of inspection. Another patient on Ward 2 did not have an entry in their progress notes for 3 days.

Our findings

Care plan audits completed showed that each patient was regularly reviewed by the multidisciplinary team and that patient's physical health needs were reviewed and updated. However, on George ward the occupational therapist and psychologist were not included in the ward reviews. Action plans had been put in place following audits and these were monitored by the clinical governance committee. However, our findings at this inspection showed that improvement was needed to ensure audits were effective and action plans encouraged improvement.

Skilled staff to deliver care

The ward teams did not always 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. They did not always support non-medical staff with appraisals. Managers supported staff with supervision and opportunities to update and further develop their skills. However, the systems to record staff supervision was not easy for staff to use. Managers provided an induction programme for new staff.

The service did not always have access to the full range of specialists to meet the needs of the patients on the ward. Across the core service there were vacancies for psychologists which meant that patients did not get the psychology input they needed during their stay. However, to ensure that patients had a psychology assessment, psychologists offered a drop-in clinic. There were also more assistant psychologists employed to do some work with patients. On Meadowcroft and Ward 2 they had recruited to the psychology posts, and these were due to start in December 2023. On Larimar ward the occupational therapist post was vacant and staff said this had been for a few months although was being recruited to. On Melissa ward the occupational therapist post had now been filled but there was no occupational therapist in post for 10 months prior to this. The activity worker left in September, but this post was not to be filled until November.

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. On 7 wards compliance with emergency life support training was below 68%. On 6 wards compliance with intermediate life support was below 65%.

Managers gave each new member of staff a full induction to the service before they started work. Staff told us they received an induction before they started working at the service.

Managers did not always support staff through regular, constructive appraisals of their work. The trust sent us rates for appraisals for all wards and this was lowest at Northcroft: George ward was at 64% compliance, Eden Acute was at 36% and Eden PICU was as low as 23%. At the other sites in this core service this was improved and ranged from 79% on Tazetta at Oleaster and Meadowcroft wards and at 100% at Mary Seacole ward 2.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work. The appraisal rates for medical staff across this core service were 100%.

Managers supported non-medical staff through regular, constructive supervision of their work. Staff told us that supervisions and reflective group practice sessions took place regularly. Most staff spoken to across all wards told us that they had regular supervision however due to the implementation of a new electronic system this was not always documented, particularly on Melissa ward. Staff told us that the new system was cumbersome, and they had experienced access and login difficulties. Some staff found the process lengthy and struggled to find time to complete.

Our findings

The trust provided figures for each ward of management supervision, and this showed that the system had not been updated to reflect what staff told us at the inspection. 11 of the wards showed that less than 75% of staff had received management supervision and on Eden PICU showed 0% of staff had received this, George ward 11%, Eden Acute 22% and Lavender and Melissa wards were at 32%.

Managers supported staff through regular, constructive clinical supervision of their work. Staff on all wards told us that they also participated in reflective group sessions, occasionally with a psychologist input. However, this was not reflected in the data provided by the trust which showed on 7 wards that the rate of clinical supervision was less than 75% with Eden acute at 15% and George ward at 31%. This shows that staff are not able to record their supervision in a timely way.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Most staff told us that team meetings were taking place regularly and that this had improved over the last few months.

Is the service well-led?

Inspected but not rated



Leadership

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

Staff spoken with on the wards were very positive about the support they received from ward managers, matrons and clinical nurse managers. At Mary Seacole House and The Oleaster staff particularly emphasised the increased visibility and approachableness of clinical nurse managers and matrons.

Staff said that managers above the local level were not visible apart from the Chief Executive Officer who had visited the wards.

Culture

Staff felt respected, supported and valued. Most staff said they could raise any concerns without fear.

Most staff spoken with said that they had not witnessed any bullying, harassment or racism. They felt confident to report this and said this would be dealt with seriously. However, some staff told us they did not feel able to raise concerns when they had witnessed a colleague using racist and derogatory language. We discussed this with the trust immediately as part of feedback. The trust recognised that this is not in line with their values about inclusivity and were continuing to work with staff about acceptable behaviours to promote an inclusive culture within the trust.

The trust has a Freedom to Speak Up Guardian who most staff said they knew how to contact and would do so if needed. At Mary Seacole House staff told us that the Freedom to Speak Up Guardian visited on a quarterly basis, and this included at night to include night staff. They also had a review of cultural issues in January 2023 and the themes of this were to be discussed at a staff away day so improvements could be made.

Our findings

Governance

Our findings demonstrated that governance processes had improved but they did not always operate effectively at team level.

We found that staffing was discussed at a daily huddle meeting across each location. Arrangements were made from these to ensure safe staffing levels on each ward. Staffing was discussed at board level meetings and committees.

Improvements had been made to the care plan and risk assessment audit system which included monthly 'deep dives' by matrons for 8 patients across 2 wards. The report of these was shared with ward managers and staff. The role of care plans champions was to be developed on wards where areas of good practice found to support training of other staff. The reports were also shared at the trust quality forum and action plans developed which were shared and monitored by the clinical governance committee.

Audits were completed of patients care plans and risk assessments and we reviewed some of these. They had identified across this core service that patients and their carers were not always involved in their care plans. Improvements were needed to ensure action plans were effectively monitored and improvements embedded.

Data provided by the trust showed on some wards that staff had not all completed their mandatory training which included training in emergency and immediate life support.

Our findings

Areas for improvement

- The trust must ensure that courtyards are clean and safe for patients to spend time off the ward and have fresh air. (Regulation 15)
- The trust must ensure that all eligible staff receive emergency life support and immediate life support training. (Regulation 18)
- The trust must ensure that assessed safe staffing levels are maintained on all wards at all times. (Regulation 18)
- The trust must ensure that changes to the care planning and risk assessment system are effective and embedded. The trust must ensure that patients are involved in their care plans and are offered a copy. (Regulation 9)
- The trust must ensure that all staff have access to the system to record their supervision and appraisals in a timely way. (Regulation 17)

Our inspection team

We inspected all three core services unannounced on 17th October 2023. We visited all wards of this core service from 17th to 19th October 2023.

8 CQC inspectors, 1 CQC deputy director, 1 CQC operations manager, 1 expert by experience (person who has experience of using mental health services) and 3 nurse specialist advisors carried out this inspection.

We also visited every ward in the acute and PICU core service on 17th and 18th October 2023 that related to the conditions imposed on 16th December 2020 about removing ligature points on bedroom and ensuite doors.

During the inspection we:

- Spoke with 95 staff members including nurses, occupational therapists, doctors, psychologists, ward managers, matrons, heads of nursing and trust executives.
- Spoke with 46 patients who used the service.
- Reviewed 69 care records of patients.
- Spoke with 3 carers of people who used the service.
- Visited wards and observed how staff were supporting people who used the service.
- Reviewed staff rotas.
- Attended and observed a residents council representatives meeting.
- Spoke with an independent advocate and a hospital chaplain.

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

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care