

Black Country Healthcare NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating

Good 

Are services safe?

Requires Improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Are resources used productively?

Inspected but not rated 

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

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

Ratings of services previously run by a trust acquired by another do not carry over to the new trust. This report includes ratings for the three mental health services of the newly formed trust that we inspected this time, and for mental health and community health services run by this trust under its previous name.

We have not taken into account previous ratings for mental health services formerly run by the Dudley and Walsall trust. Information about those services is available on our website pages for that trust under its new name ([cqc.org.uk/provider/RYK/reports](https://www.cqc.org.uk/provider/RYK/reports)).

Our normal practice following an acquisition would be to inspect all services run by the enlarged trust. However, our usual inspection work has been curtailed by the COVID-19 pandemic, so we inspected only those services where we had cause for concern.

We inspected the overall management of the trust and three mental health services:

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

We rated the trust overall and all three mental health services as good. In rating the trust we took into account previous ratings for services not inspected this time. We rated the trust as good because:

Our findings

- The trust was formed in April 2020 at the start of the Covid 19 pandemic and during the implementation of the lockdown measures initiated by the Government. We noted how much time the board had invested in creating the new organisation during the Covid-19 pandemic.
- The trust board was diverse. Non-executive directors represented different communities and the executive directors presented an effective mix of members from diverse backgrounds and with a wide range of skills and experience. A number of the non-executive directors had a NHS or local authority background which supported good discussions at trust board. The trust was highlighted by a national healthcare journal for having the highest share of black, Asian and minority ethnic very senior managers.
- The clinical strategy identified key priority areas of focus which were linked to the trust's vision.
- Governance processes had been implemented and operated effectively across the organisation to ensure that performance and risk were managed well. There were clear responsibilities, roles and systems of accountability to support good governance and management. There was a positive and open culture across the trust. Staff told us they felt happy and enjoyed their work. There was good staff morale in services. Staff felt respected, supported, and valued and we heard how well the trust supported staff during the COVID-19 pandemic. Leaders modelled positive behaviours, and development of staff was encouraged. There was an extensive wellbeing offer available to staff, including the wellbeing hub offering mental health support, flexible working, and aids on keeping well.
- There had been good engagement with external stakeholders. The trust had key roles in the development of the local health and social care system working and collaborated with care providers to improve mental health services. The trust engaged with local people who used services in the design of new buildings.
- The trust had developed a triumvirate management structure across its divisions that was supporting the development and focus on local services. Whilst their structure was new there was good work in developing local governance around quality and safety. A triumvirate approach brings together three managers, including operational, clinical, and managerial, to support change to local areas.
- The trust had made firm commitments to equality and inclusions. The Cultural Ambassadors programme collected equality data that fed into the trusts plans for equality and inclusions. The staff networks for black and ethnic minorities, disability, and LGBTQ+ were actively supported and had been awarded the Disability Confident Award.
- Infection prevention and control (IPC) was well managed and monitored. Services were responsive and dealt with frequent changes in IPC requirements during the pandemic.
- Staff completed and regularly updated environmental risk assessments of all wards areas and removed or reduced the majority of the risks they identified, an exception being in the wards for older people with mental health problems. Staff followed procedures to minimise risks where they could not easily observe patients.
- Patient involvement in planning care was now in place and the voice of the patient in changes to services had been considered.
- Patients we spoke to in mental health wards for adults said that staff treated them with respect and dignity. Key workers and occupational therapists were highly praised. Relatives were similar in praise to staff in older people's wards and thought their family received good care. Relatives and carers understood the need for tighter restrictions during the pandemic. However, the need for improvements were highlighted in the following areas; to be provided with more information about medication and treatment, communication between wards and carers could be improved, and access to care and support slowed the process of discharge.
- There was a good working relationship between the Mental Health Act (MHA) administration team and the wards, community teams and the executive team. This had continued during the pandemic. The MHA team provided regular reports to the executive team to provide assurance that the MHA was appropriately applied within the trust.

Our findings

- Services treated concerns and complaints seriously, investigated them and learned lessons from the results. Managers shared the outcome of complaints with their ward teams.
- The trust board, heads of departments and senior leaders had access to the information they needed to manage risk, issues and performance across the trust. Staff had easy access to clinical information and were maintaining good quality clinical records.

However:

- In two of the core services inspected, the environment had not been well maintained. These were across mental health wards for adults of working age and for older people. Maintenance teams had not undertaken repairs in a timely way. However, all areas used by patients were clean. Some patients continued to share bedroom spaces in dormitories. However the trust had clear and timely plans to eliminate dormitories.
- There were not always sufficient alarms for staff working in the wards for older people. This meant staff could not get help quickly if there was an emergency.
- The seclusion room at the Macarthur Centre psychiatric intensive care unit was poorly furnished and the toilet and washing facilities needed updating. It did not meet the requirement of the Code of Practice
- Patients on the acute wards for adults of working age did not have sufficient access to psychology services.

How we carried out the inspection

During the inspection, our inspection teams carried out the following activities across 11 wards in the three core services inspected:

- reviewed 49 care records
- reviewed 44 medication records
- interviewed 52 staff and 10 managers
- interviewed 14 patients
- spoke with 13 family members or carers of patients
- checked 14 clinic rooms
- attended 7 meetings

During our well-led inspection, we spoke with 50 senior leaders of the organisation and looked at a range of policies, procedures and other governance documents relating to the running of the trust.

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

What people who use the service say

Our findings

Patients we talked to that used the wards for adults of working age told us that they were cared for in a dignified and caring manner. They told us that staff treated them with respect and tried to include them in their care where possible. Patients spoke highly of their key workers and occupational therapists on the wards. Some patients told us that they were not given enough information about their medication or treatment, and some patients were not given a copy of their care plan.

Relatives and carers of people who had used the wards for older adult felt that their loved one was receiving good care from the hospital. They said that nurses should have more help and that they earned every penny.

Most of the carers we spoke to stated that communication was a particular problem between the ward and relatives and carers. Access to follow on care and support appeared to slow down patient's discharge.

Relatives and carers said although Covid restrictions on the wards felt quite tight it appeared to have prevented Covid in the hospitals.

Due to concerns about the pandemic and possibility of cross infection inspectors were not able to accompany staff on community visits and therefore were unable to speak to patients who were being looked after by the crisis teams.

Use of resources

During the financial year, 2021-22, the trust was estimating a turnover of circa £227m and was planning for a break-even position.

The operating financial environment since the merger had significantly changed in response to the Covid 19 pandemic and during that period the attainment of 'efficiencies (the Cost Improvement Programme) had been somewhat on the backburner in all NHS organisations. However, it was likely the financial landscape would change to a more normalised position in 2022/23 including the requirement for a fuller Cost Improvement Programme.

The non-executive directors understood their role within the unitary board and had a range of experience and backgrounds including leadership within the NHS.

The executive team had a shared understanding of the position and presented a cohesive approach.

For the financial year 2020-21 the inspection team noted that the Head of Internal Audit had given the trust an opinion of 'Partial Assurance with improvement required' – due to weaknesses in overall controls that the finance team were aware of. The external auditor had given an unqualified opinion on the annual accounts for the same period.

Areas for improvement

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

Action the trust **MUST** take to improve:

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

Our findings

Wards for adults of working age and psychiatric intensive care units

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

Wards for Older People

- The trust must ensure that repairs are completed in a timely manner and that equipment and premises are properly maintained. (Regulation 15(1)(e))
- The trust must ensure the elimination of dormitories is completed in line with its buildings replacement timetable. (Regulation 15 (1) (c))

Action the trust SHOULD take to improve:

Wards for adults of working age and psychiatric intensive care units

- The trust should ensure that all patients are involved in their treatment and care and receive a copy of their care plan.
- The trust should consider updating the seclusion room at Macarthur Centre to make the environment more comfortable for patients in seclusion.

Wards for older adults

- The trust should ensure that supervision is consistently recorded.
- The trust should ensure that all staff have access to alarms.

Is this organisation well-led?

The trust was formed on the 1st April 2020 at the start of the pandemic. Black Country Healthcare Foundation NHS Trust arose from Black Country Partnership Foundation Trust and Dudley and Walsall Mental Health Partnership NHS Trust. The previous organisations had both been rated as good overall. There had been changes at both executive director level and non-executive director. The Chief Executive Officer (CEO) had recently been approached to take the chief executive officer role for the Black Country Integrated Care System (ICS) for six months and lead its development. At the time of our inspection the trust's deputy CEO was interim chief executive officer whilst the substantive CEO was out on secondment to the Black Country Integrated Care Service.

Leadership

The trust board leadership team had the capacity, capability, skills, knowledge and experience to perform their roles. They had a good understanding of the services they had responsibility for.

The chief executive had built a strong executive team and had developed a supportive and collaborative culture within the trust board. The chair of the trust had appointed new non-executive directors alongside some that had experience of working on the boards of the predecessor organisations. These appointments brought some continuity as well as introduced new knowledge and experience to the trust board.

Our findings

The board has had a strong focus on development. They have had a programme of development in place to help with the development of skills and knowledge. A number of seminars had been held, such as that led by the Good Governance Institute (GGI); these had helped the board to focus on how the trust could best position itself and how it could relate to other organisations and the people of the Black Country. There had been sessions that had focused on the work of the organisation such as the use and management of restraint within the trust. There had also been board development sessions that had been externally facilitated on collective leadership. Plans were in place to hold follow up sessions in February 2022.

Since the creation of Black Country Healthcare Foundation Trust positive leadership behaviours had been progressed, embedded and demonstrated by the board members and amongst senior leaders. The executive team had provided clear leadership by setting clear goals and direction and setting examples for other leaders in the trust to model in their day to day work. Middle level managers understood the challenges of the trust and board members supported and encouraged them to submit plans for innovation and service development.

There was a culture of open, supportive and effective leadership with plans to sustain the progress made. The trust had recognised the need to further develop its clinical services and had developed a clinical strategy. Its initial focus was on the transformation of community mental health care. The trusts plan included strengthening support to primary care and redeveloping multidisciplinary team approach to improve access to services. Progress in implementation of the clinical strategy has resulted in improved accessibility to psychologists and therapists who were now part of community mental health teams in some areas across the trust. This reduced the need for clinicians and teams to make referrals to one another which reduced the amount of time patients had to wait for treatment and interventions. The trust hoped that this would become the standard approach across the trust.

The non-executive directors told us that there was confidence in the capability of the executive leadership of the trust and that they had the capacity to fulfil their roles. They felt there was transparency across the board and honesty in communications. They talked about their engagement in the development of the clinical strategy and were positive about the progress in developing it during the pandemic. The non-executive directors (NED) had developed an informal support and discussion group they call "NED Natters" that met weekly and before board meetings. They said the chair of the board brought a perspective of the wider system and partnerships that was both helpful and informative. They reflected that the pandemic had impacted in a positive way they worked and had made them more efficient and created more effective communication. However, it had impacted negatively on their ability to visit services and talk to staff and patients and bring that information back to their board discussions.

The board was diverse and largely reflected the diversity of the communities it served. Of the nine non-executive directors five were from a black or Asian background; three of whom were female, all with extensive experience of working in the NHS, local authority, and voluntary organisations. The trust had nine executive directors, six females and three male members. There was a good cultural mix of background at executive director level that reflected the community served by the trust.

Fit and proper person checks were in place for all board members and non-executive directors. We found that recommendations from national guidance (The Lampard report 2015, recommendation 7) were in place to complete disclosure and barring checks every three years.

Our findings

A people plan 2021 to 2023 was in place with the aim of providing a framework that would support the trust's strategic vision, "Together with you to achieve healthier, happier lives" for the population they serve. The strategy covered a three-year period and identified the workforce priorities following the merging of Black Country Partnership NHS Foundation Trust and Dudley and Walsall Mental Health Partnership NHS Trust. The plan had an overarching objective for each of the five core priorities, with a set of key actions to achieve them.

There was a commitment that leaders and managers supported everyone and acted as a role model upholding the trusts values and behaviours. Consideration had been given to succession planning to support workforce plans so that the potential of staff could be maximised.

Senior managers and heads of service said executives and non-executive directors were approachable, visible and easy to talk to. Staff told us, during our core service inspection, that they knew who some board members were and had seen some of them when they had been able to visit services. However, the trust had taken action to follow national guidance to reduce face to face contact during the COVID-19 pandemic. The trust ensured a safety-first approach in line with infection prevention and control guidelines. Other methods of communication were used to deliver key messages from senior leaders, such as social media, the intranet, monthly team brief sessions and weekly presentations where staff can ask question about anything.

Vision and Strategy

The trust had developed a credible clinical strategy and clear vision with strong plans to deliver high quality sustainable care to people across the Black Country. The leadership team knew and understood the provider's vision and values and how they applied to the direction of the trust.

The new trust strategy was underpinned by a clear and refreshed governance structure. The trust's recently developed clinical strategy outlined the direction of travel for their services over the next three years. It was informed both by the local health system, and by engagement with the community to find out what was important to people. The strategy sets out to their clinical ambitions to provide outstanding quality and to support people to live their best lives within their community.

The trust had set three fundamental commitments on which their ambition was based; to co-produce with its communities as well as partners and its workforce; to work collaboratively to provide the best possible service that is joined up with Primary Care Networks (PCN) and to work collaboratively with system partners to tackle inequalities in mental health, learning disabilities and autism. They had committed to ensure that learning was at the heart of their approach so that continual improvement could be implemented within the organisation.

The vision and strategy were joined up, clear and accessible to all staff and had been developed with input from staff and those who used services. Board development sessions were used to engage the board in strategy design and used to regularly review objectives. Every member of the leadership team that we spoke with knew how their role impacted on the delivery of the strategy and the contribution their teams made to achieving the objectives. The strategy was aligned with the local health economy and considered the needs of the developing Integrated Care System (ICS).

Leaders across the trust were able to talk about the trusts vision and strategy and the part they have played in helping to develop them. Most told us how they participated in the pre-merger workshops and out of those discussions emerged the vision and values for Black Country Healthcare.

Our findings

Trust leaders talked about how related plans were integral to the clinical strategy, for example, the people plan, the developing estates strategy, research and development strategy and a workforce plan. There were several priorities the trust had an immediate focus on which contributed to achieving the vision. These included eliminating dormitories, the patient safety strategy, and a mental health transformation plan. Although work was planned for the elimination of dormitories progress was slow, despite concerns raised on previous inspections of predecessor trusts.. We saw that at the Bloxwich and Edward Street mental health units that patients continued to be cared for in shared accommodation, and we saw examples where this impacted on the quality of life and the dignity of some patents.

Culture

The trust had a developing culture that aimed to support staff development. Staff at all levels felt they were respected, supported and valued. The trust promoted equality and diversity in daily work and provided opportunities for development and career progression. The trust leadership team were committed to delivering a health and well-being support programme to staff.

The trust board used role modelling and leadership behaviours embedded within their strategy to demonstrate a positive, responsive, straight talking and open culture. This had been rooted throughout most of the organisation. Senior leaders and heads of departments were clearly values driven. However, in some of the services we inspected, we heard of some occasions where staff did not demonstrate behaviours the trust expected when caring for those who used services.

The people team had responsibility to lead on the delivery of the people plan and had a delivery programme. One of the key priorities for the first year was supporting people from a personal point of view. Trust values and how staff related to them were a priority that led to teams developing their own local team values. A golden thread of valuing people and valuing difference through a Wellbeing hub, provided mental health support to staff within the trust and to staff working in partner organisations within the Black Country. This included cultural ambassadors to support black, Asian and minority ethnic staff who go through the disciplinary process. The trust had committed to acting against racism and discrimination. The people plan was clear how such objectives would be realised and measured within clear timeframes. The reverse mentoring programme from the trust's networks, was valued and promoted by directors of the trust.

All staff we spoke with told us they felt proud to work for the trust, valued their teams and were proud to make a difference to those who used services. Staff told us they were particularly proud of the dedication staff gave to their work during the COVID-19 pandemic.

The trust provided a range of health and wellbeing offers to staff. Leaders of the trust viewed the wellbeing of their staff as a high priority. The trust offered the wellbeing hub providing mental health support, daily briefings, debriefs, flexible working, IT provision for remote working, risk assessments on personal circumstances and advice on keeping well.

There was a strong risk management culture in the organisation. Reducing risk was a common theme in meetings and committees. Improvements had been made in screening serious incidents, ensuring lessons were learnt from incidents and action plans to demonstrate learning. Safety was not compromised by finance.

Staff networks were well established, and the trust had continued to build on the success of its Ethnic Minority, Disability and LGBTQ+ networks. The Disability Staff Network, in partnership with the Equality and Diversity and human resources team, had secured the Disability Confident Award. The award demonstrated that the trust was playing a leading role in improving attitudes to disability in its workplaces. There was a proactive approach to equality, diversity and inclusion

Our findings

with regular network meetings with active support from executive members. The trust was awarded the HSJ Value Award 2020: People & Organisational Development Initiative of the Year for The Cultural Ambassador Programme. The project in partnership with Royal College of Nursing (RCN) succeeded in making a difference and to challenge unconscious bias and discrimination that had occurred for ethnic minority staff entering or during formal human resources processes.

Matters from staff networks were escalated to an executive sponsor. Staff networks signposted staff to other groups such as the unions, the Freedom to Speak up Guardian, the trust's human resources department and trust listening events. Processes and systems were in place to support staff and we heard that staff had confidence in the culture around diversity and inclusion. The equality diversity and inclusion network had recently lost both of its leads and the trust had just recruited to a new lead and deputy. However, the trust had set up anti-racism training to try and make a difference to staff and peoples experience of racism. The new people strategy developed with staff and contributed to by the networks will make the improvements wanted by the organisation. During the COVID-19 pandemic, the trust chief executive made a public statement regarding the trust's commitment to anti-racism in light of the Black Lives Matter campaign. Staff across the trust had a strong commitment to this value.

The trust had developed a culture of speaking up that was supported by a Freedom to Speak Up (FTSU) strategy and policies. The trust was in the process of harmonising the policies of both predecessor organisations. There were two Freedom to Speak up Guardians in post. Both guardians had worked in the predecessor organisations and had come together to work across Black Country Healthcare. A non-executive director had been appointed to work with the guardians, the guardians were also associated with the organisational development team acknowledging their role in promoting open positive cultures and the positive impact that has on patient safety and experience. The board received quarterly reports on both numbers and themes raised under the FTSU policy.

The trust had developed a digital platform for staff to access via the intranet and to raise their concerns. The FTSU guardians monitored the portal and were working towards this being accessible via an app on the phone. However, we found a lack of evidence to suggest that FTSU guardians followed the cases through to an outcome. Their role consisted of signposting and referral to the relevant team and then it closed the concerns. The main theme that had emerged was around attitudes and behaviours. There were workshops in development to address this. However, we found no evidence of how the FTSU guardians evaluated and shared learning across the trust except for the workshops.

The trust applied their statutory duty of candour effectively. There was a clear process in place led by the patient safety team when things went wrong. A 'culture of candour' was promoted and had been embedded in the trust investigation process. The trust offered an apology for incidents and followed guidance for statutory duty of candour when required. When there was a serious incident that required investigation duty of candour was considered at the start of the enquiry so that the trust could formally apologise and ensure families were involved in setting the terms of reference for the investigation. The trust had recently recruited a family liaison officer to provide support and engagement with families through the incident investigation process.

We were assured of trust oversight of complaints. The complaints team monitored timescale for responding to complaints and reported to the quality and safety committee. The trust showed it had received 221 complaints in 2020/21 period, compared to 303 complaints in the previous year of the two predecessor trusts. Four complaints were referred to the Parliamentary Health Service Ombudsman during 2020/21.

Our findings

The 2020 NHS staff survey had been completed by 53% of staff. Overall, there was little movement in themes from previous staff survey. The trust had an active volunteer network to which anyone with a mental health difficulty or caring for someone with mental difficulty could apply to become an expert by experience (EBE). The EBEs were able to contribute their experience of services to help shape the delivery and quality of service the trust provides. They also were able to represent the views of service users and carers.

Governance

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders had reviewed these structures. Governance processes operated effectively at board level to ensure that performance and risks highlighted were managed well. Risks and incidents in the divisions were led by the divisional directors with support from the divisional risk and safety leads. They produced, on a monthly basis, a quality and safety report that captured incidents, complaints, workforce sickness and captures trends and themes. The report was then presented at the quality and safety steering group and shared externally with partners.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. There were clear responsibilities, roles and systems of accountability between executive and non-executive directors to support good clear governance and management at trust board level. Non-executive and executive directors were clear about their areas of responsibility.

The trust had effective systems and processes in place relating to the governance of the Mental Health Act (MHA). The trust had a mental health legislation scrutiny committee. The committee had oversight of the trust's compliance with mental health act legislation in the provision of its services. The chair of the committee reported to the board on key matters from the committee meetings. It had overseen training arrangements, over seen the training programme for the associate hospital managers. The committee had regular reports from the Mental Health Act legislation operational group chaired by the chief medical officer. The MHA administrators had day to-day responsibility and oversight of the MHA within the trust.

Financial governance was overseen by a chief financial officer (CFO) for the trust. Since its merger the trust had been operating under an emergency financial regime put in place during the pandemic. The trust's financial position was stable, albeit with an underlying deficit of circa £7m, and benefited from good financial leadership. For the financial year 2020-21 the inspection team noted that the head of internal audit had given the trust an opinion of 'Partial Assurance, with improvement required' – due to weaknesses in overall controls that the finance team were aware of. The external auditor had given an unqualified opinion on the annual accounts for the same period.

The trust had associate hospital managers (members of a committee authorised to consider the discharge of patients detained under certain sections of the MHA). The hospital managers were appointed following an open recruitment process. The composition of the current hospital managers' team was representative of the diverse local community. The Hospital Managers met quarterly, and reported to the Mental Health Legislation Scrutiny Committee. Regular training was provided to the hospital managers including for example the Head of Mental Health Legislation providing updates on changes in legislation. Hospital managers undertook annual appraisals. There was a system in place for hospital managers to provide feedback of any concerns they had.

Management of risk, issues and performance

Our findings

The trust board, heads of departments and senior leaders had access to the information they needed to manage risk, issues and performance across the trust.

The trust board had developed a comprehensive board assurance framework (BAF) that identified risks to the organisation. The board reviewed the BAF on a quarterly basis or more often when it was needed. The BAF was also used at other committee meetings when looking at the details of specific risks. There was a non-executive director that had lead responsible for holding the board to account in maintaining a culture of safety. The trust board had carried out a complete refresh on the strategic risks in the summer of last year. Board members could now articulate the plans they had to continue their drive to ensure an improved and mature risk overview. Staff at ward level knew how to escalate risks to their divisional team, and in turn this could be escalated to board level through appropriate committees and the improved governance structure.

Divisional quality and safety leads had been appointed with the aim to strengthen assurances throughout the divisions. The quality and safety reports ensured information about incidents, workforce and complaints were highlighted at the quality and safety steering group.

Board members told us about the risk to the trust's estate. The current estates were considered unsustainable but had been seriously affected by the pandemic's effect on availability of materials and workmen availability to carry out work. The main estates priority was to develop two new purpose-built hospitals on the site of the Dorothy Pattison and Edward Street Hospitals. At the time of the inspection the trust did not have an estates' strategy that had been agreed as the needs of the trust were being reconsidered. There were plans to develop hubs and more frontline locations in partnership with the integrated care system and the local authority.

The board had made progress in ensuring capital investment to raise the standards of its older adults inpatient accommodation and eliminate dormitory accommodation. The funding was part of a national scheme to remove dormitory style accommodation in mental health settings. The timetable for completion of improving their wards and the building of the new unit is by spring 2024. However, at the time of the inspection progress was slow.

We noted that the trust would return to a more normalised operating financial environment in the financial year 2022/23. This would include the need to achieve efficiencies through its cost improvement plan (CIP). Planning for CIP's was largely suspended across the NHS during the pandemic and the trust recognised it would now need to give this area greater focus. As a merged organisation there were inevitable legacy issues to be resolved. Those included the need to ensure there was a consistent understanding and application of the financial systems and processes. The disruption caused by the pandemic had impacted the rollout of financial training, but this would be a key part in ensuring firm foundations for financial governance and behaviours going forward. The trust needed to agree its estates strategy in order to ensure this is reflected in its financial strategy.

The trust had met its financial targets for 2020 to 2021. The auditors did not report any significant risks to the trust securing economy, efficiency, and effectiveness in its use of resources.

The trust had put improved systems in place to identify learning from incidents, complaints and safeguarding alerts. There was now a culture of safety within the organisation which had been promoted through learning events, big conversations, emails and newsletters. The trust submitted reports to external stakeholders, including statutory notifications to the Care Quality Commission (CQC as required). The trust had put in place systems and templates on which serious incidents were reported including themes and trends such as falls, and self-harm, patient incidents and non-patient incidents.

Our findings

The trust had inherited two systems of serious incident investigation. The plan for serious incident investigation was for each of the divisions to have their own investigators so that the root cause analysis would come from and through the divisions. The governance team took the lead at a corporate level, but the aim was to have a multidisciplinary approach working across the divisions.

The trust board were aware of the current risk to safe staffing levels in services to keep patients safe. Senior leaders in the organisation told us that during the past year it had been difficult to recruit the numbers of staff they need to ensure they could provide safe care that met the needs of people who used the services. Managing staff sickness levels had been challenging because of the numbers of staff contracting Covid-19 and needed to isolate. The board received safe staffing reports regularly and ensured appropriate actions and plans were in place to mitigate the overall risk

Information Management

The trust effectively collected and analysed appropriate and accurate information about outcomes and performance. Information was challenged and acted on in a robust way by board members

The board received information on quality and safety. Committees and divisional team meetings addressed quality, safety and sustainability at all levels across the trust, within a new, strengthened divisional triumvirate and governance system. Divisional teams used information effectively to report against key performance information. Highlighted reports were used consistently to escalate issues or report on progress from divisional management teams to board. Directors told us that statistical process charts (SPC) were now regularly available to review data and performance of services and gave them a clear understanding of measuring and monitoring progress. Challenge on information received by committees was still maturing. Opportunity for non-executive directors to bring robust and detailed challenge to directors was evident when we attended Board meetings.

Staff at all levels of the organisation had access to information technology equipment and systems needed to do their work although the trust digital strategy confirmed the current digital infrastructure was not satisfactory. In March 2021 the trust surveyed its staff to understand their experience of digital services and found that more than 10% of their staff struggled to access systems. Staff told us the trust had been improving staff access to the right technology to meet patient need and continue services during the COVID-19 pandemic. The trust was praised by staff for being responsive to need at this time.

An electronic clinical notes system had been introduced to the trust in November 2020, which allowed staff to have access to patient records across the whole trust. The roll out of the project, which started in 2020, was overseen by the information management and technology team. During a responsive inspection in June 2021 we found that not all staff working on wards had access to the patient information system and that highlighted potential risks to providing care safely. We asked the trust to ensure all staff working on wards could access the patient information system. At this inspection we found that all staff had access to patients' records. However, some staff said they needed additional support to navigate the system effectively.

The audit committee functioned effectively with a non-executive director as chair with membership from directors, and external audit partners. The committee focussed on all aspects of quality improvement across the trust.

Information about how the trust worked was available to the public in a way that could be easily understood. and accessible. The trust provided a range of information on their website and access to various links that would enable staff, patients, carers and the public to find out how the trust operates and where to get more information.

Our findings

Engagement

The trust ensured that people who used services, the public, staff and external partners were engaged and involved in the design of services.

Board was committed to and engaged in supporting the development of the integrated care system (ICS) for the Black Country. Executive directors were actively working with the ICS and were positively promoting mental health within development plans.

The trust had been working in partnership with all Black Country NHS and local authority commissioners and NHS England to reduce NHS Learning Disability inpatient bed numbers. That had allowed them to strengthen community service provision supported by specialist bed provision where appropriate. They were working closely with the ICS to take this work forward.

Prior to the merger and in the early stages of the new organisation the new organisation had actively engaged its staff, those who used services and stakeholders to ensure the new trust was focussed on providing the best service that met their needs. Between July to November 2020, the Trust held several conversations with partners and stakeholders including the third sector; service users, patients and carers; local communities; governors; and staff. They also ran an online survey with current service users and patients. Those were 'big conversations' asking all to explore what the very best healthcare should look like in the future for the people of the Black Country. The trust used the feedback and the themes that emerged from the conversations by feeding them into the development of the Trust's first clinical strategy.

We saw various examples of how the trust had involved others in the design of the new organisation and acted on feedback received about existing services. Keeping in mind the diverse population of the Black Country the trusts communication strategy had been developed with that community in mind, so they were not left out of the discussion about service design and development.

The trust had embarked on new builds to replace some of their buildings and they had sought the views of their staff, service users, carers and other members of the community. It had asked for comments and people's views on their plans for the new buildings through their website and through putting the plans on display for the public to see and comment on.

The trusts organisational development team had championed the development of an 'engagement partner group'. The group was made up of enthusiastic, committed staff who were focused on creating a positive and engaging culture across the trust. The group was embedded and contributed to the developing culture of the organisation. They aimed to represent the views of their colleagues through sharing suggestions and feedback.

During the summer of 2020 the trust engaged with its membership to run elections to the board of governors and all vacant seats were filled. It held its annual general meeting as a virtual event in September 2020 which included a wellbeing workshop. They also established a monthly e-bulletin for members that provided updates and opportunities to get more involved with the trust. The trust had a governor engagement plan that it held virtually to discuss its focus and approach to engagement.

Co-production took place when projects were identified for service improvements. The trusts children and young people's (CYP) keyworker pilot was one such project that aimed to boost care and avoid hospital admission for children and young people with a learning disability, and, or autism with the most complex needs. They worked with NHS Black Country NHS and local authority commissioners and NHS England to develop the keyworker project.

Our findings

Results from the trusts 'Re-imagine' engagement with stakeholders, the communities and its staff and governors, showed a positive response with the numbers of people attending. The conversations were based on set questions that included asking them "what does the very best healthcare look like in three years' time? How do we achieve this?"

The trust used initiatives during the Covid-19 pandemic to support those staff experiencing emotional impact so they could access the right help at the right time. The trust responded by developing a Black Country-wide 'staff psychological Hub', that ensured that its staff and colleagues from partner organisations could access fast and effective mental health support when they need it.

Learning, continuous improvement and innovation

The trust had formed a relationship with Wolverhampton University and the chief nurse holds a visiting professorship with them. Many of the universities students for mental health nursing receive placements with the trust. This arrangement has allowed shared learning and collaboration to continue.

The divisional management teams evidenced clear commitment by staff to continue the changes they have made to their practices during the pandemic. We heard that changes had been consulted upon and were being implemented in line with what staff wanted. The unions confirmed that whilst there has been consultation there has not always been active listening to all their advice.

During the pandemic, the trust set up a psychological care hub to provide care and support for staff in the Black Country area working during Covid pandemic.

Staff participated in research and the trust reported its role in delivering research-based projects. There were a number of established research projects and some new studies. As part of the NHS study into staff retention called 'Should I stay, or should I go' the trust had recruited 237 staff to join the study. The trust contributed to a study into the Psychological impact of Covid-19 by recruiting 130 people. They had recruited a Development worker for underserved populations who will work across the trust and other NHS trusts in the Black Country to contribute to the delivery of local and national policy relating to equality and diversity in community and mental health services. The trust had demonstrated its commitment to research and innovations team by issuing permanent contracts to staff in the team.

The trusts community development team in partnership with Black Country and West Birmingham Healthier Futures ICS had been recognised by been shortlisted by the Health Service Journal (HSJ) award for their work around race equality.

Black Country Healthcare NHS Foundation Trust participated in the government's new 'kickstart' scheme which aimed to provide fixed-term jobs for young people across the country. The scheme was aimed at 16 to 24 year old at risk of long-term unemployment.

The trust was highlighted by the HSJ for having the highest share of black, Asian and minority ethnic very senior managers. Half of its senior management team were from a BAME background which was not only highest but topped the national table of other NHS trusts.

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Our findings

The following pages show ratings for the three mental health services we inspected this time and for mental health and community health services run by this trust under a previous name.

We have not taken into account previous ratings for mental health services formerly run by a different trust.

For further information please see the Overall summary on page 2 of this report.

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↓ May 2022	Good →← May 2022				

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement ↔ May 2022	Good ↑ May 2022	Good ↔ May 2022	Good ↔ May 2022	Good ↑ May 2022	Good ↑ May 2022
Forensic inpatient or secure wards	Requires improvement Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Specialist community mental health services for children and young people	Good Jan 2020	Good Jan 2020	Good Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020
Wards for older people with mental health problems	Requires Improvement ↓ May 2022	Good ↔ May 2022	Good ↔ May 2022	Requires Improvement ↓ May 2022	Good ↔ May 2022	Good ↔ May 2022
Wards for people with a learning disability or autism	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Community-based mental health services of adults of working age	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Mental health crisis services and health-based places of safety	Good ↔ May 2022	Good ↔ May 2022	Good ↔ May 2022	Good ↔ May 2022	Good ↔ May 2022	Good ↔ May 2022
Community-based mental health services for older people	Good Apr 2016	Good Apr 2016	Good Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016
Community mental health services for people with a learning disability or autism	Good Jan 2019	Requires improvement Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Specialist eating disorders service	Good Jan 2020	Good Jan 2020	Good Jan 2020	Outstanding Jan 2020	Good Jan 2020	Good Jan 2020

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children and young people	Good Feb 2017					

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

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

Good  

Is the service safe?

Requires Improvement   

Safe and clean care environments

The environment of the wards was not always suitable for the patient group it was intended for. The wards within Hallam Street Hospital contained several ligature risks that presented a safety risk for the patients staying on the wards.

Most of the wards were clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

The environment of the wards on Hallam Street was not conducive to delivering safe care for acutely unwell patients. Staff could not observe or reduce all the risks they identified. Hallam Street hospital is an old estate, and each acute ward was spread over two floors within the hospital. This presented some risks and challenges for staff, who were managing acutely unwell patients. On at least one of the wards, we saw a staff member assigned to the upper floor for all shifts. The wards on Hallam Street hospital contained serious ligature risks. In the two months leading up to the inspection, one patient had attempted self-harm using ligature points around the ward. The managers informed us that this was a regular occurrence. This presented safety concerns for the patients and the ward layout compromised staff ability to observe all the parts of the wards effectively. However, staff completed and regularly updated thorough risk assessments of all ward areas. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Managers ensured that staff were deployed to the top floor of wards to reduce risks to patients.

The wards complied with guidance on mixed sex accommodation and male and female patients had separate accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems. However, sometimes the call alarms did not work or were not answered in a timely manner.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well- furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. We saw evidence of a structured cleaning schedule which included areas to be cleaned, by whom and how often. This was regularly completed by all staff, including housekeeping staff.

Staff followed infection control policy, including handwashing.

Seclusion room (if present)

The Seclusion room at the Macarthur Centre Psychiatric Intensive Care Unit (PICU) allowed clear observation and two-way communication. There was a clock which was visible from within the seclusion room. However, the area was poorly furnished and the toilet and washing facilities needed updating.

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

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. Cleaning audits were completed regularly and the clinic room was checked by a pharmacist on a weekly or twice-weekly basis.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. The wards were rarely short staffed, but staff sickness sometimes meant that managers struggled to find cover arrangements in time.

The service had reducing vacancy rates. The managers informed us that nursing posts were difficult to recruit into due to a regional shortage of nurses. However, whenever shifts needed filling, managers used their pool of bank nurses to fill the shifts and rarely used agency nurses.

The service had reducing rates of bank and agency nurses and nursing assistants. The psychiatric intensive care unit (PICU) at Heath Lane had used a considerable number of bank or agency staff in October due to the increased level of need and one-to-one patient observations on the ward.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers aimed to block book shifts in advance to attempt to fill shifts by staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. If agency staff were not trained in restraint, managers swapped staff from other wards around when needed to enable trained staff to be in the right place to support patients.

The service had reducing turnover rates. Managers supported staff who needed time off for ill health. Levels of sickness were low across the wards.

The ward manager could adjust staffing levels according to the needs of the patients. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers felt able to adjust staffing levels and skills according to patient risk on the wards.

Patients had regular one to one sessions with their named nurse. Patients did not often have their escorted leave or activities cancelled, even when the service was short staffed. However, due to the pandemic and some national restrictions, some activities outside of the wards did not always take place. Staff tried to arrange other activities on the wards when this was the case.

The service had enough staff on each shift to carry out any physical interventions safely. Staff shared key information to keep patients safe when handing over their care to others. The handovers were comprehensive and detailed any changes in a patients' presentation within the last 24 hours, and any upcoming appointments or clinical reviews.

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

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Not all staff had completed or kept up to date with their mandatory training. At the time of the inspection, the wards were at 80% compliance in their mandatory training. Most individual training courses were at 85% compliance or above. However, not all staff had received the physical interventions training. The staff who had not yet completed the training were booked for upcoming training sessions.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission and reviewed these regularly, including after any incident. Staff used the Steve Morgan risk assessment form, and discussed specific risks to each patient during ward rounds.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff followed procedures to minimise risks where they could not easily observe patients.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low. Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff had been successful in practices of de-escalation with patients and prevented the need for more invasive interventions.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

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

Staff followed NICE guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.

Staff were aware of best practice, including guidance in the Mental Health Act Code of Practice, if a patient was to be put in long-term segregation. There were no patients in long-term segregation at the time of the inspection.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. Any patients who had young visitors were risk assessed, and meetings usually took place in a designated visitors' area off the wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes. The manager and staff maintained a good relationship with their local safeguarding team.

Staff access to essential information

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

Patient notes were comprehensive, and all staff could access them easily. The trust had only recently introduced RiO as their primary records keeping system, and older records had not all been uploaded to this system. However, staff could gain access to or request these records when needed.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

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

Staff followed systems and processes to prescribe and administer medicines safely. All staff completed medicines competency on an annual basis and any concerns triggered a competency assessment. The pharmacist visited the wards regularly to audit patient treatment cards and safe medicines management.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Medicines reconciliation was done through the GP to ensure that all medication was known and understood.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. All staff, whether substantive or temporary, were able to report incidents.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

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

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared learning about never events with their staff and across the trust. Managers shared learning with their staff about never events that happened elsewhere. This was usually through handovers, staff meetings and the trust intranet.

Staff met to discuss the feedback and look at improvements to patient care. Staff had access to twice weekly reflective sessions in which they discussed complex cases, improving patient care and wellbeing.

There was evidence that changes had been made as a result of feedback. For example, staff filled out a National Early Warning Score (NEWS) chart for a patient without completing all the necessary physical observations. This gave an inaccurate score and could have misled staff on the physical health needs for the patient. Staff underwent development training to ensure that the NEWS chart is completed accurately. We noted that all NEWS charts we reviewed contained the necessary information and were completed as needed.

Is the service effective?

Good  

Assessment of needs and planning of care

We reviewed 10 patient care records. Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. These physical health assessments were audited by the physical effectiveness team.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Out of the 10 care plans we reviewed, there was one care plan in which a patient's physical health condition was not accompanied by a support care plan. However, we noted that the patient's condition, and management plan, were comprehensively noted in the daily progress notes.

Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

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

Staff provided a range of care and treatment suitable for the patients in the service. The service had access to a range of multidisciplinary professionals, including doctors, nurses and occupational therapists. However, the service did not have access to psychology support for patients.

Staff delivered care in line with best practice and national guidance (from relevant bodies eg NICE).

Staff identified patients' physical health needs and recorded them in their care plans. However, we did note one care plan where a patient's physical health needs were not noted in the care plan.

Staff made sure patients had access to physical health care, including specialists as required. All wards had access to the physical health lead for the trust for advice and guidance.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. We saw leaflets on healthy eating, smoking cessation and the benefits of exercise. The wards also arranged walking groups for patients to encourage exercise.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, staff used National Early Warning Score (NEWS), Waterlow score and Health of the Nation Outcome Scales (HoNOS).

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward teams had access to a range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a range of specialists to meet the needs of the patients on the ward. For example, the ward teams included or had access to consultants, registrar doctors, nurses, the trust physical health lead and occupational therapists. However, the service did not have access to psychology support for patients.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported permanent medical and non-medical staff to develop through yearly, constructive appraisals of their work.

Managers supported medical and non-medical staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. For example, at Hallam Street and Dorothy Pattison hospital staff were able to take part in bite-size learning sessions which covered a range of topics relevant to patient care on the wards. We also saw training had been delivered on ligature assessments, autism basic awareness, speech and language awareness, safeguarding and care planning.

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

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. These were attended by the ward consultants, nurses, activity coordinators, community mental health teams and other professionals when required.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation. This included the bed management team, discharge team and other mental health services provided by the trust.

Ward teams had effective working relationships with external teams and organisations. This included social care, housing associations, GPs, commissioning groups and other mental health providers.

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

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff had access to support and guidance from their Mental Health Act administrators. Staff could request an opinion from a second opinion appointed doctor (SOAD) when necessary and they usually completed their assessment in a timely manner.

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

Patients had access to information about independent mental health advocacy and the advocates regularly visited the wards.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) and that this was not delayed for non-clinical reasons.

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

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. Staff informed patients of their right to leave upon admission. Patients we spoke with were aware of their rights.

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

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on the Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed patient capacity at admission and regularly thereafter. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

There were no deprivation of liberty safeguards applications made in the last 12 months and managers ensured that any applications were justified and done correctly. Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Is the service caring?

Good   

Kindness, privacy, dignity, respect, compassion and support

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

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

Staff were discreet, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it. We saw that staff interacted with patients in a positive and personalised way. Patients said staff treated them well and behaved kindly. All nine patients we spoke with told us that staff were friendly and helpful.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff felt able to approach their managers with concerns and felt that they were listened to.

Involvement in care

Staff involved patients in care planning and discussed their treatment options with them. Staff sought patient feedback on the quality of care provided and ensured that patients had easy access to independent advocates. However, patients informed us that they did not always receive a copy of their care plan.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff told us that they did this by taking new patients on a tour of their ward and introducing them to staff and other patients. Staff recognised that providing a good first impression of the ward was important.

Staff did not always give patients access to their care plans and risk assessments. Eight patients told us that they had not seen or been offered a copy of their care plan. However, staff involved patients in their treatment and care by supporting them to attend their weekly review meetings and patients knew who their named nurse was.

Staff tried to involve patients in their clinical reviews to ensure they understood their care and treatment. Doctors discussed patients' medication with them during their clinical review and adjusted the treatment based on the patients' agreement and presentation. However, six patients told us that they had not been given information about the side effects of their medication.

Staff involved patients in decisions and supported them to give feedback on the service and their treatment. Patients and staff attended regular community meetings, where patients discussed concerns and provided feedback about their experiences of the service they were receiving. Staff provided information about recent and proposed changes on the ward and actively sought patient feedback about these during the community meetings. Staff supported patients to give feedback on their care and treatment during their weekly review meetings.

Staff made sure patients could access advocacy services. Independent mental health advocacy posters were displayed on each ward. Staff had good links with the local advocacy service and knew how and when to refer patients to this service.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff regularly informed family and carers with changes and updates and involved them in decision-making. Staff spoke with families and carers as part of weekly review meetings and invited them to attend care planning and discharge meetings, with the consent of the patient.

Staff referred carers for a carer's assessment if this was needed.

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

Is the service responsive?

Good   

Access and discharge

Staff managed people well. A bed was available when needed and patients were not moved between wards unless this was for their benefit. Patients discharge were sometimes delayed for other than clinical reasons due to lack of onward placement.

Bed management

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. They worked with the bed management and discharge teams to ensure that discharge was not delayed. However, due to the levels of need and the lack of suitable onward placements, some patients did stay on the ward longer than was necessary.

The service had low patient out-of-area placements. Patients were usually admitted from any area covered by the trust, and out-of-area placements were admitted only on occasion. The trust had a male psychiatric intensive care unit and patients could be referred to this ward from any of the trust's male acute services. However, the trust did not have a female psychiatric intensive care unit. This meant that female patients requiring psychiatric intensive care would need to be transferred out-of-area.

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

When patients went on overnight leave, they often returned to a different bed, either on the same ward or a different ward within the trust. This meant that patients had a lack of continuity of care and had to adjust to a new environment and care team upon return from leave.

Staff did not move or discharge patients at night or very early in the morning. Some emergency admissions did take place out of hours.

Discharge and transfers of care

The service had low or reducing numbers of patient delayed discharges in the past year. Managers monitored the number of patients whose discharges was delayed.

Managers tried to ensure that delayed discharges only took place when there was a clinical reason to do so. However, due to the levels of need on the wards, and the lack of suitable onward placements or housing, patient discharge was sometimes delayed. Housing issues sometimes also led to delays in discharge.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Discharge planning started at the point of admission, and goals and objectives were assigned in collaboration with patients to work towards discharge.

Staff supported patients when they were referred or transferred between services. Staff attended patient appointments with them when needed.

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

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. Most wards had facilities which promoted patients' privacy and dignity. However, the design and layout of the wards on Hallam Street hospital could be improved to support patients' treatment and care.

Each patient had their own bedroom, which they could personalise. Patients had access to shared bathrooms on the wards. There were enough bathroom and toilet facilities for the number of patients on the wards.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. Patients were risk assessed for supervised or unsupervised access in various areas of the wards, including their bedrooms.

The service had quiet areas and access to visiting areas on or off the wards where patients could meet with visitors in private.

Patients could make phone calls in private. Patients who did not present a risk were allowed access to their mobile phone.

The service had an outside space that patients could access easily. This was risk-assessed and supervised access was given if staff felt the patient was at risk of self-harm or absconding.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food. Most patients gave good feedback on the food.

Patients' engagement with the wider community

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

Staff supported patients to access opportunities for education and work. Due to the pandemic, access to education and work opportunities had been limited.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff encouraged patients to use local voluntary services for work and recreational activities.

Meeting the needs of all people who use the service

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

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and the local community. The service could gain access to interpreter, and signing and translator services when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. The service had access to gluten-free, vegan, kosher and halal food.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information in patient areas about how to raise a concern.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints well and identified themes and trends from complaints.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good  

Leadership

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

Staff told us that they had seen members of the senior management team on the wards and knew who they were.

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

Vision and strategy

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

The trust values were visible around the wards and the values were applied and discussed in staff supervision and reflective sessions.

Culture

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

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Management of risk, issues and performance

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

Information management

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

Engagement

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

Mental health crisis services and health-based places of safety

Good ● → ←

Is the service safe?

Good ● → ←

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

During our inspection we looked at all areas that patients could access and found that staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified.

Not all interview rooms had alarms but where there were no alarms staff were issued with personal alarms linked to the front desks. In all buildings we visited there were staff available to respond.

We looked at four clinic rooms attached to the four services we visited and found that all clinic rooms had the necessary equipment for patients to have thorough physical examinations.

All areas we visited were clean, well maintained, well-furnished and fit for purpose.

We viewed cleaning records for all four services we visited and found that staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control guidelines, including handwashing. Upon entering each of the buildings we visited we were directed to hand sanitising stations and informed of the trusts policy on hand hygiene during the covid pandemic

Staff made sure equipment was well maintained, clean and in working order. Where required equipment had in date check stickers that showed us that regular checks were being undertaken as per trust policy

Safe staffing

The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

During our inspection we viewed the staffing rota for each location we visited and found that the service had enough nursing and support staff to keep patients safe.

The service had low vacancy rates overall. No service we visited had more than 3 vacancies and in all cases recruitment was underway to fill any vacant posts

Mental health crisis services and health-based places of safety

The service had rarely used bank and agency nurses. When they did use bank staff, staff were familiar with the service. In the case of agency staff, these were only used to cover long term sickness as part of a short term contract with the agency. The same member of staff filled all shifts and undertook the same training and development as a full time member of staff.

The service had low rates of using bank nursing assistants.

Managers made arrangements to cover staff sickness and absence.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low turnover rates.

Managers supported staff who needed time off for ill health. We saw a number of examples of long term sickness across all four services where managers were actively supporting staff who were unwell

Sickness levels were low. We found that the service had seen a spike in staff sickness as a result of the Covid pandemic but at the time of our inspection this had reduced to pre-pandemic levels.

Managers used a recognised trust wide tool to calculate safe staffing levels.

The number and grade of staff matched the provider's staffing plan.

Medical staff

The service had enough medical staff.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

Managers made sure all locum staff had a full induction and understood the service.

The service could get support from a psychiatrist quickly when they needed to.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. We found that all four services were within trust set key performance indicators in relation to staff training.

The mandatory training programme was comprehensive and met the needs of patients and staff. However staff at Penn Hospital were not provided with any training in the safe management of aggressive behaviour even though part of their job role was to assist ward staff in managing patients admitted to the health based place of safety. MAPPA training was not included as part of their personal development plan.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Mental health crisis services and health-based places of safety

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of patient risk

We looked at 16 patient records during our inspection and found that in all cases staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff used a recognised risk assessment tool.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. We saw that patient records were individualised and consideration had been given to individual needs in all records we looked at.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. We saw a number of cases where individualised short term management plans had been developed to manage patients changing needs. These had been reviewed and updated regularly and, where required, referrals had been made to more appropriate services.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. We found that waiting lists were within trust set targets and patients were seen within the time scale set in the key performance indicators

Staff followed clear personal safety protocols, including for lone working.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. We found that safeguarding training was below trust set targets at Quayside View and Penn Hospital. However both services were above 75% compliant with this training and there were action plans in place at both locations to address the shortfall.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we interviewed could identify their local safeguarding leads and knew who was responsible and knew who could offer support trust wide.

Managers took part in serious case reviews and made changes based on the outcomes.

Mental health crisis services and health-based places of safety

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. We found that we could easily navigate the system and find information. In cases where we could not locate a particular piece of information, staff could find it for us easily.

When patients transferred to a new team, there were no delays in staff accessing their records. The trust had introduced RIO as their electronic recording system which meant that other services within the organisation could access the patients records immediately upon referral or transfer.

Records were all kept electronically so were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

Mental health crisis services and health-based places of safety

Staff reported serious incidents clearly and in line with trust policy.

The service had no never events.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback.

Managers shared learning about never events with their staff and across the trust.

Managers shared learning with their staff about never events that happened elsewhere.

Is the service effective?

Good   

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

We looked at 16 care records and found that staff completed a comprehensive mental health assessment of each patient.

We saw that staff made sure that patients had a full physical health assessment and knew about any physical health problems. Where patients had a physical health condition there was evidence that this was monitored and discussed as part of the care planning process

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We found that, in the records we looked at, care plans were individualised and where possible had had input from the patients themselves.

Staff regularly reviewed and updated care plans when patients' needs changed. Staff held a morning meeting every day which helped to quickly identify the changing needs of patients. There was evidence in patients records that staff had responded to changing needs and updated care plans quickly

Mental health crisis services and health-based places of safety

Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance (from relevant bodies such as NICE).

Staff made sure patients had support for their physical health needs, either from their GP or community services.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes.

Staff used technology to support patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of each patient. These included consultants for each service, junior doctors, occupational therapists, nurses and care support workers. We also found that social work teams were closely linked with each of the four services and this resulted in quick access to social workers if required.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work. (use this if data covers all staff groups)

Mental health crisis services and health-based places of safety

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work. (use this if data covers all staff groups).

Managers supported non-medical staff through regular, constructive clinical supervision of their work.

Managers supported medical staff through regular, constructive clinical supervision of their work. Clinical supervision was undertaken with each member of staff regularly. Qualified nurses had supervision every six weeks and care workers received supervision every eight weeks.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Each service undertook a morning meeting at the start of every shift to discuss case loads. There was a weekly staff meeting for the manager to relay any changes or improvements to working practice. Each member of staff also had access to an electronic system that enabled managers and the trust to update staff via email.

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

Managers made sure staff received any specialist training for their role.

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

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings each week to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care.

Staff had effective working relationships with other teams in the organisation.

Staff had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

Mental health crisis services and health-based places of safety

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

Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

For patients subject to a Community Treatment Order, staff completed all statutory records correctly.

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed.

Staff completed regular audits to make sure they applied the Mental Health Act correctly. Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Good   

Mental health crisis services and health-based places of safety

Kindness, privacy, dignity, respect, compassion and support

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

All patients we spoke to as part of our inspection were complimentary of the service. They stated that they felt that the care they received was of a high standard and all were extremely complimentary of the staff that had worked with them. Staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff involved patients and gave them access to their care plans. Patients stated that they could be as involved as they wanted to be in their care without staff putting pressure on them.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Staff involved patients in decisions about the service, when appropriate.

Patients could give feedback on the service and their treatment and staff supported them to do this. All patients we spoke to stated that they knew how to make a complaint if they ever needed to and felt that staff would support them in this. They all stated that they felt they could make a complaint without fear of retribution.

Staff supported patients to make advanced statements in relation to their care.

Staff made sure patients could access advocacy services. The trust provided patients with a welcome pack upon first referral that contained information relevant to the service user. This information pack contained information about how to access advocacy services.

Mental health crisis services and health-based places of safety

Staff informed and involved families and carers appropriately.

Involvement of families and carers

Staff supported, informed and involved families or carers.

Staff helped families to give feedback on the service.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good   

Access and waiting times

The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists.

The service met trust target times for seeing patients from referral to assessment and assessment to treatment. Trust set targets were that patients would be contacted within 4 hours of calling the service and that they would be assessed within 24 hours. We found that all services we visited complied with this key performance indicator. Systems were in place to ensure that patients would be contacted and seen within these timescales

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. We attended two morning meetings where patients who were finding it difficult to engage were discussed. The team developed individualised strategies for attempting to engage with each patient.

Staff always tried to contact people who did not attend appointments and offer support. We saw evidence in patients notes and minutes from morning meetings that showed contact would be attempted and was planned soon after the missed appointment.

Patients had some flexibility and choice in the appointment times available.

Staff worked hard to avoid cancelling appointments and when they had to they gave patients clear explanations and offered new appointments as soon as possible. We found a small number of appointments had been moved as a result of staff sickness. In all cases the patient was contacted quickly prior to the appointment time and offered an alternative time to suit them.

Appointments ran on time and staff informed patients when they did not.

The service used systems to help them monitor waiting lists/support patients.

Mental health crisis services and health-based places of safety

Staff supported patients when they were referred, transferred between services, or needed physical health care.

The service followed national standards for transfer.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care.

Interview rooms in the service had sound proofing to protect privacy and confidentiality. We inspected all interview rooms in all the services we visited and found that they were fit for purpose.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. All the services we visited were accessible to people who had a disability or specific requirement. Public notices and information leaflets were available in a variety of languages and easy read versions if required and there was easy access to interpreters including British Sign Language. Out of hours the service had access to telephone interpreters if required.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Each patient was given a welcome pack at their first meeting with a nurse that contained a wide range of information about the service itself and supporting organisations such as advocacy services.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Everyone we spoke to stated that they would know how to raise a complaint if they needed to.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Mental health crisis services and health-based places of safety

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good   

Leadership

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

Managers we spoke to were able to talk us through their service in detail and demonstrated a good knowledge around all parts of service delivery. They could all talk us through measured outcomes for the service and could evidence how these outcomes were met. Where there had been improvements, managers could talk us through how these were implemented and gave credit to the individuals that had developed these improvements.

All staff we spoke to were complimentary of their immediate managers. They stated that they were supportive and visible in the service. That they encouraged staff interaction with service development and encouraged individuals to develop.

Vision and strategy

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

Staff we spoke with knew who the senior leadership team for the trust was and could tell us what the trusts visions and values were. They told us that the senior leadership team engaged with staff on in the services in a number of ways and staff felt like their voice was heard.

Culture

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

Staff could explain to us how they had been helped to develop both the skills required to undertake their role and, in some cases, where they had been supported to develop skills that allowed them to move into new roles. We noted that a number of the staff vacancies that we saw across all four services we inspected were due to staff moving on into different roles within the trust as a result of staff development programmes.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Governance processes operated well to ensure that the services were run effectively. This included close monitoring of outcome measures and key performance indicators.

Mental health crisis services and health-based places of safety

Management of risk, issues and performance

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

All information relating to the service, including patient information, was stored electronically. There were enough work stations and IT equipment available to ensure that all staff had access to the information they needed.

Engagement

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

Managers were involved in engagement with their counterparts from other local trusts to ensure an integrated health and care system.

Wards for older people with mental health problems

Good   

Is the service safe?

Requires Improvement  

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could not observe patients in all parts of the wards at some of the locations.

The lay out of the wards were different in each of the locations. Only Salter ward at Edward Street hospital had mirrors placed in some of the blind spots but not all to allow staff clear lines of sight of all areas of the wards. In some of the wards there was limited access to mirrors to mitigate the risk of blind spots.

Staff explained that patients were on observations and staff were also placed in the areas where blind spots were to mitigate risks.

Patients were cared for in mixed sex accommodation and therefore Chance ward did not comply with the required guidance. Prior to the COVID pandemic, the older adults' wards cared for both male and female patients but wards were separated into male and female areas. However, during the pandemic bed space was reduced within the service, and the wards operated an admissions area where both male and female patients would first attend for a period of isolation (up to ten days). Patients were in individual rooms next to each other and would have to share the bathroom facilities. Managers explained that in these areas staff who took the role of "dignity champions" were in place to ensure patients safety, privacy and dignity were not compromised. We saw staff in these areas on all wards we visited. Staff told us that bathrooms were thoroughly cleaned in-between patient use which we also observed this on the wards.

The introduction of the isolation areas meant that wards were utilising space in some of the male or female only corridors, therefore, some of the wards had mixed corridors such as chance ward at Edward Street hospital. At Bloxwich hospital Linden ward was used as the admissions ward where patients were isolated prior to moving to Cedar's ward, both wards had mixed corridors.

Staff regularly completed COVID tests with these patients prior to sending them to the open wards. They would have to test negative during their 10 day stay if there was a positive result then the isolation period would continue until a negative result was produced.

There were potential ligature anchor points in the service. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Wards for older people with mental health problems

The trust had an up-to-date ligature assessment and ligature management policy. All ligature risks were identified for the older adult wards through up-to-date ligature assessments and ligature footprints with pictures to identifying the risk. We saw on Holyrood ward during handover pictures of ligature risks were attached to the handover folder. Staff explained that any new members of staff or bank /agency workers would be shown the folder to be familiarise themselves with the ligature risks.

There was a programme in place to remove all ligature points and ligature anchor points

Staff did not have easy access to alarms. Staff access to alarms varied across the locations. We observed at some of the hospitals that there was a shortage of personal alarms for staff. In the meantime, to address the shortfall some staff were issued with key ring type personal safety alarms that were not connected to the main alarm system. Therefore, when activated the alarms only made a loud noise in the area where the staff member was situated to summons help. Managers at Bloxwich hospital explained they had an issue with their alarms, at the time of the inspection the ward had 13 alarms. They had another five that need calibrating and other five that had been ordered. They explained that they had to buy the panic pull alarm, but it did not alert everyone.

The panic alarms were also given to visitors attending the wards. We did see staff starting their shift at Bloxwich hospital being informed that there were no alarms.

We asked staff and managers the reason for the shortfall in provision of alarms and received a combination of issues reported. One was that agency or bank staff would forget to return the alarms after completing their shift. One of the wards had instigated an amnesty for staff to return the alarms but received a poor response. The other reason was that a lot of the alarms needed repair and as they were old alarms parts needed to repair them could not be sourced so new alarms had to be purchased.

The trust informed us that although orders had been placed for alarms, they acknowledged that there had been a supply chain issue. They were doing all they could to address this. During our inspection we saw personal alarms had been delivered to Malvern ward and managers at Bloxwich hospital confirmed alarms had been delivered and were in the process of being calibrated.

Maintenance, cleanliness and infection control

Ward areas were not always well maintained or fit for purpose; however, they were clean, and well furnished. The older adult wards were located at four separate locations with varying ages of buildings. We found that the environments on the wards required some repairs and updating. Wards had issues with showers which impacted on the privacy and dignity of the patients. We found this issue on both Chance and Malvern wards. We found one shower in a female dormitory had an out of service sign on the door, which meant there were no other shower facilities for female patients other than the shower linked to the male dormitory which serviced at least six patients both male and female.

The shower had dual access, one from the male dormitory the other from a disused dormitory used as the female lounge. Therefore, female patients did not have to go through the male patient area to access the shower facilities.

The shower required cleaning after each patient had used it, therefore patients could be waiting some time to access the shower facilities and could not be used as and when required. On a follow up visit to the ward a week later the shower still had the out of service sign on it. We discussed this with managers who informed us that the shower had been repaired and the notice should have been removed.

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The shower on Malvern ward in the male corridor leaked, there was no other shower or bath facilities available in the male area as the second bathroom did not have a bath, it had been removed due to a repair that was required. Staff told us they would have to mop up the water once it started to leak. This meant that patients were not always able to use the shower as and when required. If male patients wanted a bath, they would have to use the bath in the female area with a dignity champion in place. Managers stated they had been informed there was some delay in obtaining the parts required to repair the shower.

At Bloxwich hospital on both Linden and Cedar wards, we found there were some repairs that had not been completed. Stained tiles where the ward had experienced a leak had not been replaced, handrails had missing sections exposing a metal framework beneath that could be a risk to both patients and staff. Draws on the medicines trolley did not close properly and required repair. Staff on the older adults' wards stated that it was difficult to get repairs completed. They sometimes felt that due to the refurbishment programme senior managers were waiting for this to happen so that the repairs would be completed as part of this.

Following on from our visit we requested an update from the trust concerning the repairs and were told, most of the work had been completed. Further work had been scheduled but was subject to orders and delivery times some of which were up to an eight week wait.

Staff made sure cleaning records were up-to-date and the premises were clean.

We viewed cleaning records that showed cleaning records were up to date and had been signed daily / weekly to demonstrate cleaning had been completed.

Staff followed infection control policy, including handwashing. There were covid 19 protocols in place at the wards we visited including hand washing and protective equipment at the entrance to the wards. One ward was able to operate a one-way entrance and exit system.

Seclusion room

The service did not have a seclusion room

Clinic room and equipment

Out of the four clinic rooms we visited at the service, two were small, one required organising and the other was in need of refurbishment. We did find clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment. Records showed that staff regularly completed checks of the clinic room and the equipment.

Medicines were regularly checked. Pharmacists attended the wards twice weekly and supported staff to complete audits. Medicines we checked were all in date and appropriately stored in cupboards or in the clinic fridge.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. Across the entire older adult's service staffing levels and vacancy rates was challenging, indicated by the staffing figures presented by the trust. In the past three

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months prior to the inspection, vacancy rates for registered nurses and health care support workers were highest on Cedars ward at 46% and 24% on Meadow ward for health care support workers. All wards were using high levels of bank and agency staff to keep patients safe, cover vacancies, clinical observations, sickness, and the ongoing COVID-19 pandemic.

We were provided with three months of staffing figures that showed Meadow ward had the highest use of bank and agency staff for registered nurses. Chance ward had the highest use of agency and bank staff for health care support workers.

Managers at Bloxwich hospital stated although the trust had a monthly ongoing programme of recruitment, people opted to work in other areas of the trust rather than older adults. There was a recruitment drive advertised more locally for Bloxwich hospital. Managers explained that they had increased the staffing numbers for health care support workers to limit the amount of agency staff they used.

Across the service staff told us that they shared staff between wards. This happened when staff called in sick at short notice. Managers had regular meetings regarding staffing with all the division and shared staff when they could. Managers made sure all bank and agency staff had a full induction and understood the service

before starting their shift. Staff shared key information to keep patients safe when handing over their care to others. We attended handovers and saw that staff provided information both verbal and written to staff who were starting their shift this included any one-to-one observations and information on risk including ligatures.

The ward manager could adjust staffing levels according to the needs of the patients. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers used the safe care staffing tool to establish the number of staff required on the ward. We viewed the staffing rotas which matched the staffing numbers per shift.

Patients had regular one-to-one sessions with their named nurse. Staff explained that shortages sometimes had an impact on patient one to one sessions, however staff worked together to ensure the impact was minimal.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. On Chance ward at Edwards Street hospital they stated they had access to four doctors which included a consultant and an associate specialist. We saw doctors with their team attending ward reviews on the wards.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. The service had e-learning champions who were allocated to a shift to support staff to access their training. Managers and staff said face to face training was increasing. Wards had training records, managers at Bloxwich hospital explained they had training records for each month, but this did not consider sickness or maternity.

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We viewed the training records for the service which showed high percentage rates of staff were up to date with their mandatory training. We could not comment on dementia training because we did not see any records specific to that type of training.

Staff said there is some training that they could get on and there were others that they had to wait for such as management of actual potential aggression (MAPA).

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers and staff explained there was an electronic reminder of training they need to complete. It also provided a percentage rate of completion for the individual staff member.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 12 patient records, all had up to date completed risk assessments that were regularly reviewed.

Staff used a recognised risk assessment tool. The service used the Steve Morgan risk assessment to assess patient risk.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to, or posed by, patients. Care plans contained information and guidance on the management of patients risks. There was evidence of good interventions to reduce any ongoing or newly identified risks. Staff discussed any changes to patients' risk at handover meetings to update staff who were beginning their shift.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff were always present in-patient areas and there was also allocation of one-to-one observations in place.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low. Across the service staff developed memory boxes with patients. These were boxes that had items within it that supported patients to recall people and events from the past. Communication books were also added to the memory box that explained how the person would like to be treated, it gave information on talking points so staff can start a conversation which reduces risks.

On Malvern and Holyrood ward managers said staff had been creating life stories with the patients. As a result of this the life stores had been made into booklets and they now had proper books for each patient.

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Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff on all wards told us that restraint was rarely used and would only be used as a last resort. Any restraint that took place was documented on the trusts reporting system. The service used interventions such as positive behaviour support plans the management of actual potential aggression (MAPA) and safe wards. These interventions used techniques such as talking patients down, positive words and calm down methods to support patients. We saw in a patient support plan where staff recorded their intervention that had significantly reduced the risk of violence and aggression.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. The pathway for rapid tranquilisation was displayed in the clinic room and staff had access to the policy.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training. The service provided safeguarding training level two and three, all staff we spoke to said they were up to date with safeguarding training, which had been completed through e-learning.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a safeguarding team that staff could contact any safeguarding queries or concerns. Staff also had access to the local authority safeguarding teams and made safeguarding referrals as required.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff followed clear procedures to keep children visiting the ward safe. All visiting to the wards were based on a booking system. Patients' relatives and carers booked in advance a thirty-minute slot on dates and times that were available on the ward.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

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

Patient notes were comprehensive, and all staff could access them easily.

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(Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.) Staff said they had recently been trained to use the trusts electronic recording system. A selection of staff was trained as champions to support staff with ongoing learning across the wards. Staff reported there were still some paper records such as the Person-Centred Physical Intervention Plan (PCPIP) and National Early Warning Score (NEWS).

Prior to the merger staff were using different dementia documentation for both trusts, therefore when they merged staff were not all using the same documentation. Managers and staff stated one of the paper-based falls documentation was different for both trusts. The trust was in the process of streamlining all documents for the older adult's service so that staff were using the same ones. The falls document was now a booklet which was being put on to the electronic system. Staff used headings to document information within the patients care records. There was also a legacy viewer which allowed staff to look at historical information concerning patients who were admitted previously prior to the merger of the two trusts. Managers explained that they had specific people who had been trained in this and who were able to support other staff to obtain this information.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date. Staff stored and managed all medicines and prescribing documents safely. We reviewed 14 prescription cards, all were up to date and signed. Medicines and documentation were stored in a locked cupboard in a locked clinic room, the nurse in charge was responsible for holding the clinic room keys.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. We saw staff recorded medicines reconciliation for all new admissions to the wards.

Staff learned from safety alerts and incidents to improve practice. Staff reported any medication errors through the trusts electronic reporting system.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff addressed medication with patients in the ward reviews. Staff spoke with patients and supported them to have discussions concerning the medication they were taking and the purpose of taking the medication. They discussed any issues patients had with medication such as side effects and any impact on their physical health.

Track record on safety

The service had a good track record on safety.

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Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Following the merger of the two trusts the reporting systems were changed so that all staff were using the same system. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff understood the duty of candour and gave patients and families a full explanation if and when things went wrong.

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service. Lessons learnt were shared in monthly team meetings and supervision. Staff said that following the outcome of incidents assurance reports were shared in supervision as well as lessons learnt. There was a rolling agenda in team meetings and in supervision for lessons learnt and recent updates on audits.

There was evidence that changes had been made as a result of feedback.

Staff met to discuss the feedback and look at improvements to patient care.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Good   

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed 14 care plans across the service, we saw staff completed care plans tailored to the patients' individual needs. Staff documented patients mental and physical health care needs that were both current and historical. However, on Cedar and Linden ward, although risks had been identified the care plans did not address all the patient needs.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were personalised, holistic and recovery orientated. We found that most of the care plans we looked at contained the patients' views, however on Cedar and Linden wards we found the care plans appeared to be a standard format plan and therefore were not personalised.

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Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance. Staff completed weekly weight checks for patients and Waterlow scores which checks patients for risk of pressure sores.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required. Staff referred patients who required other physical health care intervention to other professionals such as psychology or physio therapists.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff completed diet and fluid charts.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients were able to attend smoking cessation classes. Staff provided some examples of other activities that took place on the wards such as sleep hygiene; staff were also being trained in mindfulness.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The Model of Human Occupation Screening Tool (MOHOST) was used by occupational therapists to assess people.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives. The service completed audits such as and amongst others, care planning, physical health monitoring, medication, handover and infection control. The managers collated information from all the wards and looked at best practice. Any outcomes from the audits were communicated either through supervision, team meetings or placed on the ward's notice boards.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. The service had doctors, nurses, health care support workers, occupational therapists, psychologists, physio therapists and speech and language therapists. Some wards also had an activity coordinator.

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Managers ensured staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work. Managers supported staff through regular, constructive appraisals of their work. Staff told us they received appraisals where they discussed achievements and their career progression. The service completion rate for appraisals across the wards of a high percentage.

Managers supported staff through regular, constructive clinical supervision of their work. The trust stated that due to the current demand on the wards, qualified staff working within the safe staffing numbers, were providing mentoring and supervision on a day-to-day basis. Staff told us about informal supervision they received daily as well as their formal supervision. They spoke about group supervision they regularly attended and reflective practice sessions. Only one staff told us they had not received supervision.

We reviewed supervision records that showed there was poor recording. The trust acknowledged that recording of supervision was under review and being addressed. The figures did not include either reflective practice or group supervision.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. One registered nurse reported there were developmental support and opportunities available.

Managers made sure staff received any specialist training for their role.

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

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Ward reviews took place weekly, staff said they had good relationships with external agencies. They were able to access other disciplines to attend meetings such as social workers for section 117 aftercare or discharge through a referral process.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation. Staff said they had good working relationships with the community teams. The electronic patient record helped with this as information was accessible for all professionals. Therefore, if a patient was without a care co-ordinator staff referred to the community team who allocated within five days and attended the ward review.

Ward teams had effective working relationships with external teams and organisations.

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

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

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Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Staff repeated the patient's rights to them as necessary some required daily explanations and some weekly. We saw that staff recorded this information in the patients notes and it also formed part of the care plan.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw evidence of this in the patients care records.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. The wards displayed information next to the main entry and exit doors to the ward informing patients of what to do if they wanted to leave the ward.

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Staff took part in audits concerning the Mental Health Act paperwork, if there were any issues managers discussed with staff and improvements would be made.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

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There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff regularly reassessed patients' capacity for specific decisions and documented the outcome.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. In multi-disciplinary team meetings, we saw staff discussed arranging best interest assessments for patients. They discussed the reasons for the meeting with the patient and took into consideration their preferences, this also included family and carers.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Is the service caring?

Good   

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. Patients told us they felt staff were good and supportive, staff discussed and explained medication with them. In the ward reviews we saw patients were invited to the meetings and were supported to discuss the medication that they were taking. Patients were encouraged to ask questions about their treatment and treatment plans.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff supported patients to keep in touch with their relatives and carers. Staff had received crochet hearts from members of the public which they shared with patients to give to their relatives from the patients.

Staff understood and respected the individual needs of each patient. Staff spoke about patients in their care as individuals and treated them as individuals. This was evident through the life stories that Holyrood and Malvern ward

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had completed. The life boxes contained information about the person, their likes and dislikes, past employment, hobbies and past times. Communication books also identified how the patient wanted to be treated. This information ensured that both existing and new staff members working on the ward knew more about the patient which helped to provide individual holistic care and support.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff involved patients and gave them access to their care planning and risk assessments.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). On Cedar Ward staff arranged interpreters to attend the ward seven days a week to support the care of patients who did not speak English as their first language. This support was not just for multi disciplinary meetings or Mental Health Act assessments, but provided an every day opportunity for patients to talk to staff about their care and treatment.

Staff involved patients in decisions about the service, when appropriate. Staff involved patients with the plans for a new hospital and the updating of wards and asked for feedback on what they thought of the plans. We saw that meetings were held at Edward Street hospital to discuss the proposed plans and invite feedback from people using the service. On one of the wards staff sought feedback from patients for some of the activities that were being introduced.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients had regular community meetings which were minuted by staff. At Bloxwich hospital staff explained the meetings were now done on a one-to-one basis due to COVID. The meetings had a set agenda which included, activities, meals, medication, environment, religious needs, and infection control.

Staff supported patients to make decisions on their care. Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed, and involved families or carers. The families and carers we spoke with gave mixed responses to the involvement that they had concerning the patients care. Although they said they had some communication with staff they felt it could be better and more consistent. Carers and relatives felt able to phone and ask questions but stated responses were not always in a timely manner. They were struggling with the fact that they were not able to attend

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meetings in person. One relative explained although they were invited to meetings this was always via the phone due to COVID, which they found most restrictive. Other relatives explained that they had not been invited to meetings, one relative said they had asked staff if they could attend to which staff said no but that they would contact them after the meeting, which did not happen.

Staff helped families to give feedback on the service. One relative explained that they had been informed of the trusts plans to either move or update wards across the service. We saw plans of the proposed wards and hospitals within the hospitals and on the trust, website inviting staff, patients, carers, and relatives to have their say. However, some of the relatives said that they did not have an opportunity yet to have their say as the staff were always busy. Other carers stated that they had not been provided with a questionnaire in relation to providing feedback. Although the trust website had a section for people to feedback not all carers or relatives knew about this.

Staff gave carers information on how to find the carer's assessment. We did not have any information from carers or relatives concerning carers assessments.

Is the service responsive?

Requires Improvement  

Access and discharge

Staff managed patients well. A bed was available when needed and patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

Managers made sure bed occupancy did not go above 85%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

The service had no out-of-area placements.

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

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of delayed discharges. The reasons for delaying discharge from the service were a mixture of clinical and placement availability. The hospital held a weekly delayed transfer of care meeting. Together with agencies such as the local authority they discussed delayed discharges and the reasons for the delay which included, funding approval and sourcing of residential or nursing homes. Managers explained that the service was finding it difficult to find placements for patients that had increased risk. Also, during the first wave of the COVID-19 pandemic

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placements were not available as residential and nursing homes were closed to admissions. The Multi-disciplinary team had to decide whether they should look for another placement or wait until the original placement re-opened, however there was also the possibility that the place would not be available if they waited. Relatives and carers also told us that they found issues with placements, they also became involved with trying to access placements for their family member to try and speed up the process.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We saw in patient records and at ward reviews that other professionals working with patients were involved with the discharge planning and all did their part to facilitate this.

Staff supported patients when they were referred or transferred between services. Some patients whilst on the wards required attendance for appointments or admission into other hospitals. Staff supported patients with the practical aspects of transfer and shared supporting information pertaining to their admission with the receiving hospital. Where necessary staff escorted patients and if required and appropriate remained with them.

The service followed national standards for transfer.

Facilities that promote comfort, dignity, and privacy

The design, layout, and furnishings of the ward did not always support patients' treatment, privacy, and dignity. All patients did not have their own bedroom with an En-suite bathroom but could keep their personal belongings safe in lockers. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Patients did not always have their own bedroom, which they could personalise. At Edward Street and Bloxwich hospitals we found dormitories where patients shared with other patients. Due to COVID-19 the number of patients in a bedroom was reduced, although beds remained in the space. There had been a reduction of between four and six beds per ward at the two hospitals. Patients who were sharing were of the same gender, curtains were provided around the bed space to support the patient's privacy and dignity.

We spoke to staff and senior managers about the dormitories, and they all confirmed there were plans for the removal of the dormitories and work was impending. The trust explained they had been allocated funding to support them to remove dormitories and build a new older peoples unit. A consultation process had taken place about the plans to replace Bloxwich hospital with a new purpose-built unit at the Dorothy Pattison site. Edward Street hospital will be refurbished to eliminate dormitories. All building works are scheduled to be completed by 2024.

At Malvern and Holyrood wards although patients had their own bedrooms, few of them had ensuite facilities.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private. Due to COVID – 19 patients' visitors were required to book in advance to visit their relatives in hospital. A space/ room was allocated off the ward where visitors and patients could meet for 30 mins. The room was then thoroughly clean before being used again.

Patients could make phone calls in private and had access to their mobile phones.

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The service had an outside space that patients could access easily. At Edward Street hospital, the two wards were on different levels, Chance ward was on the ground level therefore access to outdoor space was more accessible. The service had a notice on the wall stating the door to the garden would be closed in the evenings. Patients on Salter ward were based on the first floor of the hospital, outdoor space was accessible from the ground floor. All patients were risk assessed prior to accessing the garden. At Bloxwich hospital both wards were on different levels of the hospital outdoor space was in the centre of the hospital, so patients had to leave the ward to be able to access it.

Patients could make their own hot drinks and snacks and were not dependent on staff. Patients told us that drinks and snacks were available all day.

The service offered a variety of good quality food. Patients told us they had three choices of menu which they felt provided more options. Patients' carers and relatives were also able to bring food in for those who did not like what was on offer.

Patients' engagement with the wider community

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

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The wards had adaptations in place for patients who required additional support. Carers told us of adjustments that were made for their relatives to support their needs. The service provided interpreters and other communication aids for patients. At Bloxwich hospital, interpreters came in everyday for social contact and ward reviews, staff also used picture cards for patients for example to indicate what they wanted to drink.

Not all wards were dementia friendly, they were not in line with the national guidance on dementia friendly ward environments. On Chance ward, we found toilet doors were not painted in different colours which could support patients to find their way around the ward. The signs on bathroom, bedroom and toilet doors, although large and clear, did not have a clear contrasting background colour.

The wards supported disabled patients. Relatives told us how staff made adjustments to the bedrooms to accommodate patients wheelchairs and made changes to beds and chairs to make them easily accessible.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Wards for older people with mental health problems

Patients had access to spiritual, religious and cultural support. Patients at Malvern and Holyrood ward said that a vicar visited once a week.

Listening to and learning from concerns and complaints

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

Patients, relatives, and carers knew how to complain or raise concerns. We saw carers and relatives made complaints on the patient's behalf and staff responded to both complainant and patient.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We received feedback from carers and relatives concerning complaints they had made to the service. One email received through our customer service centre, stated that staff had apologised and explained how they had addressed the concerns raised.

Managers shared feedback from complaints with staff and learning was used to improve the service. Any themes or feedback from complaints were discussed at staff meetings.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good   

Leadership

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

All leaders we spoke with discussed the recent merger between the two trusts that had taken place during a time when the pandemic had just started. They spoke of the difficulties that they had all faced due to the pandemic and not being able to meet their new colleagues. There was a dedicated team approach to supporting patients and each other. It was evident that the leadership team and staff were all supportive of each other.

Staff knew their senior managers and spoke highly of the leadership team, they said that managers were approachable, understanding, and supportive.

Managers and staff were pleased that the older adult's team were now a division and felt this would increase and strengthen the service for the good of the patients.

Wards for older people with mental health problems

Vision and strategy

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

The trusts visions and values were based around working with people to achieve healthier, happier lives which included, Caring, Enabling, Working Together and Integrity.

All managers and staff we spoke to were aware of the trusts visions and values and worked together to achieve this. Staff were able to tell us what the visions and values were and how they applied it to their everyday work with patients and staff.

Managers told us that the visions and values were discussed in supervision, staff meetings and we saw the visions and values displayed around the wards.

Culture

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

Managers told us that culturally they were just starting to feel like one organisation. They explained there had been a vast number of changes due to the merger, which at times caused some confusion. Managers and staff stated that when they worked in a smaller organisation, they knew everyone and met people face to face, but having meetings over electronic systems they did not know who people were. Putting the camera on during meetings was helpful but it had been a challenge to know who to speak to concerning certain issues.

Both managers and staff agreed that morale had been up and down within the staff group but overall, it has been quite good. Managers said morale could be low if there were no bank or agency staff to cover shifts and said staff had worked above and beyond to keep the wards running, they supported each other and have received support from the public.

Managers told us how they had crochet hearts made for them and staff sent letters and the hearts to other staff who were shielding at home.

Staff said they felt respected, valued, and appreciated. We saw at Bloxwich hospital where managers had organised and appreciation day for health care support workers. There were various categories where other staff and patients nominated the health care support workers for awards. They came together to celebrate their achievements and to say thank you.

Ward managers explained that it could be lonely place working at their level which was acknowledged by the trust who introduced Shwartz rounds. This provided opportunities for all staff to have reflective practice sessions to reflect on the emotional and social aspects of healthcare. Managers said this really helped them.

Ward managers described a selection of support they had individually and collectively such as priority meetings, twice weekly meetings which senior leaders attended, supervision and weekly catch-up meetings.

Staff said they were aware of the trust whistle blowing policy and felt they could raise any concerns without fear of retribution, they would also speak to their managers and senior managers.

Wards for older people with mental health problems

Some staff we spoke to about career progression felt at the time progression was slow others said they had been provided with opportunities such as management / leadership courses.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

We saw systems and processes were mostly embedded across the service, this provided effective oversight including audits, the trust electronic patient records and the trust incident reporting systems and incident reviews and shared learning.

The service completed a range of audits which was submitted to the quality steering group who met regularly to discuss and identify themes and trends, the meeting was attended by the managers.

There had been some issues with estates and the completion of repairs across the service. Repairs to handrails, showers, bathrooms, clinic room issues, were all outstanding which managers had reported. They had a list of new and existing repairs that they brought to the fortnightly/monthly estates and operational meetings.

Although the estates had received the request for repairs, items were taking longer to source due to the delay in suppliers being able to provide what was required. This was the case for the shower room and bathroom on Malvern ward. There were long waits for parts and new items such as the personal alarms which on some wards were limited for staff.

Staffing was an issue across the service, mostly for qualified staff. There was high use of bank and agency staff to fill vacancies, and sickness. The trust had an active recruitment program to rectify this and locally services advertised within their areas.

Management of risk, issues and performance

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

Across the older adult's service there were environmental issues that staff and managers were aware of. Managers regularly checked the environment and produced environment ligature risk assessments that were available for staff to review. They added floor plans and pictures identifying where the risks were and how the risks were to be mitigated. Staff who were new to the wards were shown where ligature risks were, and pictures of the risks were shown during handovers.

The trust had a ligature mitigation program in place to remove the risks which involved updating wards and, in some cases, moving services to alternative sites for a new building to be erected.

The trust had staff in place to review patient records from the previous legacy trusts so that information was not missed, and staff would have previous information when admitting and assessing new patients.

Information management

Staff engaged actively in local and national quality improvement activities.

Wards for older people with mental health problems

Staff had access to equipment and information technology required to do their work. Some systems were recently implemented and needed some for staff to understand how to operate/navigate the system.

Managers had access to information which supported them in their roles as leaders, this included the performance of the service, staffing and patient care. Information was presented to them in a timely manner and accessible format.

Engagement

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

The trust provided information on their website about them and the services they provided, updates on potential changes to sites and wards and contact information including how people could provide feedback. They also used other platforms and websites to obtain feedback of what people to have their say about services.