Black Country Partnership NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Wards for older people with mental health problems	Edward Street Hospital	TAJ07
Acute wards for adults of working age and psychiatric intensive care units	Hallam Street Hospital Penn Hospital Health Lane Hospital	TAJ02 TAJ52 TAJ11
Specialist community mental health services for children and young people	Delta House	TAJ
Children, Young people and families services	Delta House	TAJ
Community based mental health services for adults of working age	Penn Hospital Delta Hospital	TAJ52 TAJ
Community based mental health services for older people	Edward Street Hospital Penn Hospital	TAJ07 TAJ52
Mental health crisis services and health based places of safety	Delta House Hallam Street Hospital Penn Hospital	TAJ TAJ20 TAJ52
Forensic inpatient/secure wards	Gerry Simon Clinic	TAJ11
Community mental health services for people with learning disabilities	Orchard Hills Pond Lane	TAJ55 TAJ53

Summary of findings

	Ride Hill	TAJ54
Wards for older people with mental health problems	Edward Street Hospital Penn Hospital	TAJ07 TAJ52
Wards for people with learning disabilities and autism	Heath Lane Hospital Ridge Hill Orchard Hills Hallam Street Pond Lane	TAJ11 TAJ54 TAJ55 TAJ20 TAJ53

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

Summary of findings

Ratings

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

Overall rating for services at this Provider	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Good 

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

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

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

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

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Overall summary

We have changed the overall rating for the Black Country Partnership NHS Foundation Trust from requires improvement to good because:

- We were impressed by the trusts response to the CQC inspection report that was published in April 2016. The trust had remained open and transparent regarding their action plan to meet the requirement notices from the inspection of November 2015.
- We found the quality and consistency of risk assessments and care plans had improved and that physical healthcare was embedded across the trust. We saw the trust was effectively engaged with patients, carers and staff.
- The trust had improved staffing levels and reduced vacancies in the health visiting team and acute wards for adults of working age. The trust had also introduced and embedded modern matrons across services and staff we spoke with talked of the positive impact they had made.
- We saw the trust continued to go above and beyond in some of their services to meet patient and carer needs. We were impressed by feedback about the carers group and the work they had undertook to support more than 600 families of people living in Sandwell who have mental health problems.
- The trust can continue to be proud of the caring nature of staff and teams working with people. Consistently across the trust, people were treated with respect and dignity. We noted this, particularly in, community mental health teams for adults of working age, and specialist community mental health teams for children and young people, where we rated the caring domain as outstanding.

However:

- We found that electronic patient care records were not embedded across the trust and there was variation of how records were kept.
- Although there was a plan for implementing Mental Health Act training across the trust, the take up of training remained variable since the inspection of November 2015. Some policies related to the Mental Health Act were out of date although this issue was remedied immediately by the trust when we brought it to their attention.

We will continue to work with the trust to agree an action plan to assist them in improving the standards of care and treatment.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Good

We rated safe for good because:

- The trust had recruited more staff to the health visiting family inclusion team in order to ensure that patients received appropriate and safe care and treatment.
- The trust had actioned the requirement notices in wards for people with a learning disability or autism. Patients' health and safety was assessed, staff planned against the risk of patients tying ligatures, emergency bags were accessible and wards complied with same sex accommodation.
- The trust had improved the physical environments in the acute wards for adults of working age at Hallam Street Hospital, including better lines of sight for observation of patients. The décor of the wards were cleaner and provided a better environment in which to care for patients.
- The trust had addressed access to emergency equipment and checking of fridge temperatures in community mental health teams for adults of working age. The trust had also improved the effectiveness of the single point of referral in these teams and embedded robust measures for staff to summon assistance.
- Cleaning records were available across the trust and we saw improvements in the cleaning of toys in child and adolescent mental health community services.

However:

- Although staff training in safeguarding had significantly improved since our last inspection in November 2015, some services fell below compliance rates of 75%.
- The environment in the 136 suite at Hallam Street Hospital did not support safe care to patients and staff. There were accessible ligature points for patients and staff would not be able to access emergency equipment easily if an emergency occurred.

Are services effective?

Good

We rated effective for good because:

- In community mental health teams for adults of working age, the trust had improved waiting times in the single point of

Summary of findings

referral service and was meeting targets for completing assessments. Staff in this service had received training in the Mental Health Act and were correctly completing paperwork for patients who were on a Community Treatment Order.
- The trust had improved processes to store patients' confidential information safely. This was most evident in older people's wards.
- Appraisal rates across the trust had improved. A number of services had compliance rates of 100% and the trust had met its target rate of 95% compliance.
- In older people's wards, staff were regularly auditing emergency equipment and had improved collaborative working with external agencies such as the local authority to improve discharge arrangements.
- Across the trust, services used evidenced based practice in line with national guidance, and in the case of community health services for children, young people and families, had received the highest recognition from UNICEF's baby friendly award in 2015.

However:

- Although the number of staff trained in the Mental Health Act had improved since the last inspection, the trust recorded only 49% of staff attended training.
- Mental health crisis teams and health-based places of safety did not have accessible information for staff at hand as it was recorded and stored at various locations.
- Safe food storage was not practised on all wards for people with a learning disability or autism.

Are services caring?

Good

We rated caring as good because:

- Throughout the inspection, we found staff to be caring, kind and considerate towards patients. Feedback from patients, carers and families during the inspection was consistently positive in how staff treated them. However, families in the focus group told us of individual instances where they were not treated with dignity.
- Families in the carers and family focus group spoke highly of the impact of the carers group and how supported they felt. They also recognised the trust was trying to engage and had set up meetings to support service re-design.
- Families and carers described the care received in specialist community mental health teams for children and adolescents as excellent. They described the services offered were a lifeline

Summary of findings

for vulnerable young people, that young people were actively involved in the decisions in their care and routinely participated in staff recruitment. Families whose children were admitted to hospital outside of the catchment area said that staff travelled weekly for review meetings and provided families with regular emotional support.

- Staff in community mental health teams for adults of working age went above and beyond what they were required to do. An example was the development of activities for patients in the community to increase inclusion. They linked with a local professional football club to develop a league for people with mental health issues, provided greater access to the local gym and supported the recovery college.

However:

- Although staff were seen to be kind, caring and compassionate in health based places of safety, privacy and dignity was poor, especially at Hallam Street hospital. The outside space could be overseen by passers-by and there was no adequate soundproofing, meaning that patients on another ward could hear conversations.

Are services responsive to people's needs?

Good

We rated responsive for good because:

- All services had access to interpreters and staff could access a range of accessible information in different languages when required.
- The trust received 106 complaints in the 12 months from July 2015 and June 2016. This was lower than the number of complaints reported ahead of the November 2015 inspection. The trust approach to managing and investigating complaints was effective and confidential.
- The trust received 305 compliments in the 12 months from July 2015 to June 2016. This is higher than the number of compliments received in November 2015.

However:

- Patients care and treatment at the health-based place of safety at Hallam Street Hospital could be disrupted by staff who regularly accessed the kitchen to make drinks for patients on an adjoining ward.

Are services well-led?

Good

We rated well-led as good because:

Summary of findings

- The trust had responded to the requirement notices issued at the last inspection in November 2015.
- The trust had developed and strengthened its governance structure and processes since the inspection in November 2015. There was clear reporting channels from 'floor to board', meaning that the trust were aware of quality and safety issues across the trust services. We saw evidence of good governance effecting change, for example, the improvement in recruitment, through use of workforce data, had led to a reduction in the use of agency staff across the trust.
- The November 2015 inspection highlighted strong leadership at board level however, this was not replicated at ward and team level. The introduction of eight modern matron posts had strengthened nursing leadership across the trust and improved quality and safety in a number of areas.
- Across the trust, we saw improvements in the physical health strategy, environmental improvements and risk assessments, resuscitation equipment was in place, nurses having a voice, and staff were supported during their recruitment and with training and development.

Summary of findings

Our inspection team

Our inspection team was led by:

Team Leader: James Mullins, Head of Hospitals Inspections, Care Quality Commission

Inspection Manager: Paul Bingham, Inspection Manager, Care Quality Commission

The team of 49 people included:

- 15 CQC inspectors
- one CQC assistant inspector
- one analyst
- one planner
- three experts by experience, and one helper, who have personal experience of using, or caring for someone who uses, the type of services we were inspecting
- one Mental Health Act reviewer
- 16 nurses from a wide range of professional backgrounds
- two senior doctors
- two social workers
- two allied health professionals
- four people with governance experience.

Why we carried out this inspection

We inspected the Black Country Partnership NHS Foundation Trust to find out if it had made improvements to its services since our last comprehensive inspection in November 2015 where we rated the trust as **requires improvement** overall.

We rated the trust in the five CQC domains as:

- safe: requires improvement
- effective: requires improvement
- caring: good
- responsive: good
- well-led: requires improvement.

When we last inspected the trust in November 2015, we rated:

- acute wards for adults of working age and psychiatric intensive care units as **good** overall
- wards for older people with mental health problems as **good** overall
- wards for people with learning disabilities or autism as **good** overall
- community based mental health services for adults of working age **requires improvement** overall
- mental health crisis services and health based place of safety as **requires improvement** overall
- specialist community mental health services for children and young people as **requires improvement** overall
- community based mental health services for older people as **outstanding** overall
- community mental health services for people with learning disabilities or autism as **good** overall
- community health services for children, young people and families as **requires improvement** overall
- forensic inpatient/secure wards as **good** overall.

Following the comprehensive inspection of the trust in November 2015, we issued the following requirement notices under the Health and Social Care Act (Regulated Activities) 2014 and to the following core services:

- Regulation 9: Person-centred care - mental health crisis services and health based place of safety and specialist community mental health services for children and young people
- Regulation 10: Dignity and respect - mental health crisis services and health based place of safety
- Regulation 12: Safe care and treatment - community based mental health services for adults of working age, acute wards for adults of working age and psychiatric intensive care units, wards for people with learning disabilities or autism, mental health crisis services and health based place of safety, and specialist community mental health services for children and young people
- Regulation 15: Premises and equipment – community based mental health services for adults of working age, community health services for children, young people and families, and specialist community mental health services for children and young people

Summary of findings

- Regulation 17: Good governance - community based mental health services for adults of working age, wards for older people with mental health problems, mental health crisis services and health-based place of safety, and specialist community mental health services for children and young people.
- Regulation 18: Staffing. - wards for older people with mental health problems, community health services for children, young people and families, specialist community mental health services for children and young people.

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before visiting, we requested and reviewed a range of information about the Black Country Partnership NHS Foundation Trust and asked other organisations to share what they knew. They included clinical commissioning groups (CCGs), NHS England, Healthwatch, Royal College of Nursing, General Medical Council, NHS Litigation Authority, Health and Care Professional Council, and the Parliamentary and Health Service Ombudsman. We held focus groups with three Clinical Commissioning Groups (CCGs), Healthwatch, and carers and families, with 22 people attending.

We reviewed the previous report of November 2015 and focused our inspection on the key areas where services required improvement, across either the whole service or one domain only.

As a result, in October 2016 we inspected:

- acute wards for adults of working age and psychiatric intensive care units – safe domain only
- wards for older people with mental health problems – effective domain only
- wards for people with learning disabilities or autism – safe domain only
- community based mental health services for adults of working – all domains
- mental health crisis services and health based place of safety – all domains
- specialist community mental health services for children and young people – all domains
- community health services for children, young people and families – all domains
- forensic inpatient/secure wards - safe domain only.

We did not inspect the following services based on their previous rating of good or outstanding overall:

- community based mental health services for older people
- community mental health services for people with learning disabilities or autism.

During the inspection visit, we:

- visited most of the trust's hospital locations and many of the bases from which it provides its community healthcare and community mental health services.
- held focus groups with a range of staff that worked within the service, such as nurses, doctors, and allied health professionals.
- interviewed a range of senior managers with specific responsibility for the governance of the trust including, the director of nursing, human resources manager, operational managers, medical director, non-executive directors, and the chair of the trust
- talked with 215 staff
- talked with 52 people who used services and with 31 carers and/or family members. We also visited the carers team and observed them working with families
- observed how people were being cared for and attended community treatment appointments
- reviewed 190 care or treatment records of people who use services.

We also carried out unannounced visits to forensic and older people's wards in the 10 days following the comprehensive inspection.

Summary of findings

The team would like to thank all those who met and spoke with inspectors for their open and balanced views and for sharing their experiences and their perceptions of the quality of care and treatment at the trust.

Information about the provider

Black Country Partnership Foundation NHS Trust provides a range of inpatient and community mental health services to adults, older people and children. The community the trust provides services for live predominantly in the boroughs of Sandwell and Wolverhampton, with smaller services offered in Dudley and Walsall. The trust has a staff complement of more than 2000 whole time equivalent (WTE). The trust serves a population of approximately one million people from a variety of diverse communities across the Black Country. The trust has an annual income of about £100 million. Corporate staff work from Delta House, the current trust headquarters building.

The trust provides:

• mental health and specialist learning disabilities services to people of all ages in Sandwell

and Wolverhampton

• specialist learning disability services in Walsall, Wolverhampton and Dudley

• community healthcare services for children, young people and families in Dudley

The trust provides the following core services:

• specialist community mental health services for children and young people

• acute wards and psychiatric intensive care units

• community mental health services for adults of working age

• forensic/secure wards

• wards for older people with mental health problems

• community mental health services for older people

• mental health crisis services and health based places of safety

• wards for people with learning disabilities or autism

• community mental health services for people with learning disabilities or autism

• children, Young People and Families community services.

The trust's main NHS partners are two clinical commissioning groups (CCGs) – Sandwell and West Birmingham CCG and Wolverhampton CCG. The trust also meet with Dudley CCG, Walsall CCG and NHS England regarding smaller commissioned services.

The trust is working in partnership with two local trusts under an agreement called 'Transforming Care Together'. The partnership started in December 2015 and has core aims to enhance and improve current services, develop high-quality and affordable local services, and ensure support services are efficient and effective.

The trust also forms part of NHS England New Care Models Vanguard programme and works in partnership with three other local mental health trusts. The MERIT (Mental Health Alliance for Excellence, Resilience, Innovation and Training) programme is reviewing the following areas: seven day working in acute services, crisis care and the reduction of risk, and promoting a recovery culture.

Mental Health Act reviewers had visited the trust on nine occasions since November 2015, the last being June 2016. The most common issues related to clinical records missing information, containing the wrong information or not being in line with MHA Code of Practice (31% of all issues raised across all nine visits).

The trust received an unannounced CQC inspection on 26 August 2016 following a whistleblowing alert. The inspection focused on the whistleblowing concerns, therefore we did not inspect all activities of all the CQC key questions. We could not find any evidence that supported any of the whistleblowing allegations.

Summary of findings

What people who use the provider's services say

Prior to the inspection, we met with a group of carers and families and met with Healthwatch representatives from Sandwell and Wolverhampton.

The family and carers who attended a focus group before the inspection were very positive about the support they received from the carers' team and the positive impact it had made in their lives. However, it is a service that meets the needs of people who live in the Sandwell area so is not accessible to people who live in Wolverhampton. Carers spoke highly of the manager and the team that supports a diverse population. Carers reported feeling alienated and isolated from the trust regarding the information they received about their relatives and the carers' team had bridged some of those gaps. Carers spoke positively about activities on offer to patients at Hallam Street Hospital, the work undertaken at the Recovery College plus their experience when relatives were admitted to the MacArthur Unit. The carers thought that the trust was starting to listen to them and formed part of decision making in the trust however it was still early days to say what changes had been made. However, they had a number of concerns about services in the trust. They did not think that relatives were safe on the wards and described assaults and theft. They told us of a lack of communication at the point of discharge and poor planning of aftercare. Although they recognised that staff worked hard, the group described them as stressed and this was reflected in how they were spoken to. More than 20 carers in the group spoke of poor attitudes of some staff during a relatives inpatient stay. Many of the carers described experience of their relatives absconding from acute mental health wards meaning they were not safe.

Families who had relatives in older peoples wards felt engaged with care and treatment, and staff treated patients with kindness and dignity.

Patients and carers were complimentary about staff in acute wards and PICUs for adults of working age. They stated that they were well cared for and were treated with kindness and dignity.

Patients we spoke to under the care of community mental health teams for adults of working age said staff treated then with compassion and respect. Patients could access support when they needed and staff had a kind and gentle approach.

Healthwatch spoke positively about their contact with the trust recently and describe it as open, honest and transparent. Feedback from patients in Wolverhampton is less positive than in Sandwell plus families in Wolverhampton do not feel engaged with the trust. Healthwatch said they received little information regarding mental health services provided by the trust. They remarked that they felt the trust was safe. However, they had concerns about waiting times for patients following referrals into services.

Good practice

The health visiting team and the nursery nurse team achieved the UNICEF's stage three baby friendly award in 2015. This award reflected how the service supported parents to build close and loving relationships with their babies, and supported optimum health and development when feeding babies.

The physiotherapy service, in community health services for children, young people and familes, followed national guidance to assess gross motor function for children with cerebral palsy.

The trust practice development team won the Royal College of Nursing innovation award for mental health practice in April 2016. The team devised and introduced care plans to address violent behaviour and reduce the use of restraint. The patient and nurse together develop the person-centred physical intervention protocol that identifies measures to reduce crisis behaviours.

The carers' team support over 600 families in the Sandwell area whose relative have or are receiving care and treatment in the trust. We received positive feedback from families and carers on how the team go above and beyond what they are supposed to do. The team run a series of groups that reflects the local population, for example, we saw a support group for women whose origin was South-East Asia.

Summary of findings

The three wards at Hallam Street Hospital developed a risk assessment document that contained photographs of ligature anchor points and provided a narrative of how each risk should be managed. This provided staff with knowledge of the potential risk and how to reduce risk to patients.

Sandwell community mental health team and the Wolverhampton complex case team had introduced dedicated physical health teams. This has improved physical health monitoring to patients who received a particular anti-psychotic medication, meaning they would receive their medication in a timelier manner. Patient feedback was positive, saying the clinics were efficient and had improved their experience of care.

The lead psychologist in Sandwell community mental health team had developed a specific training programme for staff. Staff learnt a range of skills to support care and treatment to patients, for example, cognitive behaviour therapy for personality disorder. Learning was further supported by psychologists running group supervision where staff could discuss how they put skills into practice.

Risk assessments in forensic wards followed the 2014 Department of Health policy: Positive and Proactive Care, and had reduced the need for restrictive interventions.

The children's palliative care service offered respite for families and a benefits advisor provided families with support to access benefits.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must ensure that patients admitted to the health-based place of safety at Hallam Street Hospital are safe. The trust must assess the risk of ligature points inside the bathroom and reduce the potential risk and patients harming themselves.
- The trust must ensure that staff working across its services attend mandatory training.
- The trust must ensure in specialist community mental health teams for children and young people, that systems are in place for the processing of referrals are established and operated effectively.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure that it monitors policies on the Mental Health Act and Code of Practice and keeps them up-to-date.
- The trust should ensure patient information is stored consistently within records in wards for older people with mental health problems
- The trust should ensure care plans are up-to-date and show a range of needs and views in wards for older people with mental health problems
- The trust should ensure clinical supervision is carried out in line with trust policy and that it is recorded properly in wards for older people with mental health problems
- The trust should ensure safe food storage is practiced on all wards for people with learning disabilities or autism.
- The trust should ensure acute wards and psychiatric intensive care units (PICU) for adults of working age meets its own targets in relation to mandatory training, in particular safeguarding level one, two and three.
- The trust should ensure acute wards and PICU for adults of working age provide clear information to training in The Mental Health Act and The Mental Capacity Act. This should include information relating to refresher training and responding to changes to the acts.
- The trust should ensure acute wards and PICU ward for adults of working age develop a system to ensure staff undertake training. This should include a process of assessment to ensure that staff have the knowledge that they require to undertake the role for which they are employed.

Summary of findings

- The trust should ensure all services use one system for record keeping, ensuring that staff can access information when needed in community mental health services for adults of working age.
- The trust should ensure that staff transfer information from contact notes to care plans and that Sandwell community mental health teams record patient's involvement in the development of the care plans.
- The trust should ensure that the wellbeing service in community mental health services for adults of working age have clear guidance about the purpose of the new service and a permanent base where they can see clients and work as a team.
- The trust should, in mental health and health-based places of safety, ensure that all areas visited by patients for their clinical reviews have accessible emergency equipment such as automated external defibrillators and oxygen in mental health crisis services and health based places of safety.
- The trust should, in mental health and health-based places of safety, ensure that a patient's privacy, dignity, and confidentiality should not be compromised.
- The trust should, in mental health and health-based places of safety, ensure that there are clear systems of records management so that records are well organised and different team members can access patients' records when needed.
- The trust should, in mental health and health-based places of safety, ensure they are compliant with the revised Mental Health Act Code of Practice for the health-based places of safety.
- The trust should, in mental health and health-based places of safety, ensure there is an effective system in place to evaluate patient experience and make improvements through service user feedback in mental health crisis services and health based places of safety.
- The trust should ensure that forensic wards, when the use of seclusion is authorised, documentation is completed in line with trust policy guidance.
- The trust should ensure that forensic wards continue to monitor and reduce ligature risks until it has completed building work to remove them.
- The trust should ensure staff in specialist community mental health teams for children and young people report all required incidents using the electronic reporting system.
- The trust should ensure specialist community mental health teams for children and young people continue to improve staff compliance with mandatory training.
- The trust should ensure specialist community mental health teams for children and young people continue to improve the quality and consistency of care plans and risk assessments.
- The trust should ensure specialist community mental health teams for children and young people fill vacant posts.
- The trust should identify a designated executive lead for children.
- The trust should ensure leaders increase their visibility within the children, young people and family service so it is fully supported to feel part of the organisation.
- The trust should ensure the service has access to professional peer support for children's' services.
- The trust should ensure that all notifications of DOLS applications are sent to CQC

Black Country Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

The trust had nine Mental Health Act (MHA) reviewer visits in the last 12 months, the last being June 2016. The most common issues related to clinical records missing information, containing the wrong information or not being in line with MHA Code of Practice (31% of all issues raised across all nine visits). Ridge Hill, as part of learning disability wards had the highest number of issues found during their visit with eight. There was not a significant difference in number of issues found on the announced compared to unannounced.

The trust Mental Health Act Scrutiny Committee, chaired by a Non-Executive Director, meet quarterly and receives reports including, the number of detention across the trust, ethnicity of detained patients and use of holding powers. This is a sub-committee of the trust Board.

The Mental Health Law Group is an operational group for the oversight of mental health law and interagency working. It is chaired by the Medical Director and is attended by trust MHA and Mental Capacity Act (MCA) leads with Police and Local Authority representation. This group reports monthly to the Quality and Safety Steering group monthly.

The trust had a team who deal with administration of the MHA. There is no electronic system to support the team to capture up-to-date information about people who are detained under the MHA. The MHA team phone the wards daily to see if there any new detentions under the MHA 1983.

Mental Health Act incidents are reported on Datix, an electronic records database. The trust had reported 26 incidents in the 12 months leading up to the inspection. Four MHA detentions were declared invalid, one Approved Mental Health Practitioner (AMHP) application had a page missing, two AMHP applications had been made out to the wrong hospital, and one joint medical recommendation form was not signed and dated by one of the doctors. Medication had been administered without authorisation on 16 occasions across the trust. On two occasions, detained patients were allowed to leave the ward without signed authorisation under Section 17 of the MHA 1983. The trust further reported 142 patients who were absent without leave (AWOL) from wards between October 2015 and October 2016. Of these AWOL, 104 involved patients detained under the MHA, 24 patients were informal, and 14 were patients attempting to abscond whilst on escorted leave.

The trust had improved training compliance figures since the inspection in November 2015. However, the trust was not meeting its target for 75% training compliance. The trust had a training plan for staff across the trust to undertake Mental Health Act (MHA) training to reach the compliance target. Overall, trust compliance rates for training were 49%.

Detailed findings

Access to independent mental health advocates (IMHA) was available and provided by the local authority. Patients we spoke with were aware of IMHA and could access the service on request. Staff across the trust were aware of how to contact IMHA services.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff were trained in and had a good understanding of the Mental Capacity Act 2005, in particular the five statutory principles. The trust had appointed a Lead for DoLS (Deprivation of Liberty Safeguards) who also provided training in the Mental Capacity Act (MCA). MCA training was incorporated into safeguarding training and this had been updated by the trust. This training was mandatory for the appropriate clinical staff. The lead had developed a database to monitor training activity and training was planned through to 2017. The overall trust compliance rate was 86.7%.
- The MCA is not applicable to children under the age of 16. Staff assessed using Gillick competence, which balances children's rights with the responsibility to keep children safe from harm, for those under 16. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her medical treatment, without the need for parental permission or knowledge. Training in Gillick competence was incorporated into MCA training. Staff working in specialist community mental health child and adolescent services demonstrated good knowledge of Gillick competence and its application in practice, however, 70% of staff had accessed the training that falls below trust training compliance rates.
- Following the inspection in November 2015, the trust had increased the size of the safeguarding team from 14 to 17 people. Advice regarding the Mental Capacity Act was available through this team, managers, policies and the intranet.
- Most wards when needed had made appropriate Deprivation of Liberty Safeguards applications. We saw that best interest assessments had taken place for patients who lacked capacity. Staff in older people's wards routinely referred informal patients for a DoLS assessment. The trust provided information around the Deprivation of Liberty Safeguards applications they have made between 1 April 2016 and 31 July 2016 (four-month period). Between 1 April 2016 and 31 July 2016 the trust have advised they made twelve DoLS. All of these were approved. Over the last year, the CQC received only four DoLS notifications from the trust.

Good

Are services safe?

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

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

Summary of findings

We rated safe for good because:

- The trust had recruited more staff to the health visiting family inclusion team in order to ensure that patients received appropriate and safe care and treatment.
- The trust had actioned the requirement notices in wards for people with a learning disability or autism. Patients' health and safety was assessed, staff planned against the risk of patients tying ligatures, emergency bags were accessible and wards complied with same sex accommodation.
- The trust had improved the physical environments in the acute wards for adults of working age at Hallam Street Hospital, including better lines of sight for observation of patients. The décor of the wards were cleaner and provided a better environment in which to care for patients.
- The trust had addressed access to emergency equipment and checking of fridge temperatures in community mental health teams for adults of working age. The trust had also improved the effectiveness of the single point of referral in these teams and embedded robust measures for staff to summon assistance.
- Cleaning records were available across the trust and we saw improvements in the cleaning of toys in child and adolescent mental health community services.

However:

- Although staff training in safeguarding had significantly improved since our last inspection in November 2015, some services fell below compliance rates of 75%.
- The environment in the 136 suite at Hallam Street Hospital did not support safe care to patients and staff. There were accessible ligature points for patients and staff would not be able to access emergency equipment easily if an emergency occurred.

Our findings

Safe and clean care environments

- The physical environment around the trust was generally clean, well maintained and was appropriately decorated to meet the needs of patients. The trust had responded to our feedback following the November 2015 inspection and improved the décor in the acute wards at Hallam Street Hospital. The wards had been re-decorated, cleaning schedules were in place and the trust had improved the ways the wards smelt.
- Patient-led assessments of the care environment (PLACE) are self-assessments undertaken by NHS and independent health care providers, and see local members of the public (known as patient assessors) as part of the assessment team. The team assesses how the hospital environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. The trust score of 99.2% overall in the 2016 PLACE assessments was high when compared against the national average of 97.8%.
- The trust had improved environmental and individual risk assessments meaning that staff observed patients more safely. We found that the layout of the wards generally allowed clear lines of sight for staff to observe patients. Where this was not the case, the trust had installed observation mirrors or developed processes to reduce this risk. This was the case in the acute wards at Hallam Street Hospital where the trust had identified ligature risks in the environment and developed a process to provide staff with guidance on how this risk should be managed. However, the 136 suite at Hallam Street Hospital did not maintain the safety of patients. A 136 suite is a health-based place of safety where a person is transferred to if the police have concerns about their mental health and requires assessment. There were ligature risks in the ward and the external fence could be scaled easily to aid absconsion.

Good

Are services safe?

- Fire procedures and equipment were in place at all services. Staff received fire safety training and were aware of what to do in the event of an emergency.
- Inpatient wards had clear arrangements for ensuring accommodation was single sex, in line with Department of Health and the Mental Health Act Code of Practice guidance. Female and male patients' did not share any bathroom or toilet facilities and mixed wards had separate female lounges.
- The trust had two seclusion rooms; one at the MacArthur Unit and the other at the Gerry Simon Clinic. On inspection, the seclusion room at the Gerry Simon Clinic did not meet the standards required under the Mental Health Act Code of Practice. There had been structural damage to the door surround and a gap had appeared. The trust was told of the concerns and acted immediately to repair the door. We returned the following day and found that the repairs had taken place and as such the trust to be compliant with the Code of Practice regarding the seclusion rooms.
- All clinic rooms we visited appeared clean and were fit for purpose. Clinic rooms were well stocked with equipment that was checked regularly to ensure that it was in good working order so that they could be used in an emergency. Fridge temperatures were regularly checked across the trust. The trust had introduced a new system for monitoring fridge temperatures in community mental health teams. The fridge thermometer was linked to the local hospital so that an alarm was activated if there was an issue out of hours. However, there were gaps in the checking of fridge and freezer temperatures in the Pines and Larches units. This meant that medication might not be stored at the right temperature in line with the manufacturer's guidance.
- Staff across the trust followed infection control principles including handwashing. Wards and community buildings displayed information on how to apply infection control principles. We saw staff regularly use hand sanitisers and practising procedures to support good hygiene in services.
- Staff used appropriate alarms and nurse call systems across the trust. Staff we spoke with knew how to access personal alarms and how they would be used. The alarms were regularly tested.

Safe staffing

- The trust managed staffing issues through performance management and regular monitoring of vacancies. There was a system in place to identify where there were shortfalls in staffing and trust processes supported recruitment into vacant posts.
- Since the previous inspection in November 2015, the trust had improved its processes for the recruitment and retention of staff. The vacancy rate across the trust was 13.1% at the time of our inspection in October 2016 compared with 15.4% in November 2015. The trust-wide turnover rate reduced from 17.4 % in June 2015 to 14.6% in June 2016.
- The vacancy rate for qualified nurses across the trust was 14.6%. Acute and PICU Wards (26.7%), specialist community mental health teams for children (21.1%), and crisis and health-based places of safety teams (19.1%) all reported higher vacancy rates for qualified nurses. The vacancy rate for nursing assistants across the trust was 16.9%. Community mental health teams for adults of working age (31.2%), learning disability wards (21.5%), specialist community mental health teams for children (33.6%), wards for older people (21.5%), and crisis and health based places of safety teams (21.7%) reported higher than average vacancy rates for nursing assistants. The core services that reported vacancy rates for both qualified nurses and nursing assistants that were lower than the trust average were community health services for children, young people and families and forensic wards.
- The trust sickness rate for June 2016 was 5.4%. This was almost the same rate as of June 2015. Community health services for children, young people and families reported lower than the trust average at 2.2%. All of the other core services reported higher sickness rates than the trust average. Forensic wards (9.7%) and wards for older people (8.9%) reported the highest rates of sickness across the trust.
- The trust reviewed staffing levels for all inpatient areas and community areas. The trust monitored and reported on shift fill rates for the wards. In the information provided to us by the trust for the 12 months between June 2015 and June 2016, 14,353 shifts were filled by bank and agency staff due to sickness absence or vacancies. The highest rate of use was acute

wards for adults of working age (4,206) and forensic wards (1.365) compared to the lowest, community-based mental health services for adults of working age (108) and specialist community mental health services for children and young people (244).

- Following the inspection in November 2015, the trust had recruited nine midwives into the community health service team for children, young people and families. The trust had further recruited staff into specialist community mental health teams for children and adolescents, however, there remained eight vacant posts at the time of our inspection. The trust was undertaking a rolling recruitment programme to fill these vacancies with suitably skilled staff.
- The trust recruitment strategy included initiatives to support student nurses on completion of their training to secure jobs, for apprentices to work towards full-time jobs as healthcare support workers and reduce the time to process job applications. The trust had developed links with agency staff and had a preferred staff list, meaning they undertook trust training programmes and were familiar with the wards and patients.
- We found that managers were supported by the trust to adjust staffing levels across services to meet the needs of patients.
- Medical cover levels had been maintained since the inspection in November 2015. Doctors were available to meet the needs of patients during outside of nine-to-five working hours and see them urgently when required.
- The trust had improved compliance with mandatory training since the CQC inspection in November 2015. As at 30 June 2016, the training compliance for trust-wide services was 82.3% against the trust target of 85%. This was an improvement on the November 2015 inspection when the trust compliance rate was 58.9%. Community children, young people and families and the forensic team had the lowest training compliance rate at 71.3% and 74.2% respectively. The following training courses had the lowest compliance rates; Safeguarding adults level 3 at 66.2% and 'Moving and Handling Practical-Patient Handling' at 72.9%. Ahead of the previous inspection, the trust reported a trust wide compliance rate of 26% for 'Safeguarding Adults Level 3' training compared to the current compliance rate of 66.2%. This improvement was also evident in the completion rate for Safeguarding Children Level 3, where the current rate was 78.7% compared to a rate of 57% reported ahead of the inspection in November 2015.

Assessing and managing risk to patients and staff

- The trust routinely recorded and monitored risk. The trust leadership team, through the quality and safety steering group, reviewed and disseminated lessons learned from risk incidents. The board assurance framework detailed the trust risk register to ensure oversight and management of risk.
- The trust had a specific safeguarding team that had increased from 14 to 17 staff and recruited a Deprivation of Liberty Safeguards lead. Trust structures and processes had developed since the last inspection in November 2015 and the Board had a better understanding of their responsibility. For example, the non-executive directors of the trust had undertook training in safeguarding. The trust had governance oversight of safeguarding policies and responsibilities in partnership with local safeguarding boards.
- The trust had a proactive strategy to govern all safeguarding alerts and referrals. There was evidence of multi-agency working and reporting across teams. The trust reported into four local authorities and communicated effectively with local clinical commissioning groups (CCGs). The trust had policies and procedures in place related to safeguarding and raising concerns. Most staff described situations that would constitute abuse and could demonstrate how to report concerns. Staff entered safeguarding details into an electronic system called Datix and staff were familiar with this system.
- Between July 2015 and June 2016, there were 434 adult safeguarding alerts and 87 children's safeguarding referrals. Of the 434 safeguarding alerts, acute mental health wards for adults of working age reported the most with 93. Similarly, specialist community mental health services for children and young people reported the most safeguarding alerts for children at 22.
- The trust had policies and procedures in place to assess and manage risk effectively. Risk was routinely discussed across all services we inspected and through board governance structures. The introduction of modern matrons had embedded the use of risk

assessments across the trust and improved quality. The trust used a nationally recognised and standardised risk assessment tool that staff understood and completed. In addition, specialist risk assessment tools were used in a number of services, including older people and forensic wards, and palliative and occupational therapy services. We reviewed over 150 care records that had risk assessments in place. The majority of care records had risk assessments that had been completed on admission into services and were regularly reviewed. Following the inspection in November 2015, risk assessment processes and documentation had been developed in wards for acute and psychiatric intensive care units for adults of working age.

- The trust had a policy to support staff manage patients who potentially become aggressive or violent. The trust had a specialist training team to deliver training to staff and this was tailored to meet the needs of patients and staff. The policies and training were in line with guidance from the national institute for health and care excellence (NICE). Between January and June 2016, there were 632 incidents of restraint on patients; of those incidents, 65 were in the prone position. At the end of July 2016, 85% of trust staff were complaint with violence and personal safety training. Staff working in some services were trained to hold patients in prone restraint, meaning face down . Staff across the trust used NICE guidance in the administration of rapid tranquilisation and recorded details in care records. Staff in learning disability wards used person centred physical intervention protocols for each patient and we saw evidence of this in care records. The trust was rolling out these protocols across the trust following positive feedback about the impact of the interventions.
- The trust had a restrictive interventions reduction programme in place in conjunction with the local clinical commissioning groups in Sandwell and Wolverhampton. The programme focussed on key areas such as reducing blanket restrictions, implementation of safe wards, rapid tranquilisation, observation and to ensure that inpatient areas were safe, therapeutic spaces. The programme was part of the trusts quality improvement plan and reports on progress were tabled at the quality and safety committee.
- Personal safety and lone working procedures were in place across the trust. Community staff operated a system where they were checked in and out of buildings and contact was made at the end of each day. Staff had use of mobile phones and personal alarms. If there was a potential risk then staff would visit patients in twos or arrange to see patients on trust premises.
- The trust had an up-to-date policy in the use of seclusion and long term segregation. There were 229 incidents of use of seclusion across the trust between 1 July 2015 and 30 June 2016 and no incidents of long-term segregation. We saw that records were kept up-to-date and multidisciplinary staff maintained oversight of patient safety during seclusion.
- The trust had a robust medicine management policy that was supported by a local pharmacy team. The introduction of modern matrons had strengthened procedures in ward and community services. The modern matron in forensic services had a role to improve training and compliance with medication reconciliation and quality and safety standards. Similarly, the modern matron in wards for people with a learning disability or autism oversaw clinical governance and medicines management to ensure it was in line with the trust policy. We reviewed 98 medicine charts and found that the vast majority were in comprehensive and complete. Specialist child and adolescent mental health services participated in national audits including those by the prescribing observatory for mental health. The prescribing observatory for mental health aims to assist specialist mental health trusts to improve their prescribing practice.

Track record on safety

- NHS trusts are required to submit notifications of incidents to the National Reporting and Learning System (NRLS). In total, the trust reported 2,105 incidents to the NRLS between 1 July 2015 and 30 June 2016. Of the incidents reported, 73% were 'No Harm', 23.6% were 'Low', 2.1% were 'Moderate', 0% were 'Severe' and 1.2% resulted in Death.
- The trust reported 52 serious incidents between July 2015 and June 2016. Twenty-six incidents involved the unexpected death of a patient. The core services that reported the highest number of incidents were community based mental health services for adults for adults of working age (20), acute mental health wards

for working adults/ PICU (18) and wards for older people (10). The most common types of serious incidents were 'other' (14), 'apparent/actual/suspected self-inflicted harm meeting serious incident criteria' (13) and 'slips, trips and falls meeting serious incident criteria' (11).

- Serious incidents were reviewed at board and local level. Oversight of incidents sat with the quality and safety steering group and there was an embedded culture to share and learn from safety concerns.

Reporting incidents and learning from when things go wrong

- The trust had a system in place to capture incidents and accidents and to learn from them when things went wrong. Staff were able to explain the process they used to report incidents through the trusts reporting system. Staff were aware of how to complete incident reports and their responsibilities in relation to reporting incidents. An on-line incident form was completed on the trusts Datix system following any incident.
- The trust had a weekly telephone meeting to discuss risks, incidents and to ensure action had been taken to reduce the potential for similar incidents to happen. Information gathered at the weekly telephone meeting was shared with on-call managers working at weekends to ensure awareness of ongoing risks or potential risks. Monthly updates from the trust called 'learning lessons' were sent to all staff. Lessons learned were discussed weekly in the team meetings and monthly divisional meetings.
- A quality and safety group meeting chaired by a non-executive director received reports of incidents from operational managers and professional leads across trust services. Following review of the incidents, the group reported all serious incidents to the trust board. Serious incidents were investigated using root cause analysis methodology.
- Following incidents, de-brief sessions were offered to all staff. Some wards had appointed de-brief leads to take the lead in organising the de-brief sessions. In acute wards for adults of working age, a new system of debrief was being trialled that was facilitated by specially trained staff from across all staff grades, including health care support workers. This meant it was everyone's business to support each other following an incident. Trust staff stated that they felt that this system felt like a more comfortable process, there was less pressure to provide reasons for incidents, and it was easier to focus on learning from the incident.

Duty of Candour

- The trust had a policy in place regarding duty of candour. The trust assured itself that the requirements of duty of candour legislation had been implemented. Divisional quality and safety meetings scrutinised incidents where the duty of candour was applied locally.
- Trust senior managers promoted an open and transparent culture and supported its staff to understand and follow duty of candour legislation. Staff have been trained with regards to duty of candour and staff were able to explain the core principles of an open and honest approach following incidents or mistakes.

Anticipation and planning of risk

- The trust had incident response and recovery plan in place. The plan was detailed and contained information on trust emergency and major incident responses as well as processes for debriefing and learning lessons. The plan was available to all staff via the trust intranet.

Good

Are services effective?

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

Summary of findings

We rated effective for good because:

- In community mental health teams for adults of working age, the trust had improved waiting times in the single point of referral service and was meeting targets for completing assessments. Staff in this service had received training in the Mental Health Act and were correctly completing paperwork for patients who were on a Community Treatment Order.
- The trust had improved processes to store patients' confidential information safely. This was most evident in older people's wards.
- Appraisal rates across the trust had improved. A number of services had compliance rates of 100% and the trust had met its target rate of 95% compliance.
- In older people's wards, staff were regularly auditing emergency equipment and had improved collaborative working with external agencies such as the local authority to improve discharge arrangements.
- Across the trust, services used evidenced based practice in line with national guidance, and in the case of community health services for children, young people and families, had received the highest recognition from UNICEF's baby friendly award in 2015.

However:

- Although the number of staff trained in the Mental Health Act had improved since the last inspection, the trust recorded only 49% of staff attended training.
- Mental health crisis teams and health-based places of safety did not have accessible information for staff at hand as it was recorded and stored at various locations.
- Safe food storage was not practised on all wards for people with a learning disability or autism.

Our findings

Assessment of needs and planning of care

- The trust had undertaken work since the last CQC inspection to improve on the standards of risk assessments and care plans and safe storage of patient health records. The trust had introduced an electronic health care records system, however, staff within some trust services were also using paper based records.
- We examined 164 patient care records and 98 medication cards across the services inspected. Care records contained risk assessments completed on the patients' first appointment. There had been improvement in the holistic nature of most records we reviewed and patients and carers views were reflected in most care plans. Care plans reflected the diverse treatment needs of patients, in particular, in specialist services, and the diversity and equality needs of patients across the trust.
- In older people's wards, the trust had improved the storage of personal information and patient notes were now locked. Staff had easy access to risk assessments electronically, however, there were two sets of notes for patients, kept by either doctors or nurses. This could cause delay in accessing notes, for example, mental capacity and consent notes were found in either doctors or nurses notes, not both. They were not in the same place for every patient and the information was not easily accessible.
- Staff in community mental health teams for adults of working age completed assessments for all patients, however, they did not always transfer information from notes to care plans. Not all care plans showed that patients had been involved in their development.

Best practice in treatment and care

- Staff were aware of and continued to follow national institute for health and care excellence (NICE) guidelines. The child and adolescent mental health services were using the national institute for health and care excellence guidelines on managing challenging

behaviours and continence with young children with learning disabilities. Across the trust, staff followed British National Formulary (BNF) and NICE guidance when prescribing medication. NICE guidance on schizophrenia was routinely applied in mental health services. Children's and young people and families teams followed national guidance in a range of areas, such as, 'promoting the quality of care of looked after children'.

- There continued to be good access to psychological assessments and interventions. For example, we saw that psychologists were an integral part of the acute wards and psychiatric intensive care wards. Therapy sessions took place regularly using a range of psychological interventions including cognitive behavioural therapy, mindfulness and solution focussed therapy. Staff, including occupational therapists and nurses supported people with organic illness with cognitive stimulation and reality orientation therapy. The psychological professionals group we spoke to told us they felt valued in their work and also within solving issues within the trust.
- Patients continued to have physical healthcare checks completed on admission and their physical healthcare needs were being met. Medical staff following the patient's admission to the ward documented physical health examinations and assessments. Ongoing monitoring of physical health problems was taking place. Most patients had a care plan that showed staff how to meet these physical healthcare needs. On older people's wards, all patients had a comprehensive physical healthcare assessment using recognised assessment tools. Physical health checks were carried out at least yearly but would occur more regularly if a patient's physical health deteriorated. Physical health teams had been developed in community mental health teams to support, assess and monitor patients who were prescribed anti-psychotic medication. There were clear arrangements were in place for partnership working around physical healthcare needs with colleagues in primary care.
- The trust used a variety of outcome measures specific for it services and had been adapted to meet the needs of patients. Staff working in specialist community mental health services for children and young people had developed an outcome measure in pictorial format at the Inspire learning disability team. The same team had used health of the nation outcomes scales for children and adolescents to measure the severity of their needs and the effectiveness of treatment. Community mental health teams for adults of working age used mental health care clusters to monitor outcomes for patients. Staff used the malnutrition universal screening tool to monitor patients' nutrition and hydration in wards for older people. Staff in older people's services used evidence based tools to record nutrition and hydration, depression in dementia, challenging behaviour and the measurement of pain in people who cannot verbalise.
- Staff were involved in a range of audits to monitor how safe and effective services were across the trust. The trust maintained the audit of the physical environment and actioned plans when issues were identified. This meant staff observed patients more effectively on wards. We saw staff undertaking clinical and environmental audits including record keeping, medicines management, infection control and physical health. Staff also carried out specific audit to meet the needs of patients for example, staff working in specialist community mental health services for children and young people captured the experiences of patients and families who used the service. Managers across the trust routinely shared learning from audits to staff at team meetings.

Skilled staff to deliver care

- The trust had a range of skilled staff to meet the needs of patients' across its services. Skilled staff worked in multidisciplinary teams to deliver safe and good treatment and care.
- The necessary skills to deliver care were available across the trust. All the staff in the learning disabilities service were trained in the skills to work with that client group. In the community, child and adolescent teams, there were staff from different disciplines to enable them to care for children and young people that was robust, proactive and well planned. Staff working in the community-based teams for adults of working age were trained in talking therapies such as dialectical behavioural therapy, cognitive behavioural therapy and solution focussed therapy. The trust had improved the access to, and delivery of training in the Mental Health

Act and Mental Capacity Act since the inspection in November 2015. Across the trust, staff demonstrated the necessary skills to support patients who were detained or needed support to make specific decisions.

- All new staff had access to the trust induction. This was supported by local induction across the trust to familiarise them with team functions and new staff had opportunity to shadow experienced colleagues. The trust ran a preceptorship programme for newly qualified nurses and they were supported into their role through supervision and training. Student nurses we spoke to were positive about the support they had received in trust services. The trust ran a scheme whereby student nurses were guaranteed a job at the end of their training so long as they had met all of their competencies.
- Most staff in the trust had access to managerial or clinical supervision. Teams across the trust used supervision in a number of ways to improve care delivery. Staff told us that they valued supervision. Staff working in the community-based teams for adults of working age accessed psychology led group supervision for cognitive behavioural therapy (CBT) and had access to the personality disorder network. There was regular access to psychology led reflective workshops and group supervision for staff working in older peoples' wards. However, not all staff and teams' recorded formal supervision so it was difficult to assess the effectiveness in practice.
- Appraisal rates had improved across the trust since our last inspection. The trust's target rate for appraisal compliance was 95%. As of June 2016, the overall appraisal rates for non-medical staff was 99.1% in comparison to 97% in June 2015. The core service with the highest average appraisal rate were forensic wards, older peoples wards, community based services for older people and 'crisis/ HBPoS services' at 100%. This is in comparison to the previous highest of 95% for mental health wards, learning disability and forensic in November 2015. In the NHS Staff Survey 2015: the percentage of staff appraised in the last 12 months was six percentage points higher than the national average and is equal to the best score nationally. The trust scored 3.00 for its quality of appraisals, which was slightly below the national average.
- Managers across the trust regularly addressed staff performance in line with trust policies and procedures. Poor performance of staff was managed promptly and effectively at a local level. Managers knew how to escalate issues of poor performance and would use the support of the trusts human resources department if a more formal process was required.

Multidisciplinary and inter-agency team work

- Effective team working was a new indicator for the 2015 NHS Staff Survey. The trusts score is 0.10 lower than the national average for Combined Mental Health, Learning Disability and Community Trusts and was marked as being a negative outlier.
- All teams that we visited evidenced regular and effective multidisciplinary team (MDT) meetings. MDT meetings across the trust were attended by a range of staff including doctors, nurses, psychologists and allied health professionals. We observed staff engaged in discussions about the holistic needs of patients such as, physical and mental health, risk, recovery planning, and safeguarding. New referrals were discussed and planning of discharge was central to most meetings. There were weekly referral meetings held in community teams that involved the multidisciplinary team meeting, discussing, and allocating new referrals for assessment and treatment. Patients and families could see members of the MDT independently of these meetings.
- We observed regular handovers in wards across the trust. Community teams held meetings daily to support handover of patient information. Risk was discussed in detail and staff routinely demonstrated good knowledge when planning to reduce and manage risk. However, we saw poor risk management in crisis teams and health based places of safety.
- Teams continued to work effectively between themselves and with agencies external to the trust. There were good working relationships between the home treatment team, the approved mental health practitioner teams and the crisis teams. We were told by one young person that teams had managed their transition from adolescent to adult services had been planned in advance and they were supported safely to move between teams. Across the trust, we saw good working relationships with a range of organisations including, GPs, schools, hospitals, the local authority

and clinical commissioning groups (CCGs). Staff working in older peoples' wards would attend care homes where patients would be discharged to, supporting transition from hospital.

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

- Following our previous inspection in November 2015, the trust had improved access to, and delivery of, training in the Mental Health Act. Across the trust, we found that staff demonstrated good knowledge of the Mental Health Act (MHA) and was using it effectively in practice. Training was delivered to staff dependent on their level of need, with a MHA level 1 course covering basic awareness, MHA level 1a and 1b delivered to allied health professionals and community mental health staff, and MHA level 2a and 2b to qualified inpatient nursing staff, including those in need of Section 136 training. However, across the trust, staff attendance in training was 49%, below the trust target of 85%. Community mental health services for older people and adults of working age met trust targets, however, all services, except for acute wards and psychiatric intensive care units, had compliance rates of less than 50%. Community mental health services for children and young people recorded 9.7% of staff had received MHA training and forensic wards recorded 11.1%.
- Staff across the trust knew how to access administrative and legal advice. A small Mental Health Act team deal with the administration of the MHA. The MHA scrutiny committee was a sub-committee of the Board and met on a quarterly basis. The committee was chaired by a non-executive director, and attended by the Medical Director and associate hospital managers. It received and reviewed reports on the number of detentions per quarter (excluding s136), the ethnicity of detained patients, the use of holding powers, any changes in status of detained patients, and the number of tribunal and hospital manager hearings and their outcomes. The Mental Health Law Group was an operational group for the oversight of mental health law and interagency working. Managers we spoke to who had responsibility for the Mental Health act were knowledgeable and accessible to staff.
- There was no system to capture details about the Mental Health Act in the trust and information was stored in different notes, including carenotes and oasis. The MHA team had to phone wards daily to identify if there had been any new detentions under the MHA. The MHA team would then physically go to the wards and fetch the paperwork. The MHA team stored paperwork securely and collated MHA activity using their own spreadsheets.
- There were a number of Mental Health Act policies and standard operating procedures on the trust website. However, there was reference to the old MHA Code of Practice in the seclusion and Section 136 policy. The trust acted by the end of the inspection week to remove the Section 136 policy off the website and amended the seclusion policy to reflect the new and updated MHA Code of Practice. The trust had a number of policies marked as under review and it was not clear how long they had been under review or when the review would be completed. They related to consent to treatment, displacement and delegation of nearest relative and Section 17 leave of absence.
- Mental Health Act incidents were reported on Datix, an electronic incident reporting system. Staff knew how to report incidents and the main type of incidents over the past 12 months were invalid detentions (four) and a lack of Section 58 authorisations in place. There was 16 cases of medication being administered without the correct MHA authorisation.
- The trust had nine Mental Health Act (MHA) reviewer visits in the 12 months prior to our inspection, the last being June 2016. The most common issues related to clinical records missing information, containing the wrong information or not being in line with MHA Code of Practice (31% of all issues raised across all nine visits). Ridge Hill, as part of learning disability wards, had the highest number of issues found during their visit with eight. There was not a significant difference in number of issues found on the announced compared to unannounced.
- Staff understood and adhered to consent to treatment and capacity requirements. We saw consent to treatment forms were routinely attached to medication charts when it was required.
- Rights under the Mental Health Act were read to patients' on admission. Staff regularly updated patients' of the rights and carried out regularly audit to check that this had been done.

Good

Are services effective?

- Patients' had access to independent mental health advocacy services. Information was accessible and posters detailed information about advocacy services. Staff knew how to make a referral and patients' said staff supported them to make contact when they needed to.

Good practice in applying the Mental Capacity Act

- Most staff were trained in and had a good understanding of Mental Capacity Act 2005, in particular the five statutory principles. The Trust had appointed a Lead for DoLS (Deprivation of Liberty Safeguards) who also provided training in the Mental Capacity Act (MCA). MCA training was incorporated into safeguarding training and this had been updated by the trust. This training was mandatory for the appropriate clinical staff. The lead had developed a database to monitor training activity and training was planned through to 2017. The overall trust compliance rate was 86.7%.
- The MCA is not applicable to children under the age of 16. Staff used the Gillick competence, which balances children's rights with the responsibility to keep children safe from harm, for those under 16. Training in Gillick competence was incorporated into MCA training. Staff working in specialist community mental health child and adolescent services demonstrated good knowledge of Gillick competence and its application in practice, however, only 70% of staff had accessed the training. This fell below the trust training compliance rates.
- Following the inspection in November 2015, the trust had increased the size of the safeguarding team from 14 to 17 people. Advice regarding the Mental Capacity Act was available through this team, managers, policies and the intranet.
- Most wards, when needed, had made appropriate Deprivation of Liberty Safeguards applications. We saw that best interest assessments had taken place for patients who lacked capacity. Staff in older people's wards routinely referred informal patients for a DoLS assessment. The trust provided information around the Deprivation of Liberty Safeguards applications they have made between 1 April 2016 and 31 July 2016 (four month period). Between 1 April 2016 and 31 July 2016 the trust advised they made twelve DoLS applications. All of these were approved. In the same period, the CQC received only four DoLS notifications from the trust.
- Independent mental capacity advocacy (IMCA) was available to patients across the trust. Staff were aware of the IMCA and knew how to contact them on behalf of patients.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

- Throughout the inspection, we found staff to be caring, kind and considerate towards patients. Feedback from patients, carers and families during the inspection was consistently positive in how staff treated them. However, families in the focus group told us of individual instances where they were not treated with dignity.
- Families in the carers and family focus group spoke highly of the impact of the carers group and how supported they felt. They also recognised the trust was trying to engage and had set up meetings to support service re-design.
- Families and carers described the care received in specialist community mental health teams for children and adolescents as excellent. They described the services offered were a lifeline for vulnerable young people, that young people were actively involved in the decisions in their care and routinely participated in staff recruitment. Families whose children were admitted to hospital outside of the catchment area said that staff travelled weekly for review meetings and provided families with regular emotional support.
- Staff in community mental health teams for adults of working age went above and beyond what they were required to do. An example was the development of activities for patients in the community to increase inclusion. They linked with a local professional football club to develop a league for people with mental health issues, provided greater access to the local gym and supported the recovery college.

However:

- Although staff were seen to be kind, caring and compassionate in health based places of safety, privacy and dignity was poor, especially at Hallam Street hospital. The outside space could be overseen by passers-by and there was no adequate soundproofing, meaning that patients on another ward could hear conversations.

Our findings

Kindness, dignity, respect and support

- PLACE assessments are self-assessments undertaken by NHS and private/ independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services. The trusts score for privacy / dignity and wellbeing is around 3% lower than the England average of 86%. All sites except Penn hospital scored slightly lower than the England average, Penn scored 1% higher for privacy, dignity and wellbeing.
- Results of the Friends and Family test showed 68% of staff would recommend the trust as a place to receive care. This score was 10% lower than the national average for similar mental health trusts. This has also decreased from 71% at the time of the previous inspection. In the same period, 12% of respondents for the trust said they were either 'extremely unlikely' or 'unlikely' to recommend the trust as a place to work, 5% higher than the England average. However, staff across the trust we spoke to did not reflect the views expressed in the staff survey. Overall, staff were positive about their experience of working in the trust.
- At the start of 2015, a questionnaire was sent to 850 people who received community mental health services. Responses were received from 235 people at Black Country Partnership NHS Foundation Trust. The trust scored 'about the same' as other mental health trusts in all questions.

Good

Are services caring?

- We observed examples of staff treating patients with kindness, compassion and communicating effectively. We saw staff engaging with patients in a kind and respectful manner throughout the trust.
- Staff were caring, kind and mindful of the patients' needs. Patients we spoke to said that staff were available and they could get support immediately if they needed it. One patient said staff had supported them to change their worker when they felt they did not have a rapport with their allocated care coordinator.
- One patient told us that they could choose whether to have a family member present or not during one to one sessions and that, staff maintained confidentiality.
- The trust had improved confidentiality of patient records, in particular in wards for older people, where notes were stored securely. However, in health-based places of safety, confidentiality of patients was not always maintained at Hallam Street Hospital.

The involvement of people in the care they receive

- Most patients and their carers told us that they were orientated to their ward on admission and were shown around by staff. They had received information leaflets relating to the trust. Welcome pack for patients was available in most wards that contained information to help patients orientate and provide them with information they might need whilst in hospital.
- Where possible, learning disability patients visited the ward with their relative or carer before admission.
- We received good feedback from patients about their involvement in the care they receive. Documented evidence of patients having input to their care plans was consistent. Patients told us they were consulted about their care plans and felt involved in their care.
- Information was displayed on the wards and in the community services about advocacy services and specifically the Independent Mental Health Advocacy (IMHA) service for patients detained under the MHA. Most staff was familiar with the role of advocates and they knew how to contact them on behalf of patients.
- The trust ran a group aimed at carers and families of those being treated by the trust. They often had outside speakers come to talk to them and senior managers and ward managers had attended. Carers who attend the carers group received a carer's assessment annually and received a carer's care plan. They felt they had been listened to and some changes had been made because of this. For example, a bike rack was installed at Hallam street hospital site, and a dividing fence erected in the garden on one of the acute ward sites to stop males gaining unsupervised access to the women's part of the ward.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated responsive for good because:

- All services had access to interpreters and staff could access a range of accessible information in different languages when required.
- The trust received 106 complaints in the 12 months from July 2015 and June 2016. This was lower than the number of complaints reported ahead of the November 2015 inspection. The trust approach to managing and investigating complaints was effective and confidential.
- The trust received 305 compliments in the 12 months from July 2015 to June 2016. This is higher than the number of compliments received in November 2015.

However:

- Patients care and treatment at the health-based place of safety at Hallam Street Hospital could be disrupted by staff who regularly accessed the kitchen to make drinks for patients on an adjoining ward.

Our findings

Service planning

- Trust services were planned to meet the needs of a diverse and populated area that contained health inequalities and deprivation in some local areas. The trust met the demands of people living in largely urban areas, covering the district of Sandwell and the city of Wolverhampton. The trust also delivered services to Dudley and Walsall, including smaller towns and rural areas.
- The trust met regularly with four local Clinical Commissioning Groups and NHS England who commissioned specialised mental health services. The CCGs fed back that the trust was open and transparent and engaged with them in service development. They were positive about the workforce race equality scheme and thought it reflected the diverse needs of the local population. The trust had regular meetings with Wolverhampton Healthwatch and had increased its engagement with Healthwatch in Sandwell.
- The trust had a sustainability strategy in line with the five-year forward plan and the sustainability and transformation plan. The trust recognised that it needed to partner another organisation to sustain care and treatment in future, leading to the 'Transforming Care Together' programme. The trust works with two local NHS trusts to ensure that care is safe and efficient.
- The trust was a key partner in the MERIT vanguard, a model of providing crisis care in partnership with three other mental health NHS trusts in the West Midlands. Although much partnership working had taken place at board level, at the time of the inspection, there was no clear evidence that the partnership arrangement had made any impact with the teams and services.

Access and discharge

- Patients were able to access urgent assessment and care across the trust. Staff working in adult crisis teams triaged new referrals on the same day and prioritised them using a screening tool. Records showed that urgent referrals were seen on the same day. Community mental health teams for adults were meeting their targets for assessment of new referrals and seeing patients within seven days of discharge. The trust had been above the England average for following up patients on the Care Programme Approach (CPA) in five of the 12 quarters in the period covered. This has typically ranged between 95.8% - 98.2%. Specialist community mental health teams for children and young people were meeting targets in line with national NHS England 18 week referral to treatment times guidance. Pond Lane (Adult Community Learning Disabilities Services) reported the longest referral to treatment time with 23.3 days.
- The trust provided details of bed occupancy for wards across its services between August 2015 and July 2016. The trust wide bed occupancy without leave was 87% in July 2015 and fell to 84% in June 2016. Three out of four core services had bed occupancies of 85% and above.

Good

Are services responsive to people's needs?

- Overall, the trust had an average of 35 days length of stay across all wards for discharged patients in July 2016 and 36 days for patients discharged over the previous year.
- There were 44 out of area placements between 1 August 2015 and 31 July 2016. Forty-one of these were for adults. The trust monitored out of area patients alongside CCGs. There was no Tier 4 mental health hospital provision for children and young people to use however, the trust liaised with NHS England to source appropriate beds. Families told us that staff working in specialist community mental health teams reviewed these children weekly and contacted families regularly. They felt the team exceeded their expectations.
- There were 178 readmissions within 28 days reported by the trust between 1 June 2015 and 31 May 2016, across 13 wards. The significant majority of readmissions within 28 days occurred in 'Adult Acute and PICU' with 158 (88.8% of all readmissions within 28 days). The average gap between discharge and readmission trust wide was 9.7 days.
- The trust provided the number of delayed discharges between August 2015 and July 2016, there were a total of 173 delayed discharges. Ten per cent of all discharges across the trust were delayed. At the previous inspection, Penrose had the most delayed discharges at 25% for the period between December 2014 and May 2015.
- There were a total of 178 readmissions within 28 days reported by the trust between 1 June 2015 and 31 May 2016, across 13 wards. The significant majority of readmissions within 28 days occurred in 'Adult Acute and PICU' with 158 (88.8% of all readmissions within 28 days). The average gap between discharge and readmission trust wide was 9.7 days. This is different to the previous inspection that saw the highest proportion of re-admissions to Ridge Hill, which is a learning disabilities inpatient unit that had 53% of red-admissions between December 2014 and May 2015.
- One hundred and fifty-one patients had delayed transfers of care: from July 2015 to June 2016. The number that was the responsibility of social care was higher than or equal to the number that was the responsibility of the NHS in every month except in January and February 2016. This is a rather different pattern to the period covered in the previous data pack, where the number that was the responsibility of the NHS was greater than the number that was the responsibility of social care until February 2015, although the total numbers are similar. 'Public funding' was the main reason for delayed patients.

The facilities promote recovery, comfort, dignity and confidentiality

- The majority of the Trust's services had the quantity and range of rooms and equipment needed to support treatment and care. Following the inspection in November 2015, the trust had improved the environment in the Sandwell child and adolescent service using funds made available by local commissioners. The environment had been refurbished and equipment and furnished were installed to meet the needs of young people such as, a television, Wi-Fi, new toys and books.
- There was sufficient information across the trust's services that provided detail on treatments, local services, how to complain and support services. There was easy read versions of information and leaflets in different languages.
- In relation to food, PLACE data (self-assessments undertaken by NHS and private/ independent health care providers), the trust was 1% below the national average of 87%. Hallam Street Hospital scored 80% that was 6% lower than the trust average. Patients across the trust had the ability to make hot drinks and snacks dependent on their risk and capability. Quiet areas were accessible in wards across the trust and there was access to open spaces. However, staff were using the kitchen in the health-based place of safety at Hallam Street Hospital when patients were admitted, compromising their privacy.
- Across community services, either interview rooms were soundproofed or staff had mitigated against overhearing patient conversations.

Meeting the needs of all people who use the service

- Dudley, Sandwell, Walsall and Wolverhampton presented a large geographical area across what is known as the Black Country due to its industrial heritage. All three areas had large ethnic populations from the Black and Asian community. There has been a

Good

Are services responsive to people's needs?

growth in people from Central Europe such as the Polish community. Twenty-six percent of the population of the Black Country was from a Black or Minority Ethnic (BME) background. Of the 2,100 people that the trust employed, 27% were from a BME background.

- The trust showed that they understood and knew how to meet the diverse needs of the population. Community mental health teams for older adults had a treatment and recovery unit at Edward Street Hospital and had developed a cognitive simulation group for those that used Punjabi as a first language. The group recognised the different early life experiences of the patients using services.
- Staff could access interpreters for patients and their families whose first language was not English.
- Staff told us they could access information in a range of languages if needed. We saw posters in a range of languages that asked patients to point to their language and let the receptionist know. There was a range of leaflets in different languages in the community mental health teams for adults. This meant that non-English speaking/reading patients were able to get information in the languages they understood. Staff told us they had access to a range of leaflets in various languages through the trust's intranet translation services.
- The health visiting team based at Ladies walk clinic had implemented a monthly clinic running between 5pm and 7pm so that the clinic could be accessed by working parents. That was the best-attended health-visiting clinic across the trust.
- Dietary needs were catered for by the trust. Patients wanting halal or kosher meals had those provided for them.
- Patients in the Gerry Simon clinic had access to spiritual leaders for support. Some patients were supported to attend places of worship such as church or mosque.
- Patients and carers who had used the services of the complex care team north had made adjustments to the building. The south team had raised concerns that wheelchair users could not access the building easily.

Listening to and learning from concerns and complaints

- Across the trust, we saw information related to complaints was visible and accessible. Patients and carers we spoke to knew how to make a complaint and staff were knowledgeable to support them to do so. The patient advice and liaison service (PALS) was promoted within the trust to support those who wished to raise a concern or complain. PALS offered a confidential advice, support and information service.
- Before our inspection, the trust recorded 106 complaints in the 12 months from July 2015 to June 2016. This is lower than the previous inspection in November 2015. Fifty-three per cent of complaints were upheld or partially upheld. Acute wards and psychiatric intensive care units for adults of working age received the most complaints (49.5%).
- One complaint had been upheld by the parliamentary health service ombudsman in our previous inspection of November 2015. However, there were no complaints referred at the time of our inspection of October 2016.
- Between July 2015 and June 2016, the trust received 305 compliments, which was higher than the previous inspection in November 2015. The service that received the highest level of compliments was acute wards and psychiatric intensive care units for adults of working age (96).
- Complaints and concerns, where possible, was dealt with locally by staff seeking a local resolution. Complaints were discussed at team meetings through to Board level. Learning lessons information was shared within a trust newsletter and team managers

Good

Are services well-led?

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

Summary of findings

We rated well-led as good because:

- The trust had responded to the requirement notices issued at the last inspection in November 2015.
- The trust had developed and strengthened its governance structure and processes since the inspection in November 2015. There was clear reporting channels from 'floor to board', meaning that the trust were aware of quality and safety issues across the trust services. We saw evidence of good governance effecting change, for example, the improvement in recruitment, through use of workforce data, had led to a reduction in the use of agency staff across the trust.
- The November 2015 inspection highlighted strong leadership at board level however, this was not replicated at ward and team level. The introduction of eight modern matron posts had strengthened nursing leadership across the trust and improved quality and safety in a number of areas.
- Across the trust, we saw improvements in the physical health strategy, environmental improvements and risk assessments, resuscitation equipment was in place, nurses having a voice, and staff were supported during their recruitment and with training and development.

Our findings

Vision, values and strategy

- Following the CQC inspection in November 2015, the trust had maintained its vision and values. The trust had reviewed its strategic direction based on national policy drivers such as the NHS England 5 year forward view and local drivers such as sustainability and transformation plans
- The trust continued to use its strapline; 'our community: you matter, we care'. To work with local communities to improve health and well-being for everyone. This was shared with staff across the trust. The trust's values remained 'Valuing people as individuals, providing high quality innovative care, working together for better lives, openness and honesty and exceeding expectations'
- The trust's strategic goals were to; Nurture a culture, which provided safe, effective, caring, and responsive and well led services; Involve and listen to patients, carers and family's experience to continually improve services; To be a leading provider of specialist mental health, learning disability and children's services; proactively seeking opportunities to develop services building partnerships with others; to strengthen and expand the services provided; attract and retain a well-trained, diverse, flexible, empowered and valued workforce and use resources effectively, innovatively and in a sustainable manner.
- The trust had a clear 'business as usual' approach to changes across the health and social care economy. The trust was open about the strategy it needed to take to reflect its future sustainability. The trust were part of the development of a local Sustainability and Transformation Plan (STPs). Each STP covered a 'place' footprint, reflecting the whole population and future delivery of healthcare from primary care to specialist services, but reflecting local government provision. To support trust sustainability, it was working with two local NHS trusts under an agreement called 'Transforming Care Together' that started after our previous inspection. The partnership commenced in December 2015 with the core aims to improve current services, ensure effective and efficient support services, and develop affordable and high quality services. Senior managers and executives in the trust regularly discussed the implications and future direction of both partnership working and the STP. However, they recognised the daily need to maintain the quality and safety for patients, staff and carers.

Good

Are services well-led?

- Trust board members were clear about the trust's vision and values. They understood current challenges across the health and social care economy and their role in maintaining a strategic overview to manage future change.
- The trust quality strategy had identified five strategic objectives that were mainly financial and workforce related. This was monitored through the board assurance framework and was reviewed regularly throughout the year.
- The trust maintained engagement with staff throughout the trust, staff knew who senior managers were and spoke about the vision and values of the trust.

Good governance

- We found evidence that the trust had developed and strengthened its governance processes and structures, because of previous feedback and change in senior personnel. The trust maintained the board assurance framework to monitor progress against its strategic objectives and operational delivery. The governance structure flow chart was clear and the reporting channels from 'floor to board' went both ways. Assurance and scrutiny of reporting to the board was through the quality and safety committee that received information from the quality and safety steering group (QSSG). The QSSG received information from ward, team and operational managers to assure itself of good governance. Under quality, the group reviewed as an example, patient experience and engagement, and equality and inclusion. Under safety, the group reviewed a number of factors including, incidents, the risk register, safe staffing and environmental issues. The CQC action plan, following the inspection of November 2015, was monitored and updated through the QSSG. We reviewed three months of minutes and found effective and pro-active changes, for example, there was improvement in workforce and recruitment data leading to a reduction in the use of agency staff. This was a concern raised at the last inspection.
- Staff across the whole of the trust were clear about their roles and responsibilities. The introduction of modern matrons had strengthened the nursing leadership in clinical areas and improved the reporting channels between clinical staff and the trust board.
- The majority of staff working across trust services had received their mandatory training. The overall compliance rate for mandatory training across the trust was 82.3%.
- As of June 2016, the appraisal rates for non-medical staff was 99.1%; this met the trust's target rate of 95% compliance. The trust had improved its compliance rates from June 2015 where 97% of staff had an appraisal.
- Clinical supervision was embedded across the trust and services found innovative ways to deliver supervision. Team leaders and managers maintained records of staff who had undertaken supervision, however, not all staff kept a record. The trust did not have a centralised electronic recording system to collect and collate data however, ESR was scheduled to be rolled out in November 2016.
- Medical supervision is managed through peer review. All consultants attended a weekly graduate meeting and a continuing professional development group linked to the Royal College of Psychiatrists (RCP). All consultants are up-to-date with their appraisals that is monitored by the RCP. Speciality doctors had weekly one-to-one supervision with a consultant and compliance was 100%.
- We found that there was sufficient staff across the trust to provide safe care. The trust had acted upon the findings of the inspection in November 2015 and increased staffing levels in services where we had concern.
- Multidisciplinary staff working in local services participated in regular audit across the trust.Staff learnt about the outcomes of audit through team meetings and the trust newsletter. There was a range of audit across trust services undertaken including prescribing medication, infection control, dignity, record keeping, and transition across services and environmental checks. The results of audit are discussed in senior management and board meetings.
- Outcomes of patients were monitored and audited by the trust. This included the monitoring of quality priorities. The trust had updated its quality principles for 2016/2017 to include; improve the physical health of inpatients (through improved monitoring of their weight, Body Mass Index and the risk of malnutrition);

review the use of anti-psychotic medication in challenging behaviour and listen to and learn from regular user feedback across all services. This was different to the previous inspection where the quality principles were medication administration errors, the reduction of restrictive interventions in learning disabilities inpatient units. The trust monitored and reported on progress against these indicators and priorities. Commissioners met with the trust to review the progress they made against their quality priorities.

- The trust had clear policies and procedures for the reporting of and responding to incidents. There was robust review of incidents across the trust and staff were trained to undertake investigations and root cause analysis. Oversight of incidents was through the Quality and Safety Steering Group and they would report serious incidents directly to the trust Board. Key findings from incidents were shared across the trust, including themes and learning points, through the trust newsletter, team meetings and supervision.
- Team leaders and ward managers maintained oversight of complaints locally and the trust collated information about complaints to identify if there was systemic or trust wide issues. Complaints were regularly referred to the patient advice and liaison service. Staff across the trust were aware of the complaints procedure and knew how to support patients and families to raise concerns.
- Restrictive practices across the trust were monitored in line the Mental Health Code of Practice. Staff working in clinical areas had access to information from a range of resources to support safe delivery of care when considering restraint, seclusion and segregation. The trust Mental Health Act team and the Quality and Safety Steering Group provided oversight and scrutiny of practice. Staff had access to and were trained in delivery of restrictive interventions through a course accredited by the British Institute of Learning Disabilities (BILD).
- The trust had strengthened processes and procedures to assure itself that arrangements were in place to comply with the Mental Health Act, Mental Capacity Act and safeguarding. The trust had improved the knowledge base of staff in the Mental Capacity Act and safeguarding, however, staff training the Mental Health Act were a long way below the target set by the trust.
- The trust complied with the Equality Act 2010 and had a clear plan to develop equality and diversity for patients, families and staff. The trust developed four equality objectives under the term 'play fair' to embed governance structures, make better use of quality information, support an inclusive culture for staff and, build stronger relationships with diverse local communities. The trust equality and diversity strategic group oversees implementation of policies and procedures and feeds into trust board governance. CCG feedback was positive about the workforce race equality scheme (WRES) and the trust was taking actions to improve the working life and career opportunities for black and minority ethnic (BME) staff.
- The trust board had good oversight of resource and budget management. There was regular meetings between the Director of Finance and managers across the trust. The trust had not compromised over the quality of clinical services in managing its budget, however, financial pressures had an impact on the delivery of IT services into clinical area.
- The board assurance framework of June 2016 detailed five objectives, with assurance plans associated with each, and described associated high level risks. The five objectives reflected the need to deliver high quality and safe services to the local population. The board assurance framework held the executive team to account and monitor progress against operational delivery and strategic objectives. The trust board used a quality dashboard to assure itself of key performance indicators (KPIs) in the delivery of care and treatment. Trust board members sat on all of the sub-committees to strengthen 'ward to board' oversight of performance. Operational managers worked with team leaders and ward managers to ensure team and individual KPIs were met.
- The trust had good working relationships with the four clinical commission groups (CCGS), NHS England and four local authorities where care and treatment is delivered. Engagement with external stakeholders is delivered by operational and local managers however, the trust maintained oversight through its governance structures.

Fit and proper persons test

Good

Are services well-led?

- Healthcare providers are required to ensure that all directors are fit and proper persons (FPPT) for their senior roles within healthcare organisations. The CQC requires trusts to check that all senior staff met the stated requirements on appointment and set up procedures and policies to give continuous assurance that senior remained fit for role throughout their employment.
- The trust had a policy and assurance process in place to check that directors complied with the fit and proper persons test. The trust undertook a self-assessment and completed checklists on all board members.
- We reviewed nine executive directors files and found appropriate documentation in most files. We found full evidence of robust recruitment processes, competency based interviews, annual declarations of FPPR and all had an appraisal. However, not all files had information on professional qualifications, valid disclosure and barring service (DBS) checks and references. We spoke to the trust, in particular about DBS checks and information related to DBS checks was transferred into director files.

Leadership and culture

- The Black Country Partnership NHS Foundation Trust saw a response rate of 34% in the NHS staff survey, when 637 staff took part. This is below the 40% response rate in 2014 and falls below the national average for similar NHS providers.
- The trust had three key findings that exceeded the national average: the percentage of staff appraised in the last 12 months; the percentage of staff reporting most recent experience of violence and, the percentage of staff reporting errors, near misses or incidents witnessed in the last month.
- The trust had 26 key findings below the national average in the 2015 staff survey. Fourteen per cent more Black and Minority Ethnic staff than white staff experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months, which is 10% higher than the average for comparable trusts. Staff motivation at work, staff recommending the organisation as a place to work and the quality of appraisals were also rated negatively in comparison to similar trusts. However, across the trust, staff told us that they were motivated in their work and were proud of the care they delivered. Senior managers told us consistently that staff morale was good and they were proud of the staff group. Most staff said they felt valued, in particular, by local managers.
- Sickness rates were comparable between June 2015 and June 2016, and vacancy rates had improved.
- The understood the diverse needs of the workforce and promoted equality and diversity. The Workforce Race Equality Scheme provided a framework to monitor the needs of BME staff and support areas such as promotion and access to specialist training. The ratio of BME staff working in the trust reflected the wider population in the Black Country.
- The trust had a duty of candour policy in line with duty of candour legislation. The trust assure itself that the requirements of Duty of Candour legislation are being implemented through scrutiny of all incidents where the Duty of Candour is applied at local level and it is reported and scrutinised via Divisional Quality and Safety meetings. In addition, it is monitored weekly through the trust-wide patient safety conference call. At our inspection, we found the trust was open and transparent across all services and at all levels, from 'floor to board'. Staff consistently told us of the principles of duty of candour and staff were able to give examples when they were or would be open with patients and carers.
- Staff were aware of how to raise concerns and understood their role in monitoring and assessing risks. Managers were seen as approachable and would listen to concerns. Staff knew who the senior managers were in the trust and understood the processes to raise concerns.

Engagement with the public and with people who use services

- The trust had continued to build on engagement with the public and people who use its services however, there was still limited processes in place for consultation.
- The carers team in Sandwell and carers we spoke to in the focus group felt the trust could do more to better engage families and carers. They spoke positively about

Good

Are services well-led?

the relationship they had with the Associate Director in the Quality and Safety team who listened and supported them with any questions or issues. Overall, they felt the trust was a listening organisation.

Quality improvement, innovation and sustainability

- The trust participated in accreditation schemes for ECT and forensic networks. Wards for older people with mental problems, community-based mental health services for older people and adults of working age are registered and accredited as excellent with ECTAS (the ECT accreditation scheme). The Royal College of Psychiatrists quality network for forensic mental health services reviewed the Gerry Simon Clinic low secure service in April 2016 and re-accredited with a score of 83%.
- The physical health care team, as part of the Wolverhampton complex care team south, had received a highly commended award at the recent trust excellence/quality awards for the development of the service. Staff and patient feedback was very positive and they agreed that the clinics were efficient and had improved the patient experience.
- In collaboration with children, young people and their families, a psychologist in the child and adolescent community mental health team had been developing a website. One young person had taken a lead in the development of the website and presented the work to trust managers. At the time of our inspection, the trust were preparing to offer a contract to the young person to continue with the development of the website.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for patients. The bathroom located at Hallam Street Hospital health based place of safety had a lockable door. This door could be locked from the inside, where there were a number of ligature risks.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust, in specialist community mental health teams for children and young people, did not ensure that systems are established and operated effectively. This includes the coordination of electronic systems for the processing of referrals. This was a breach of regulation 17(1).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust did not ensure that staff were adequately compliant with mandatory training or training in the Mental Health Act.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 18 (2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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