Birmingham and Solihull Mental Health NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	North croft site Mary Seacole House The Barberry Little Bromwich Centre The Zinnia Centre	RXT54 RXT47 RXTD3 RXT37 RXTD2
Long stay/rehabilitation mental health wards for working age adults	Ross House Dan Mooney House David Bromley House Hertford House Grove Avenue Forward House Endeavour House Endeavour Court	RXT67 RXT96 RXT96 RXT27 RXT27 RXT54 RXT54 RXT54
Child and adolescent mental health wards	Trust Headquarters B1 50 Summerhill Road Birmingham West Midlands B1 3RB	RXTC1
Wards for older people with mental health problems	Juniper Centre Ashcroft	RXTD5 RXT06
Forensic Wards	The Tamarind Centre Reaside Clinic Arden leigh Hospital	RXT37 RXT64 RXTO5

Summary of findings

	Hillis Lodge	RXT29
Community-based mental health services for adults of working age	Trust Headquarters B1 50 Summerhill Road Birmingham West Midlands B1 3RB	RXTC1
Mental health crisis services and health-based places of safety	The Barberry Oleaster Centre North croft	RXTD3 RXTD3 RXT54
Specialist community mental health services for children and young people	Trust Headquarters B1 50 Summerhill Road Birmingham West Midlands B1 3RB	RXTC1
Community-based mental health services for older people	Trust Headquarters B1 50 Summerhill Road Birmingham West Midlands B1 3RB	RXTC1

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	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

Summary of findings

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Summary of findings

Overall summary

Following the inspection in March 2017, we have changed the overall rating for Birmingham and Solihull Mental Health NHS Trust from **Good** to **Requires Improvement** because:

- Feedback from staff and evidence from the most recent NHS staff survey suggested a disjoint between the board and staff at service level. Staff groups in several areas reported feeling under-valued and as being unheard concerning key decisions and service re-design.
- The trust had taken a blanket approach to searches and ordering of food from take away restaurants. The decisions made at board level in relation to the restrictions did not take account of individual risk assessment or patient choice.
- The oversight and safety of medicines management was compromised as the trust did not have a medicines safety officer in post. The trust policy concerning rapid tranquilisation was also out of date and did not reflect updated guidance from the national institute of health and care excellence.
- Staff knowledge, understanding and application of the Mental Capacity Act was poor in those community services that cared for children and young people and in the wards for older people with mental health problems.
- We found that the trust processes for assuring their contractual obligations concerning equality and diversity lacked robustness. In some teams, the provision of information for Non-English speakers was insufficient and in contravention with the Equality Act 2010.
- The Board Assurance Framework did not focus on strategic risks and instead was an extension of the corporate risk register. This meant that the board were unable to provide robust evidence of an understanding of the trusts corporate risks.

However:

- Staff, throughout the organisation, were caring, compassionate, kind and treated patients with dignity and respect. Feedback from patients and carers was positive and highlighted the staff as a caring group.
- Staffing levels across the trust were generally safe and sufficient to provide good care.
- The trust was involved in several vanguards and new models of care partnerships with external partners. Overall, external bodies were positive about the trust and its role in addressing the challenges faced by the local health economy.
- Trust services were responsive to the needs of the patient group; this was evident in the inpatient and community services that we visited.

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?

Requires improvement

We rated Birmingham and Solihull Mental Health NHS Trust as **requires improvement** for safe because:

- There was a high use of prone restraint in the trust; out of 1229 restraint between December 2015-November 2016; 580 of which were carried out in the prone position.
- The trust had implemented blanket restrictions with regards to ordering of food from takeaways and also in relation to searches. Staff stated that the policies were difficult to apply and did not promote an individualised approach to patient choice or risk.
- The trust did not have a medicine safety officer in post. This was contrary to guidance from NHS England requiring trusts to appoint one. There was limited pharmacy involvement in inpatient settings, which meant that visits to wards by the pharmacy team was cancelled due to low pharmacy staffing levels.
- The trust rapid tranquilisation policy was based on outdated NICE guidance: NG25 2005. This guidance had been superseded by NICE guidance NG10, published in May 2015.

However:

- The trust had implemented a system of environmental and ligature risk assessments that identified and provided mitigation to protect people at risk of self-injurious behaviour.
- Staffing levels across the trust were safe in the majority of services. The trust had been proactive in the 12 months prior to the inspection in embarking upon a focussed recruitment drive for key staffing areas such as registered nurses and healthcare support workers.
- Mandatory training levels were high across the trust with an average of 94% of staff compliance.
- Staff understood their responsibilities under the duty of candour.

Are services effective?

Requires improvement

We rated Birmingham and Solihull Mental Health NHS Trust as **Requires Improvement** for effective because:

Summary of findings

- Staff within the specialist community mental health teams for children and young people displayed limited knowledge, understanding or application of Gillick competence.
- Staff on the wards for older people with mental health problems also displayed a poor understanding of the mental capacity act in relation to recording of decisions and how the act applied to administering covert medication.
- Care plans were not always personalised and showed little evidence of patient involvement.

However:

- The trust had implemented the 'WHAT' tool that was used for an interactive and informative handover on most wards.
- We found evidence of a multi-disciplinary approach to patient care delivery, which included external professionals such as local authorities, the GP, third sector and voluntary agencies.
- Staff were involved in a range of clinical audits to monitor the effectiveness of the services provided. These included audits of infection control and prevention, health and safety and physical health.

Are services caring?

Good

We rated Birmingham and Solihull Mental Health NHS Trust as **good** for caring because:

- The trust's overall score for privacy, dignity and wellbeing in the patient led assessments of the care environment (PLACE) 2016 was 93.9%, which was around 4.2% higher than the England average of 89.7%. All sites scored above the national average.
- We saw that staff interacted with patients in a positive, friendly and respectful manner and most patients we spoke to were positive in their views of staff.
- Most wards had information and systems to orientate patients at the time of their admission.
- Wards had regular community meetings. Staff kept minutes of these meeting and displayed these on wards.
- The trust had developed the 'See Me' project for service users that involved them in forums and meetings across the trust.

Are services responsive to people's needs?

Good

We rated Birmingham and Solihull Mental Health NHS Trust as **Good** for responsive because:

Summary of findings

- Most teams were responsive to the needs of patients who required access to services during periods of crisis or for routine appointments. Staff were proactive in reaching out to patients who did not attend for appointments.
- The trust's approach to managing and investigating complaints was effective and confidential involving a patient experience team, patient advice and liaison service (PALS) team. The organisation disseminated lessons learned from complaints through a process that included the circulation of a newsletter to all staff and through team meeting discussions.

However:

- Some patients had long length of stays in forensic and long stay rehabilitation mental health wards. The high lengths of stay were attributed to a group of patients who had a bed for life and some patients who were subject to Ministry of Justice approval before discharge
- In some services, information for patients who did not speak English as a first language was also displayed in English. This meant that Non-English speakers might suffer a delay in accessing treatment or support.
- Between December 2015 and November 2016, 164 patients were placed out of area. Post inspection the Trust provided figure which showed that the range of out of area placements between October 2016 and February 2017 was between two and six, showing a good improvement
- We found that over 300 patients experience delayed transfer of care.

Are services well-led?

Requires improvement

We rated Birmingham and Solihull Mental Health NHS Trust as **Requires Improvement** for well led because:

- The trust had not implemented the Equality Delivery System (EDS2). A senior staff member was unaware that implementation of EDS2 was a contractual requirement. Equality analyses were not completed for all major decisions or policies.
- The Board Assurance Framework did not focus on strategic risks and instead was an extension of the corporate risk register.

Summary of findings

- Staff groups in several areas reported feeling under-valued and as being unheard with regards to key decisions and service re-design.
- The Allied Health Professional (AHP) group lacked identified leadership.
- In seven of the nine services that we inspected we rated the safe key question as required improvement.

However;

- Staff received mandatory training and the trust had an overall compliance rate of 94%. This meant that staff were given the training they needed to carry out their roles.
- Processes for assuring that directors were 'fit and proper' were clear and consistent. We reviewed four director files and found all checks and declarations had been completed.
- Services were well led at local level and staffing was sufficient to provide patients with good care and treatment.
- The trust was a key partner externally in several of the local vanguards and new models of care. Feedback from local partners in health, local authority and oversight groups was positive.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Mick Tutt, Non-executive director & vice chair, Solent NHS trust

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

Inspection Manager: Kenrick Jackson, Inspection Manager, Care Quality Commission

The team of 80 people included:

- 17 CQC inspectors
- one CQC assistant inspector
- four allied health professionals
- one analyst
- four experts by experience who have personal experience of using, or caring for someone who uses, the type of services we were inspecting
- three Mental Health Act reviewers
- 25 nurses from a wide range of professional backgrounds
- one planner
- one pharmacist
- six senior doctors
- six social workers
- nine people with governance experience

Why we carried out this inspection

We undertook this inspection to find out whether Birmingham and Solihull Mental Health NHS Trust had made improvements to its services since our last comprehensive inspection on 12 -15 May 2014 where we rated the trust as **good** overall.

When we inspected the trust in May 2014 we rated:

- **The acute wards for adults of working age and psychiatric intensive care units**
  - Requires improvement overall.
  - Safe – Requires improvement
  - Effective – Good
  - Caring – Requires improvement
  - Responsive – Good
  - Well led – Requires improvement
- **The long stay / rehabilitation mental health wards for working age adults**
  - Good overall
  - Safe – Requires improvement
  - Effective – Good
  - Caring – Good
  - Responsive – Good
  - Well led – Good
- **The wards for older people with mental health problems**
  - Requires Improvement overall
  - Safe – Good
  - Effective – Requires improvement
  - Caring – Good
  - Responsive – Good
  - Well led – Requires improvement
- **The community based mental health services for adults of working age**
  - Good overall
  - Safe – Good
  - Effective – Good
  - Caring – Good
  - Responsive – Good
  - Well led – Good
- **The mental health crisis services and health based place of safety**
  - Good overall
  - Safe – Good
  - Effective – Good
  - Caring – Good
  - Responsive – Good
  - Well led – Good
- **Specialist Eating Disorders**
  - Good overall
  - Safe – Good
  - Effective – Good

Summary of findings

- Caring – Good
- Responsive – Requires improvement
- Well led – Good

In May 2014, we issued the trust with three compliance actions. These related to the following regulations under the Health and Social Care Act (Regulated Activities):

- **Regulation 9:** service users must be protected against the risks of receiving care or treatment that is inappropriate or unsafe.
- **Regulation 13:** protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording and safekeeping of medicines.
- **Regulation 20 (1) (a):** ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them. By means of the maintenance of an accurate record in respect of each service user, which shall include appropriate information and documents in relation to the care and treatment, provided to each service user.

How we carried out this inspection

To fully understand 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 the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received.
- We asked a range of other organisations for information, These included:
- NHS England
- Clinical Commissioning Groups
- Health watch,
- Health Education England
- Royal College of Psychiatrists
- Other professional bodies,
- We met with six representatives from these groups before inspection.
- Sought feedback from carers through attending a user and carer group focus group
- Received feedback from managers of care homes
- Received information from patients', carers and other groups through our website

During the announced inspection from 27 March to 31 March 2017, the inspection team:

- visited 69 wards, teams and clinics
- spoke with 210 patients
- spoke with three former patients
- spoke with 44 relatives and carers who were using the service
- collected feedback from 228 patients, carers and staff using comment cards
- spoke with 421 staff members
- spoke with 49 managers
- attended and observed 14 handover meetings and multidisciplinary meetings
- joined care professionals for 12 home visits and clinic appointments
- attended 17 focus groups attended with staff
- interviewed 24 senior managers, executive team, non-executive directors and governors
- looked at 371 treatment records of patients' including risk assessments
- carried out a specific check of the medication management across a sample of wards and teams and looked at 305 prescription and administration charts
- looked at 16 seclusion records
- attended three activity groups for children and young people
- looked at a range of policies, procedures and other documents relating to the running of the service
- requested and analysed further information from the trust to clarify what was found during the site visits

Summary of findings

We also carried out unannounced visits to the older adults' community hubs, the Crisis resolution and home treatment team and Health based place of safety in the 10 days following the comprehensive inspection.

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

Information about the provider

Birmingham and Solihull Mental Health NHS Foundation Trust was established on 01 July 2008. Before becoming a foundation trust, the organisation was created on 1 April 2003, following the merger of the former North and South Birmingham Mental Health NHS Trusts.

The Trust provided a comprehensive mental healthcare service for residents of Birmingham and Solihull, and to communities in the West Midlands and beyond. The Trust operated out of more than 50 sites serving a population of 1.2 million, with an annual budget of £237 million and a dedicated workforce of over 4,000 staff.

The catchment population was ethnically diverse and characterised in places by high levels of deprivation, low earnings and unemployment. These factors create a higher requirement for access to health services and a greater need for innovative ways of engaging people from the most affected areas.

Birmingham and Solihull Mental Health NHS Foundation Trust provided a wide range of inpatient, community and specialist mental health services for service users from the age of 26 years and upwards in Birmingham and for all ages in Solihull. These services were located within five service areas: North, East, West and Addictions; South and East Central and RAID; Solihull, Youth and Older Adults; Secure Services, Specialties and Offender Health; and Specialist Psychological Services.

In September 2015, it was announced that the Trust had been successful in a bid to become one of 50 'vanguards' across the country that were developing new models of care.

Birmingham and Solihull Mental Health NHS Foundation Trust was last inspected 12 to 15 May 2014 and received an overall rating of Good. Neuropsychiatry, Perinatal and Rehabilitation Services were also inspected but did not receive a rating. Forensic Inpatient/Secure Wards also underwent an inspection on 25 May 2016[1] at Reaside Clinic; no rating was given for this.

The trust provided the following core services:

- acute wards for adults of working age and psychiatric intensive care units
- wards for older people with mental health problems
- long stay/rehabilitation mental health wards for working age adults
- children and adolescent mental health wards
- mental health crisis services and health based places of safety
- community-based mental health services for older people
- specialist community mental health services for children and young people
- community-based mental health services for adults of working age

What people who use the provider's services say

Before the inspection took place, we met with a group of carers, local authority representatives, commissioners and local health watch.

- The carers raised several issues about the service they and their relatives have received from the trust services. They told us when patients were moved to another team it could be very difficult getting help from the new team if their relative's referral had not yet been accepted. They said that left them feeling isolated.
- The Newington centre was given as an example of a service that worked well with carers through their carer support group. Most of the carers were very complimentary about the Recovery College. They were very concerned about the shortage of beds and the

impact that had for their relatives and themselves. It meant that they could travel for over an hour to visit their relative or attend a ward review. They said there were pockets of excellence but large groups of poor response to their needs. They were concerned about the communication between health and social care. There was a limited range of psychological therapy available and anything other than CBT had to be paid for privately.

- Health watch representatives told us that they continue to work closely with the trust, having been involved in the review of the trust's care programme approach and produced a report that had been shared with the local health economy.
- Patients and carers were happy with the way that staff approached them; describing them as respectful, caring, and responsive. Patients recalled that staff provided contact numbers for crisis resolution home treatment services, in and out of hours.
- Patients reported concerns about the way in which teams delivered services, their involvement in the care planning process, and the involvement and support provided to family member or carers.
- Three of the completed CQC comment cards were negative and related to the quality of care and attitudes of staff at one team in the trust.

Good practice

We found good practice in several areas across the trust:

Forensic wards:

- At Reaside, we found that patients could engage in further education and obtain qualifications up to City and Guilds level. There was partnership working with education bodies to ensure that patients could develop skills and qualifications that could be useful to them on their return to the community.
- At Ardenleigh, the forensic service had developed "The Hub" which was a suite of rooms where patients from both the women's and adolescents pathway could engage in occupational therapy and practical skills. These ranged from art and music sessions to a project to set up a bicycle repair workshop. At The Tamarind Centre, we also found that consideration had been given to developing sessions and methods of engaging the patient group in off ward activities. Horticultural projects had been set up in the grounds and session rooms were well equipped and could deliver a wide range of activities.
- Hillis Lodge had developed community links and patients accessed activities in community settings. We saw that patients used their leave to take part in a wide range of activities from sports groups and health and fitness sessions to religious and spiritual support. As the environment at Hillis Lodge was limited by both its size and location, staff had considered the individual needs and likes of the patients. They had then sourced activities in the local community that were both engaging and therapeutic. We found an extremely motivated staff group who worked well together across all disciplines.
- We saw individual cases of good practice across the forensic services. The trust has developed a project called "Dragons Den" where staff can develop a business plan to create new ways of working and approach the trust for funding. We saw several examples of this across the forensic service. A member of staff at The Tamarind Centre had developed a healthy eating group and had approached the trust for funding for ingredients so that patients could prepare takeaway style food in the evenings and weekends. This had resulted in a significant reduction in take away orders. Funding had also been acquired to buy tools and materials to improve the woodwork rooms and bicycle repair shop at Reaside and Arden leigh.

Older people mental health wards:

- All Ward had 'All about Me' documents which gave a summary of patient's likes, dislikes, preferences, and life history and was used when a patient was discharged and may not be able to tell carers about themselves. It gave any new care setting a good personalised view of the patient to help ensure quality, person-centred care.

Older people community mental health:

Summary of findings

- The trust website provided useful information for patients and for GPs, about how to refer patients to the memory assessment service. There was also a useful presentation GPs could download called "Dementia Recognition and Diagnosis in Primary Care".
- The memory assessment service was accredited with the Royal College of Psychiatrists. It worked closely with the Alzheimer's Society who they commissioned to provide follow-up support and information along with information about local sources of support.
- The service had a care home liaison team, which supported care home staff to positively manage patient need before reaching a crisis point, therefore reducing the risk of placement breakdown.
- Patients could access a wide variety of group therapies to support their wellbeing and recovery.

Mental health Crisis and Health based places of safety:

- The trust provided staff with additional safeguarding training that was appropriate to the communities they served, for example, female genital mutilations.
- The trust's electronic incident recording system included 'It Takes 3', a serious of short films sharing learning from incidents across the trust with staff.

Specialist Community mental health teams for Children and Adolescents:

- Staff at the looked after children services, had delivered adoption preparation training. Provided clinical advice on attachment, brain development and trauma and delivered a fostering resilience programme to parents beginning their fostering journey.

Areas for improvement

Action the provider MUST take to improve

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

- The trust must consider using mirrors on wards with multiple blind spots to mitigate against ligature risks to patients.
- The trust must ensure fridge temperatures are monitored and recorded routinely and that staff know the procedure for reporting issues when they arise.
- The trust must ensure healthcare assistants receive training in the Mental Health Act and Mental Capacity Act.
- The trust must ensure section 17 leave paperwork is completed fully, recorded properly and accessible to patients.
- The trust must ensure that capacity to consent to treatment forms are completed and decision specific.
- The trust must ensure section 62 paperwork is reviewed and that referrals are made to SOAD in a timely manner.
- The trust must ensure that it undertakes active and individual assessment of risks posed to patients who return from leave and use this in order to base decision on searches.

Child and adolescent mental health wards

- The Trust policy on rapid tranquilisation must be inline with guidance issued by the National Institute for Care and Health Excellence in May 2015.
- The trust must ensure that patients' have access to a clock whilst in seclusion.
- The trust must ensure that the practice of adult patients being transported to and using the seclusion facilities on CAMHS wards is reviewed and addressed.

Forensic inpatient/secure wards

- The provider must ensure procedures are put in place to ensure that monitoring of clinical equipment is undertaken and recorded.
- The provider must ensure that seclusion procedures maintain the dignity and safety of the patient, other service users and staff.

Long stay/rehabilitation mental health wards for working age adults

- The trust MUST ensure that it undertakes active and individual assessment of risks posed to patients who return from leave and use this to base decision on search.
- The trust must take action to ensure that all fridge temperatures are recorded daily.
- Trust must consistently maintain medicine at correct temperatures in all areas.

Summary of findings

- The trust must take action to ensure that staff are aware of procedures to follow when fridge temperatures are not within the normal limits.
- The Provider must take action to ensure patients are discharged in a timely manner.

Mental health crisis services and health-based places of safety

- The trust must ensure that a process is in place to record relevant details in a prescription stock control system to aid reconciliation and audit trailing.
- The trust must ensure allergy status of patients is completed on all prescription charts in a timely manner.
- The trust must ensure that staff have access to appropriately lockable cases to transport medications between crisis resolution home treatment bases and patient's homes.
- The trust must ensure that staff at the health based place of safety have access to personal alarms and patients have access to alarm points when using trust facilities.
- The trust must ensure that all alarm triggers used at the psychiatric decisions unit are effectively checked and maintained.
- The trust must ensure that effective processes are in place to monitor the quality of recorded information for all patients assessed in the health based place of safety.

Community-based mental health services for older people

- The trust must ensure that they have processes in place to monitor and support the safe and secure handling of medicines.
- The trust must ensure that staff caseloads are manageable.

Specialist community mental health services for children and young people

- Consent to treatment is routinely established and recorded within care records.
- Consideration of capacity to consent and Gillick competence is routinely established and recorded within care records.
- Identification of parental responsibility is routinely established and recorded within care records.
- Care plans and risk assessments are completed in a standardised format and shared with people using the service.
- Prescription pads are stored securely in line with trust policy and guidance.
- Audits are carried out of prescribing protocol and practice in the community teams.
- Policies and procedures are reviewed and updated inline with identified timescales.
- Ligature risks are identified and mitigating factors put in place to reduce risk to people using services.
- Locations with shared access to waiting rooms must have safeguards in place to monitor people entering or leaving the building.
- Lone working practice and personal safety protocols are used in both community locations in accordance with trust policy and guidance.
- Interview rooms are fitted with alarms and staff have access to and are trained in the use of personal alarm systems.
- There are sufficient numbers of skilled and qualified staff to provide an effective service.
- Staff receive appraisals and managerial supervision inline with trust policies, and records are maintained of this process.
- Equipment for the use of physical health monitoring is maintained in line with manufacturers recommendations.
- Cleaning and maintenance schedules and audits are in place for toys used by children and young people at the community teams.

Wards for older people with mental health problems

- The service must ensure appropriate mental capacity assessments and best interests decisions are in place when administering medicines covertly for physical health conditions.

Provider/Quality report

- **The trust must ensure that it undertakes active and individual assessment of risks posed to patients who return from leave and use this in order to base decision on searches**

Action the provider SHOULD take to improve

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

Summary of findings

- The trust should improve access to psychological therapies for patients on acute/PICU wards.
- The trust should ensure all wards are completing regular audits.
- The trust should review the windows in the entrance doors to the ward at Newbridge House as this could compromise patient's privacy and dignity.
- The trust should display notices in other languages explaining that leaflets in those languages are available on request.
- Trust should ensure that the prescribing,administration, and monitoring of physical health of patients are completed as detailed in the NICE guidelines [NG10] on-Violence and aggression: short term management in mental health, health and community settings.
- The trust should address the issue of beds and the fact patients on overnight leave sometimes have to return to another ward effecting continuity of care.
- The trust should review the actions it takes when an informal patient refuses to be searched on admission.

Child and adolescent mental health wards

- The trust should ensure that informal patients on Larimar ward have timely access to an escort to leave when they request to do so.
- Hand gel should be available in all areas where it indicates people should adhere to hand hygiene.
- The trust should ensure that patients on Atlantic and Pacific have access to seclusion when needed.
- The trust should ensure staff training rates for emergency life support meet the trust target of 85%.
- The trust should display notices in other languages explaining that leaflets in those languages are available on request.
- Staff undertaking the daily environment 'sharps'checklist on the medium secure wards should ensure ward documents are signed to indicate that the tasks have been completed.

Community-based mental health services for adults of working age

- The trust should ensure that fridge temperatures are regularly checked.
- The trust should ensure that care plans can evidence that they were written collaboratively with patients.
- Posters and information on information boards should be written in languages that are spoken by the local communities.

Forensic inpatient/secure wards

- The provider should ensure that there is a consistent approach to the recording of risk assessments.
- The provider should ensure that there is a consistent approach to the recording of care planning documentation.
- The provider should ensure that there is a consistent approach to the recording of capacity assessments and the recording of actions taken in line with the Mental Health Act.
- The provider should ensure there is a consistent approach to recording inpatient documentation.
- The provider should ensure that staff and patients are informed and updated about the future plans for services.

Long stay/rehabilitation mental health wards for working age adults

- The provider should take action to ensure that all prescription charts are signed and dated.
- The provider should take action to ensure that the patients' allergy status is recorded on prescription charts.
- The trust Should review the actions it takes when an informal patient refuses to be searched on admission.

Mental health crisis services and health-based places of safety

- Staff should ensure that care records demonstrate patient involvement and the sharing of treatment plans with patients.
- Staff should ensure that care records demonstrate how and with who patient information can be shared with during a treatment episode.
- The trust should ensure that patient facilities at the health based place of safety and psychiatric decisions unit promote comfort and are well maintained.
- The trust should monitor the night time staffing levels of crisis services and health-based places of safety and take action to ensure that the number of staff on duty consistently meets required levels.
- Staff should ensure that they follow agreed lone working practices.

Summary of findings

- The trust should ensure that staff's emergency contact details and regularly reviewed and updated to support lone working practices.
- The trust should ensure that night time staffing at the crisis resolution home treatment service and RAID teams consistently meets agreed levels.
- Staff should ensure that care plans demonstrate the individual needs of patients and patient involvement in the planning of care.
- Staff should ensure that care records demonstrate that staff undertake a physical health examination of patients accessing crisis services.
- The trust should ensure that staff accessible resources used to plan and monitor patient treatment is up-to date.
- Staff should ensure that all patients know how to complain.
- The trust should ensure that patient information is accessible in a range of formats that reflects the diversity of the communities that their services serve.
- The trust should ensure completion rates of all individual mandatory training courses meets the trust's target of 85%.
- The trust should ensure that the length of patient stays at the psychiatric decisions unit do not exceed 12 hours.

Community-based mental health services for older people

- The trust should address waiting times where there are waiting lists for patients to access psychological therapies.
- The trust should consider how they demonstrate to staff that they listen to staff feedback, particularly during times of reorganisation.
- The trust should ensure that staff feel able to report concerns and use the whistleblowing process without fear of recrimination.
- The trust should ensure that staff offer to refer carers to the local authority for an assessment of their needs under the Care Act 2014.
- The trust should ensure all consulting rooms where staff see patients provide facilities which promote dignity and privacy.

Specialist community mental health services for children and young people

- Interview rooms are sufficiently soundproofed to ensure confidentiality is maintained.
- Information for people using the service is available in a range of languages and child friendly formats.

Wards for older people with mental health problems

- Cleaning records were not always completed on Rosemary ward. Checks by the manager of the ward did not note this. Systems should be in place and used to ensure cleaning records are completed.
- The service should consider options for having a safe, therapeutic room for short periods for any patient who might be at risk to themselves or others.
- The service should ensure mental capacity assessments are always clearly completed. On Rosemary and Bergamot wards there were incomplete capacity assessments.
- The service should look further at ways to reduce the number of falls.

Provider/Quality report

- **The trust should review the actions it takes when an informal patient refuses to be searched on admission**
- **The trust should review practice of not allowing patients to buy food from a takeaway shop of their choice**

Birmingham and Solihull Mental Health NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

Birmingham and Solihull Foundation NHS Trust has had 11 MHA review visits since December 2015 to January 2017. Ten of those visits were unannounced and looked at a mix of Domains 1 and 2. In total 70 issues were raised during those visits. The most common areas for issues were; Protecting patients' rights and autonomy' and 'Care, support and treatment in hospital.

Bergamot ward at the Juniper Unit received the most issues in a single visit (10), while Larimar ward at Arden leigh received the fewest (four). The three visits made at locations in the Wards for Older People with Mental Health Problems yielded 22 issues, which was the most of any of the six core services visited. The most common issues highlighted were regarding protecting patients' rights and autonomy and care, support and treatment in hospital.

As at 05 January 2017, 95% of trust staff had undertaken recent training in the mental Health Act. This course is mandatory for staff. One core service failed to achieve the trust's 90% compliance target for this training course. Community Mental Health Services for Children and Young People had the lowest compliance rate with 63%.

The trust's team of MHA administrators and assistants receive regular updates to legislation, policies, feedback from lay managers, lessons learnt and problem solving. The head of mental health legislation leads on the recruitment of Lay managers and provides support and training to them.

Lay managers can give feedback on issues via reports, shared with senior staff. One issue of concern reported was that the suspension of s17 leave for infringing the smoking ban was coming up frequently in Managers' hearings. There were no paper hearings: all panels operated in person, even if the patient chose not to attend. That meant they (patient) could change their mind about attending right up until the time of the hearing.

The trust had a current Mental Health Act policy and staff told us that they were aware of this. Staff we spoke to had a good understanding of the Mental Health Act and explained how to apply it to their work with patients. All staff reported they were aware that support and legal advice were available from the trust's Mental Health Act office. We found that most patients' had their rights under the MHA explained to them on admission and regularly thereafter.

Access to independent mental health advocates (IMHA) was available. Patients we spoke with said that they were aware of these services, able to use advocacy services and staff supported them to do so when required. Mental health advocates we spoke to during inspection told us that staff

were generally confused about the appropriateness to refer to an IMHA or independent mental capacity advocate (IMCA) possible due to not fully understanding how roles differ.

The majority of MHA paperwork was completed and stored correctly. However, nursing staff on the wards for older people with mental health problems carried out capacity to consent to medication assessments rather than the patient's responsible clinician. The community mental health teams Community Treatment Order documentation was, for the most part, up to date, competed properly and stored correctly.

We noted during inspection that the acute inpatient wards had effective MHA administration systems in place that ensured patient files contained accurately completed and up to date documents. Staff followed consent to treatment and capacity requirements and attached copies of consent to treatment forms to medication charts where applicable. Regular audits ensured that staff applied the MHA correctly and there was evidence of learning from these audits.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had a current policy on Mental Capacity Act (MCA) including deprivation of liberty safeguards (DoLS) that staff were aware of and could refer to it. Staff were trained in and had a good understanding of MCA 2005, in particular the five statutory principles. Mental Capacity Act training at the trust was mandatory and had a 90% target compliance level. Of the nine core services, seven had compliance over 90%. The overall trust compliance was 95% in January 2017.

The MCA is not applicable to children under the age of 16. Trust staff working in child and adolescent mental health services (CAMHS) did not use the Gillick competence guidance to ensure they balanced children's rights with the responsibility to keep children under 16 safe from harm.

Advice regarding MCA, including DoLS, within the trust was available from the trust's Mental Health Act and Mental Capacity Act team.

There was a policy on the deprivation of liberty safeguards (DoLS) which staff were aware of and could refer. Staff made appropriate deprivation of liberty safeguards (DoLS) applications when needed. Staff across services assessed mental capacity on a decision specific basis. Patients' were generally involved in decision-making when appropriate and families were involved for those who lacked capacity when making best interest decisions to assist in recognising individual wishes, feelings and culture.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated Birmingham and Solihull Mental Health NHS Trust as **requires improvement** for safe because:

- There was a high use of prone restraint in the trust; out of 1229 restraints between December 2015-November 2016; 580 of which were carried out in the prone position.
- The trust had implemented blanket restrictions with regards to ordering of food from takeaways and also in relation to searches. It is appropriate for the trust to provide patients with information on hygiene rating and explain the benefits, however patients with mental capacity have the right to order takeaways from the shop of their choice. Staff stated that the policies were difficult to apply and did not promote an individualised approach to patient choice or risk.
- The trust did not have a medicine safety officer in post. This was contrary to guidance from NHS England requiring trusts to appoint one. There was limited pharmacy involvement in inpatient settings, which meant that visits to wards by the pharmacy team was cancelled due to low pharmacy staffing levels.
- The trust rapid tranquilisation policy was based on outdated NICE guidance: NG25 2005. This guidance had been superseded by NICE guidance NG10, published in May 2015.
- However:
- The trust had implemented a system of environmental and ligature risk assessments that identified and provided mitigation to protect people at risk of self-injurious behaviour.
- Staffing levels across the trust were safe in the majority of services. The trust had been proactive in the 12 months prior to the inspection in embarking upon a focussed recruitment drive for key staffing areas such as registered nurses and healthcare support workers.
- Mandatory training levels were high across the trust with an average of 94% of staff compliance.
- Staff understood their responsibilities under the duty of candour.

Our findings

Safe and clean care environments

- The physical environment around the trust was generally clean, well maintained and decorated appropriately for the patient groups that it catered for. However, rooms used by young people visiting community teams were lockable from the inside and contained ligature points that could be used by a young person. Staff did not have any means of access to rooms once locked from the inside, meaning that a young person could lock themselves in the room and harm themselves.
- In the acute wards we found blind spots that had not been reduced with equipment such as mirrors. Observation was used to mitigate the risks however, staffing levels and the patient needs prevented a consistent use observation
- The trust-wide ligature risk policy was in date. Managers had undertaken an annual ligature risk assessment in most inpatient areas and patient areas within community team bases (A ligature point is any feature in the environment that could support a strangulation device). . All wards also had updated ligature risk assessments that identified how staff mitigated risks where there were ligature risks.
- The layout of some wards allowed clear lines of sight for staff to observe patients. Where this was not the case for some wards, the trust had installed observation mirrors or used staff observation to mitigate this risk.
- 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 was provided, as well as supporting non-clinical services. In relation to cleanliness, PLACE data for Birmingham and Solihull Mental Health NHS Foundation Trust was 99.6% at the time of inspection. This was just over 2% above the national average of 97.8%.

- On inpatient wards, there were clear arrangements for ensuring that there was single-sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice. Female and male patients did not share any bathroom or toilet facilities and there were separate lounges available on mixed wards.
- Staff on all wards we visited followed infection control principles including handwashing. Wards displayed information on how to follow infection control principles in all key areas. We saw staff using alcohol gel and practising good infection control procedures through hand washing hygiene and food hygiene. All services had regular infection control and prevention audits in place and staff addressed all actions.
- All clinic rooms that we visited appeared clean and most were fit for purpose. Staff checked equipment regularly to ensure that it was in good working order so that equipment was safe for use in an emergency. Not all community team bases had specific clinic rooms but had height and weight measuring devices and equipment for carrying out monitoring of vital signs.
- The trust had a programme in place to carry out portable appliance tests consistently for all equipment used. This included stickers to indicate that staff had checked equipment and displayed next test dates to ensure that it was safe for use.
- There was access to appropriate alarms and nurse-call systems in the majority of services. There were alarm systems in place at all of the community sites where patients attended. Some sites had alarm trigger points within interview rooms, while at others; staff carried personal pinpoint alarms. However, in the health based place of safety staff did not have access to personal alarms which meant they could not summon help quickly if it was needed.

Safe staffing

- The trust had a recruitment strategy in place and recognised its workforce recruitment challenges. The trust had been proactive and focused on improving recruitment. They recognised staff recruitment challenges but had strong nursing recruitment pipeline through local universities.
- At the time of our inspection, we concluded that the number of nurse staffing was generally sufficient on the inpatient wards to provide safe care. The establishment for nursing staff as of 30 November 2016 was 1018 whole time equivalent (WTE) for qualified nursing staff and 595 WTE for nursing assistants. We did find staffing across the crisis resolution home treatment teams to be variable. The trust had determined the numbers for the teams based on population needs and demographics of the catchment areas.
- Crisis resolution home treatment teams held a number of vacancies. Where shifts remained unfilled managers covered the vacancies by using bank staff that either worked within crisis resolution home treatment teams or were familiar with the service. During a night visit we found two night shifts allocated to bank staff had not been filled leaving one nurse to provide a crisis resolution service across the trust.
- Trust data showed an increase in vacancy rates for qualified nurses between December 2015 and November 2016 from 12.2% to 16.1% and a decrease in vacancy rates from 5.6% to 2% for assistant nursing staff.
- As of 30 November 2016, the average turnover rate across core services was 15%. Child and adolescent mental health wards had the highest turnover rate at 38.4% while crisis and health based place of safety had the lowest rate of 6.2%.
- The trust's overall sickness rate for all staff for the 12 months to 30 November 2016 was 4.3%. Child and Adolescent Mental Health Wards had the highest average sickness rate of any core service with 8.5% and Crisis Services and Health Based Places of Safety the lowest with 4.2%.
- Between December 2015 to November 2016 there were a total of 32,797 vacant shifts across the trust. The overall percentage of total shifts for qualified nurses filled by bank staff over the period was 42%. Long Stay/ Rehabilitation Wards for Working Age Adults had the highest rate of 88%, whilst Child and Adolescent Mental Health Wards had the lowest of 9.6%.

Requires improvement

Are services safe?

- The greatest demand for qualified bank or agency staff to fill shifts came from the forensic inpatient secure wards. We reviewed the trust data for staff fill rates for a twelve-month period from December 2015 to November 2016. This data indicated how many shifts were staffed at any given point in time. It showed that the average fill rate for qualified nursing was 88% on day shifts and 91% on night shifts.
- Most staff and patients that we spoke with told us that staffing numbers were sufficient to carry out physical examinations, facilitate 1:1 sessions and leave when required. However, in the acute wards and PICU, we found that patient's 1:1 time with their named nurse; escorted leave and activities were sometimes cancelled due to staffing levels and meeting the wide range of needs on the wards. Staff carried out physical interventions when required although this took them away from other areas of the ward and affected the time spent with other patients.
- Community mental health teams had a varied caseload that managers reviewed regularly through caseload management supervision. The Small Heath team had the largest caseload per care coordinator of 82, whilst Ladywood and Handsworth community team had the smallest with 37.
- The trust used a formula to determine staffing levels required within the older adults community service. The formula used the number of referrals and the percentage of patients on the Care Programme Approach to determine the number of nurses required to staff the team. Managers felt the system worked well overall.
- To support the safety of staff working alone in the community, the trust had a lone working policy. Staff were provided with mobile telephones that were enabled as personal alarms and a global positioning system. Most staff were clear about the policy and managers told us they were assured the system worked and it was a useful additional tool for their staff to use when lone working.
- Medical cover was acceptable across inpatient and community services during working hours and included rapid access to a psychiatrist when required. There was an out of hours on call system in place to provide psychiatric medical cover to all services and teams.
- The Trust has implemented a formal target compliance rate for completion of mandatory training. For the twelve months to 5 January 2017, the trust's overall compliance was 94.5%.

Assessing and managing risk to patients and staff

- The trust had policies in place relating to safeguarding and raising concerns (whistleblowing procedures). We found that all but a few staff had received their mandatory safeguarding training and knew about the relevant trust wide policies relating to safeguarding. For the twelve months to 5 January 2017, safeguarding training attainment was 96% across all core services. Most staff described situations that would constitute abuse and could demonstrate how to report concerns and liaise with relevant social care agencies. Staff on the ward for learning disability or autism shared and explained safeguarding procedures in easy read format with patients and relatives.
- The trust did not use a nationally recognised risk assessment; instead, they used a bespoke version to suit the needs of the patient groups. The tools used by staff appeared to be fit for purpose and collected the same information as nationally recognised formats. We looked at the quality of individual risk assessments across all the services we inspected. In total, we viewed 371 treatments records including risk assessments during our inspection. Staff completed the trust's risk assessment at the point of admission and updated these at regular intervals or following any identified change. Staff in teams discussed risk presentations at multi-disciplinary meetings. We saw, where applicable, treatment records containing crisis or personal safety plans developed from concerns identified in risk assessments.
- The trust had a restraint policy, which contained guidance and best practice for restrictive and physical interventions including guidance for children. It also included actions that staff were required to take after an incident; including where to report it and post incident learning. Between December 2015 and November 2016, the trust recorded 1229 uses of restraint. Of these restraints, 580 were prone restraints and 756 resulted in the use of rapid tranquilisation. The trust told us the high level of prone restraints reported was due to staff always recording when patients were put into a prone position for any length of time.

Requires improvement

Are services safe?

- The Positive and Proactive Care Expert Panel oversaw the trust five year violence reduction plans. A multi-disciplinary team of seven clinicians drove the positive and proactive care agenda in the organisation. The panels objectives were a reduction of assaults on staff, service users, and reduce the use of restrictive practice in inpatient services. The trust five year plan and purpose of the panel was to reduce restrictive practice, to reduce assaults on staff and patients by 30% and to reduce the use of restraint and seclusion by 10%. At the time of the inspection, we found that the trust needed to continue to improve in this area concerning reducing the use of restraint.
- The trust had blanket restrictions in place across all services in relation to food ordered from takeaway restaurants. The trust clinical governance committee arrived at a decision that within each ward and team, the ward/reception area will not display promotional materials/takeaway menus, unless they are on the trust list of approved suppliers or have 4 or more stars on the 'scores on the doors' web site. A designated member of staff on the ward took responsibility to ensure an up to date list is kept and reception areas are not displaying marketing material from suppliers where by a 4 or 5 hygiene rating has not been awarded. The blanket policy appeared to be inconsistently managed and difficult to apply. Feedback from patients and staff confirmed this was the case. The trust had further blanket restrictions in place with regards to patient searches for all new admissions and patients returning from periods of leave. The context for this approach derived from a serious incident involving an injury sustained by a member of staff in March 2015. Following the incident, the trust was found by the Health and Safety Executive to be in contravention of The Health and Safety at Work Act 1974; Sections 2 and 3 which relates to the general duty placed upon an employer within the HSWA to ensure a safe and healthy working environment for its employees and those not in its employ. The reasons given by the HSE for their opinion as to why the trust were contravening or have contravened health and safety law were:
- "Whilst acknowledging that the Trust operates within a variety of legal frameworks including both HSWA and The Mental Health Act, the drafting of policies should be made in reference to applicable legislation and policies should be written so as to provide both a reasonable and robust set of policies balancing and addressing both the dignity of service users and at the same time ensuring the safety and welfare of these users, their visitors and those employed to supply their care".
- Following this, the trust search policy was extensively reviewed alongside the need to improve staff members' ability to search service users with the latest technology. The revised policy was circulated for Trust wide consultation, to ensure that the way staff searched service users was consistent, effective and robust. Feedback from staff consistently told CQC that the policy was both difficult and overly time consuming to apply and that recording of searches was poor. It was also clear that the trust interpretation of the HSE judgement resulted in the decision to enforce a blanket approach rather than take a risk based and individualised approach to searches.
- The organisation's seclusion policy was in date. At the time of inspection, the policy contained criteria for secluding a service user, the seclusion environment, long-term segregation, monitoring and evaluating seclusion. For the period of 01 June 2016 to 30 November 2016, data showed 194 uses of seclusion and figures reported 11 incidents of long-term segregation in this period. Of note, the adult mental health services showed the highest number of incidents of seclusion and long-term segregation.
- The trust had personal safety and lone working procedures in place for all teams. In most instances, community staff operated a system that recorded the location for all community visits and staff were provided with mobile phones by the organisation for use when working in the community. Staff completed risk assessments of all patients' before undertaking community visits.

Medicines Management

- The trust pharmacy department had both clinical and supply role. The trust pharmacy services provided medicines and ward-based services for over 100 wards and teams. This included inpatients (intensive care, acute and non-acute), forensic, forensic CAMHS, home treatment, assertive outreach, day units, and community mental health. The trust was rolling out electronic prescribing and had both electronic and paper prescriptions in use at the time of our inspection.

Requires improvement

Are services safe?

- A multi-disciplinary Medicines Safety Group monitored and investigated medication incidents at the Trust. The learning from medicine related incidents was then shared with staff via e-mails and team meetings. However, although there had been a NHS England and MHRA patient safety alert: Improving medication error incident reporting and learning (March 2014) requiring the trust to appoint a Medicine Safety Officer (MSO), there had not been one in post for 12 months. This could have resulted in an increased risk to patient safety.
- Due to the capacity of the team, there was limited involvement of clinical pharmacists in the inpatient multi-disciplinary meetings. Several staff members commented that the ward visits were cancelled at the last minute due to other more pressing dispensary based tasks. In addition, the community-based mental health teams did not have any regular medicines management support to ensure safe and effective administration of medicines. This could have resulted in an increased risk of incorrect safe and secure handling of medicines.
- We saw evidence that medicines reconciliation occurred for each patient admitted to a ward. (Medicines reconciliation is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, or GP). However, we found that the trust's medicine reconciliation policy was considerably out of date and had been due for review in June 2011.

Track record on safety:

- Between 1 January 2016 and 24 October 2016, the trust reported 98 serious incidents requiring investigation (SIRIs). None of these were recorded as never events (never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers). Of the 98 incidents, 59 were Apparent/actual/suspected self-inflicted harm meeting SIRI criteria. The highest number of incidents was 26; these occurred within Community-based mental health services for adults of working age (27%).
- The trust had clear policies and processes for the responding to and reporting of serious incidents. All key findings of incidents across the organisation, themes and learning points, were shared through bulletins and learning lessons, and discussed within staff supervisions.
- Root cause analysis investigations were carried out for serious incidents and subsequent learning shared with staff, including feedback to staff within team meeting minutes ,through supervision and where it took place reflective practice sessions. We saw evidence of changes in practice, for example, guidance on how staff should approached patients when giving medication and which staff might be most appropriate to carry out searches, undertake escorted leave etc. so that patients felt more comfortable.

Reporting incidents and learning from when things go wrong:

- NHS trusts are required to submit notifications of incidents to the National Reporting and Learning System (NRLS). In total 9,203 incidents were reported to the NRLS between 01 January 2016 and 31 December 2016. The majority, 77% of these, resulted in no harm; 20.2% resulted in low harm. Moderate harm incidents accounted for 2.2% of incidents and severe harm incidents accounted for 0.2%. There were 39 incidents categorised as deaths during the period that accounted for 0.42% of all the incidents reported. Adult mental health accounted for 44.7% (4,133) of incidents reported to NRLS, forensic mental health followed with 21.2% (1,952) incidents. Adult mental health accounted for 33 of the deaths reported.
- The NHS safety thermometer measures a monthly snapshot of areas of harm including falls and pressure ulcers. Services can used this as an improvement tool for measuring, monitoring and analysing trends over time. During the period between October 2015 and October 2016, the trust reported 11 new pressure ulcers, 10 falls resulting in harm and no catheter and new urinary tract infections.
- Some of the responses to questions in the NHS Staff Survey 2016 provide circumstantial evidence about the culture of safety and incident reporting. The trust was worse than average for the key finding regarding staff witnessing errors, near misses or incidents in the

previous month, staff reporting errors, near misses or incidents they had witnessed in the previous month, in comparisons with all mental health trusts. The trust scored 3.6 for staff agreeing that they would feel secure raising concerns about unsafe clinical practice, which is also worse the average for all mental health trusts. Some of the responses to questions in the NHS Staff Survey 2016 provide circumstantial evidence about the culture of safety and incident reporting. The trust was worse than average for the key finding regarding staff experiencing physical violence from patient's relatives or the public and also from staff in the last 12 months. The trust was also worse than the average for mental health trusts for staff experiencing harassment, bullying or abuse from patients relative or the public and from staff.

- Staff reported they were aware of how to complete incident forms and their responsibilities in relation to reporting incidents. They were able to explain the process they used to report incidents through the trust electronic reporting systems.

Duty of Candour:

- The trust had a duty of candour policy, which was updated August 2016. The policy stated that its requirements under the duty of candour include a requirement to tell the patient what has happened if a mistake is made and apologise as soon as is reasonably possible. Providing the patient with a full and true account of all the known facts; advising what else the organisation will need to do; providing reasonable support to the patient and follow-up with a written letter which confirms the information already provided, results of further enquiries and an apology. The trust aimed to promote a culture of openness.
- All staff we spoke to during our inspection described a transparent culture of explaining to patients' either face to face or in writing if there had been an error. Staff were able to share examples of this. Inspectors also saw evidence of letters written to patients' and notes in patient files of discussions.
- In the forensic wards, we saw examples of duty of candour during our inspection. Two of these related to explanations given to patients in connection with investigations and one related to communication from medical staff relating to a patients care planning. Both examples were recorded in patients' notes. The incident reporting system had a section on duty of candour, which meant that all staff were reminded about their responsibility.

Anticipation and planning of risk:

- The trust had major incident and business continuity 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.

Requires improvement

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 Birmingham and Solihull Mental Health NHS Trust as **Requires Improvement** for effective because:

- Staff within the specialist community mental health teams for children and young people displayed limited knowledge, understanding or application of Gillick competence.
- Staff on the wards for older people with mental health problems also displayed a poor understanding of the mental capacity act in relation to recording of decisions and how the act applied to administering covert medication.
- Care plans were not always personalised and showed evidence of patient involvement.

However:

- The trust had implemented the 'WHAT' tool that was used for an interactive and informative handover on most wards.
- We found evidence of a multi-disciplinary approach to peoples care delivery, which included external professionals such as local authorities, the GP, third sector and voluntary agencies.
- The trust was a key partner externally in several of the local vanguards and new models of care. Feedback from local partners in health, local authority and oversight groups was positive.
- Staff were involved in a range of clinical audits to monitor the effectiveness of the services provided. These included audits of infection control and prevention, health and safety and physical health.

Our findings

Assessment of needs and planning of care

- We examined 371 treatment records across the services inspected. Treatment records contained the trust's initial comprehensive assessment completed on patient's first appointment.
- Care records showed, in most trust services, that staff completed care-planning processes in a timely manner following patients admission. However, care plans were not always personalised, written in patients' own words, demonstrated choice or were recovery orientated. Staff in the child and adolescent community service did not routinely use care planning documentation.
- At the time of inspection, the information needed to deliver patient care was stored on electronic care notes. There was an index that clearly demonstrated to staff where they could find the information they needed. This meant that records were stored securely and could be accessed by staff from different locations. Staff accessed the electronic system on computers with individual passwords.

Best practice in treatment and care

- Staff followed national institute for health and care excellence (NICE) guidelines such as the use of antipsychotics for people with dementia, prescribing and the management of personality disorders. However, the trust policy covering rapid tranquilisation was based on previous NICE guidance NG25 2005. This guidance had been superseded by the NICE NG10 guidance, May 2015. The updated guidance advised how to treat patients in order to manage episodes of agitation, when other calming or distraction techniques had failed to work. We found the prescribing at the Trust to be in line with their policy; however, this was not always in line with current NICE guidelines. This was evident within the CAMHS service, where patients were prescribed medicines outside current NG10 guidelines for young people.
- Services monitored physical health needs of patients' and ensured physical health care plans were current. The wards carried out regular physical health checks to

enable earlier detection of any illnesses and monitored patients' weight, blood pressure, lifestyle choices such as diet and exercise and side effects from medication. Patients' had access to specialists when required.

- Trust services offered patients a wide range of psychological therapies including cognitive behaviour therapy, dialectical behavioural therapy, cognitive analytic therapy, anxiety management, methods of assessing behavioural functions, coping skills, emotion management and solution focussed therapy.
- Staff across the trust's services used a range of outcome measures such as health of the nation outcome scales (HoNOS), model of human occupation screening tool (MoHOST) and health equalities framework (HEF) to ensure that staff closely monitored patient progress and recovery.
- For patients identified as at risk, teams used falls screening and the waterlow assessment tool for assessing the risk of pressure sores.
- Staff were involved in a range of clinical audits to monitor the effectiveness of the service provided. The records reviewed included care records, medicines, infection control and prevention, health and safety and physical health audits. Where staff identified areas of improvement, action plans were completed and followed up. Staff used the findings to identify and address changes needed to improve outcomes for patients.

Skilled staff to deliver care:

- The trust had the right staff with the right skills in most services to deliver good and safe treatment and care. All teams were multidisciplinary and where they did not have a particular profession, links were made with appropriate teams and agencies in order to provide advice and support.
- Acute wards had had occupational therapists allocated as part of the establishment figures and had taken on tasks normally fulfilled by nursing staff. They informed inspectors that they had received training to do this and felt supported by ward managers; however, they felt concerned about losing their professional identity. Occupational therapists had one day a week where they were outside of the establishment figures so they could complete their assessments but felt this was not long enough to complete these and write reports. Some felt that there was disconnect between safe staffing levels and therapeutic staffing levels. The trust carried out appropriate consultation and impact assessments prior to commencement of the integrated model. Risks identified included an increase in turnover, loss of skills/ knowledge and impact on continuity of service and care provision.
- All new permanent staff completed a formal trust induction. This involved attending a corporate induction, learning about the trust and trust policies, followed by a period of shadowing existing staff before working independently. Most services also offered new staff local inductions in which they shadowed all disciplines of the team to support and familiarise them with the team functions.
- Across the organisation, the trust was investing in recruiting the right staff for the right roles to deliver care. Although senior management acknowledged that there were still some areas that required further recruitment, strategies were in place to address these areas.
- Staff had opportunities to receive the training they required to undertake their roles. Some healthcare assistants trained to NVQ level 3 and that gave them the opportunity to apply to take part in a programme to become band 4 associates. Staff across the CAMHS wards had access to weekly-continued professional development sessions such as training in autism spectrum condition. Staff in older adults' community had opportunities for further training such nurse prescribing.
- Most staff in the organisation received management and clinical caseload supervision regularly.
- The average appraisal rate for non-medical staff across the trust was 87.8% at the 30 November 2016. Long stay rehabilitation had the highest appraisal rate of 95%. Community based mental health services for children and young people had the lowest appraisal rate of 72.1%. The key finding 'quality of appraisals' was also within the average range for mental health trusts and scored around the same as the 2015 survey.
- For the period 1 December 2015 to 30 November 2016, the trust reported that 97% of doctors had revalidated.

Requires improvement

Are services effective?

- Staff had access to regular team meetings. Meeting minutes enable those who did not attend to be informed of discussions and information shared. Some team could access group supervision in addition to individual supervision.
- Student nurses at the trust at the time of inspection told us that they felt well supported through inductions, mentoring, shadowing opportunities and involvement in multi-disciplinary team meetings and regular reflective practice groups. This group of staff told us that they had experienced and observed evidence based practice, patient and carer engagement in care planning and very good activity co-ordination on the inpatient wards.
- The organisation addressed poor staff performance promptly and effectively. Team leaders and managers in services across the organisation demonstrated when and how to escalate concerns and knew how to access support from human resources or occupational health teams.

Multidisciplinary and inter-agency team work:

- Some of the responses to questions in the NHS Staff Survey 2016 provided circumstantial evidence about the effective team working and the appraisal process. The trust was below the average for mental health trusts in the key finding regarding effective team working.
- All teams that we visited evidenced regular and effective handovers and multi-disciplinary team (MDT) meetings. We attended several MDT meetings in which we observed in depth discussions that addressed the identified needs of the patients' such as risk, discharge planning, changes to care plans, new referrals, waiting lists, safeguarding issues and some teams also had individual patient case study discussions.
- Teams worked well internally within the trust and established effective networks and relationships with relevant agencies externally. The trust overall had developed and built upon relationships with external organisations. The trust was a key partner in the MERIT, Solihull together for better lives and modality vanguards as well as the local sustainability and transformation plans. Furthermore, the trust was a partner in the newly developed 'accountable care organisation' with other NHS and independent sector organisations. Feedback from local partners in health, local authority and oversight groups was largely positive.

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

- Staff were trained in and had a good understanding of the Mental Health Act (MHA), the Code of Practice and the guiding principles. Mental Health Act training and the mental capacity act and deprivation of liberty training was combined and non-mandatory with a 90% target compliance level. Of the nine core services, eight had compliance rates of 90% or more, leaving four services below the trust target. The overall compliance against Mental Health Act training was 95%. Community Mental Health Services for Children and Young People had the lowest compliance of 63%.
- Staff across the trust reported they were aware that administrative support and legal advice on the implementation of the MHA and its code of practice was available for staff from the Mental Health Act office and Mental Health Act managers. The MHA team carried out regular audits across services to check that staff applied the MHA correctly.
- Staff adhered to consent to treatment and capacity requirements and attached copies of consent to treatment forms to medication charts where applicable. Section 17 paperwork on the acute wards and psychiatric intensive care units did not always give detail of the condition of the leave or the number of escorts needed.
- Patients in most services across the trust had their rights under the MHA explained to them on admission and regularly thereafter.
- Access to independent mental health advocacy services was available. We saw posters with information of how staff could support patients to engage with the independent mental health advocate when needed. Patients we spoke with said they were aware of these services, able to use advocacy services and staff supported them to do so when required.
- The trust's team of MHA managers received training on the revised code of practice, regular refresher training for in-depth issues and managers' forums held

throughout the year for development and support. Mental Health Act associate managers spoken with detailed knowledge and awareness of the legislation, systems and processes associated with the exercise of their powers of discharge under section 23 of the MHA. The managers told us they received specific training in respect of the Code of Practice and were provided with regular legal update training and support. They focused on appeals and renewal panels and were aware of their wider responsibilities when interviewed.

Good practice in applying the Mental Capacity Act

- Staff were trained in and had a good understanding of Mental Capacity Act 2005, in particular the five statutory principles. Mental Capacity Act training at the trust was non-mandatory for healthcare assistants. Of the nine core services, seven had compliance rates of 90% or more, leaving four services below the trust target. Overall compliance against Mental Capacity Act training was at 94.9%. Community Mental Health Services for Children and Young People had the lowest compliance rate with 50%.
- Advice regarding MCA, including DoLS, within the trust was available from a number of sources including managers, best interest assessors, the intranet and the MHA administration team. Staff on the wards for older adults supported patients to make decisions where appropriate. Where they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history. Staff showed a good awareness of the capacity of patients with dementia to make specific decisions.
- There was a policy on the deprivation of liberty safeguards (DoLS) which staff were aware of and could refer. This outlined how the DoLS would operate within the trust and included a statement of the principles, an overview of the process and a definition of the responsibilities of all partners.
- The majority of staff reported a good understanding of the Mental Capacity Act (MCA) 2005, in particular the five statutory principles. Staff were able to demonstrate knowledge of how to access support and advice in connection with the MCA. They could give examples of steps that they had taken to assist a patient in making a decision and described occurrences where staff had made decision specific capacity assessments.
- Deprivations of Liberty Safeguards (DoLS) applications were made when required. Between 1 June 2016 and 30 November 2017, the trust made 40 DoLS applications; 23 of which (57.5%) were granted. All 40 DoLS applications made were in the Wards for Older People with Mental Health Problems core service.
- The MCA is not applicable to children under the age of 16. Staff should use the Gillick competence, which balances children's rights with the responsibility to keep children safe from harm, for those under 16. Staff we spoke to within child and adolescent mental health services (CAMHS) did not demonstrate knowledge or application of Gillick competence.
- Staff across services assessed capacity to consent to treatment on a decision specific basis. We saw detailed information on how capacity to consent or refuse treatment had been sought.

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 Birmingham and Solihull Mental Health NHS Trust as **good** for caring because:

- The trust's overall score for privacy, dignity and wellbeing in the patient led assessments of the care environment (PLACE) 2016 was 93.9%, which was around 4.2% higher than the England average of 89.7%. All sites scored above the national average.
- We saw that staff interacted with patients' in a positive, friendly and respectful manner and most patients' we spoke to were positive in their views of staff.
- Most wards had information and systems to orientate patients at the time of their admission.
- Wards had regular community meetings that were recorded and the notes displayed on the wards for everyone to read.
- The trust had developed the 'See Me' project for service users that involved them in forums and meetings across the trust.

Our findings

Kindness, dignity, respect and support:

- The trust's overall score for privacy, dignity and wellbeing in the patient led assessments of the care environment (PLACE) 2016 was 93.9%, which was around 4.2% higher than the England average of 89.7%. All sites scored higher than the national average.
- The staff Friends and Family Test (FFT) launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff and patients whether they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work. On average 90% of patients' responding to the trust's Friends and Family Test were either 'likely' or 'extremely likely' to recommend the trust as a place to receive care, compared to the national average of 80%. On average 14% percent of staff were 'extremely unlikely' to recommend the trust as a place to receive care.
- The trust performed 'about the same' as other trusts in the care quality commission (CQC) Community Mental Health Patient Experience Survey for all questions.
- Throughout our visit, we saw staff interacting with patients' in a positive, friendly and respectful manner and most patients' we spoke to were positive in their views of staff. We also observed staff speaking about patients' positively in referral and multidisciplinary meetings. Most patients' said that staff addressed their individual needs in care planning and care. All staff were found to be caring and respectful during inspection.
- Most teams had systems in place to welcome and orientate new admissions to their wards and services.
- We saw that staff maintained patient confidentiality by using only trust approved electronic communication systems, storing records correctly and not discussing patient information in public areas.

The involvement of people in the care they receive:

- Most inpatient wards facilitated regular community meetings where staff took notes and displayed these on the wards. Patients in the acute and psychiatric intensive units had lots of opportunity to feedback on the service they received. They could do this by completing a form, in community meetings or by talking to the peer support worker or the 'See Me' worker.
- We did not see evidence on the wards of patients being involved in service development and recruitment although the trust showed a commitment to using former patients by employing them as peer support workers.
- In the community services for adults, we saw there was appropriate involvement of, and provision of support to families and carers. Patients felt that staff took families opinions into account and one patient told us in detail how the trust supported their daughter as their carer and worked to meet her needs.

Good

Are services caring?

- The trust provided comments boxes in waiting areas to capture the feedback of people using trust services. Staff told us that patients could leave feedback on the trust's website. The trust had developed 'See Me' user involvement project to gather insight into users' views and to obtain feedback on services. They organised regular meetings and encouraged service users to get involved in training, interviewing and other project works. The See Me user involvement workers had a place on all key trust meetings and supported users to attend those meetings.

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 Birmingham and Solihull Mental Health NHS Trust as **Good** for responsive because:

- Most teams were responsive to the needs of patients who required access to services during periods of crisis or for routine appointments. Staff were proactive in reaching out to patients who did not attend for appointments.
- The trust's approach to managing and investigating complaints was effective and confidential involving a patient experience team, patient advice and liaison service (PALS) team. The organisation disseminated lessons learned from complaints through a process that included the circulation of a newsletter to all staff and through team meeting discussions.

However:

- Some patients had long length of stays in forensic and long stay rehabilitation mental health wards.
- In some services, information for patients who did not speak English as a first language was also displayed in English. This meant that Non-English speakers might suffer a delay in accessing treatment or support.
- Between December 2015 and November 2016, 164 patients were placed out of area.
- We found that over 300 patients experience delayed transfer of care.

Our findings

Service planning:

- The trust planned services to meet the needs of the local population of Birmingham and Solihull. The trust delivered services to a catchment population that was ethnically diverse and characterised in places by high levels of deprivation, low earnings and unemployment. These factors create a higher requirement for access to health services and a greater need for innovative ways of engaging people from the most affected areas.
- We found good involvement of external stakeholders in the planning and delivery of services. The trust had embarked on a partnership with other providers to establish a forensic pathway with support from NHS England. Feedback from the local clinical commissioning groups (CCG's) was that the trust had improved their engagement and involvement of the CCG's; particularly in relation to addressing the establishment of Forward Thinking Birmingham services.

Access and discharge:

- The trust operated a single point of access (SPOA) for all mental health referrals to the trust from professionals from 08:00am to 7:30pm Monday to Friday. On receipt of a referral, staff contacted patients directly, recording a range of information including contact details, an assessment of risk and safeguarding. Staff prioritised referrals to crisis resolution home treatment teams; when a risk was identified, the SPOA staff contacted emergency services.
- Crisis resolution home treatment teams acted as a gatekeeper to inpatient beds in the trust. The trust reported that it had achieved the national 95% target for the proportion of admissions to acute wards gate kept by crisis resolution home treatment teams.
- The trust provided details of bed occupancy rates for 45 wards from 01 December 2015 to 30 November 2016. Forty-one out of forty-five wards had bed occupancy rates of 85% and above. The ward with the highest average bed occupancy was the Lavender Ward at the Zinnia Centre (Acute Wards for Working Age Adults and PICU) 121.6%. Of the four wards with bed occupancy below 85%, three of these were in Child and Adolescent Mental Health Wards.The trust had discussed bed occupancy with commissioners who had commissioned an independent review of mental health inpatient bed capacity'

Good

Are services responsive to people's needs?

- Across the trust, average length of stay from 01 December 2015 to 30 November 2016 was 265.3 days. During this period, discharged patients had an average length of stay ranging from 1,743 (Hills Lodge, Forensic Inpatient/Secure Wards) days to 2.7 days (The Barberry, Acute Wards for Working Age Adults and PICU). The high lengths of stay were attributed to a group of patients who had a bed for life and some patients were subject to Ministry of Justice approval before discharge could occur.
- Bed occupancy in Acute/PICU wards from December 2015 to November 2016 the average for these wards was 105%. Only two wards averaged occupancy under 100%. The trust had a bed management team who looked at the availability of beds on a daily basis. Due to a shortage of beds, patients were allocated a bed that was not always on the ward nearest to their home.
- Patients on overnight leave often found that no bed was available upon their return and they would be allocated a bed in another ward, which might not be on the same hospital site. This affected continuity of care for patients.
- Readmission figures for the period 01 December 2015 to 30 November 2016 show readmission of 168 patients' (across 24 wards). The significant majority of readmissions within 28 days occurred in Acute Wards for Working Age Adults and PICU with 154 (91.7% of all readmissions within 28 days).
- One hundred and fifty six patients' experienced a delayed transfer of care from 01 December 2015 to 30 November 2016. Over this period, the number that was the responsibility of the trust was higher than the number that was the responsibility of the social care in 11 out of the 12 months (and equal in the remaining month). The majority of delayed transfers of care were attributed solely to the NHS. This amounted to 64.3% in the period. There was an increase in the number of delays that were the responsibility of the NHS, which started in July 2016 and continued to rise until the end of December 2016. The final two months of the period saw the highest two months in terms of overall total. Over the 12 months, the most prominent reasons over the year were as follows: awaiting further NHS non-acute care (123 patients delayed accounting for 34.6%), awaiting nursing home placement or availability (74 patients delayed accounting for 20.8%), and awaiting residential home placement or availability (68 patients delayed accounting for 19.1%).
- Between December 2015 – November 2016, there were 156 delayed discharges at the trust. Mental Health Wards for Older People had the highest percentage of discharges being delayed (28.8%) and Forensic Inpatient/Secure Wards was the second highest (23.4%).
- Out of area placements from December 2015 to November 2016, showed 164 adult inpatients' placed out of area for care and treatment in this period. These all related to the acute wards for working age adults and the PICU core service. The average length of placements was 40.4 days. The longest placement took place between 02 January 2015 and 09 January 2016 (372 days), two other placements lasted longer than 360 days, one 364 days and one 363 days. Post inspection the trust provided figures which showed that the range of out of area placements between October 2016 and February 2016 was between two and six , showing a good improvement.
- The community teams for adults took a proactive approach to engage with people who found it difficult or were reluctant to engage with mental health services. Those included conducting assessments at home, visiting with other professionals if required and visiting when supportive family members or carers were there.
- We saw the teams took a pro-active approach to re-engaging people who did not attend appointments by visiting them at home or engaging their GP or other professionals involved in their care. Duty staff also conducted safe and well checks weekly for patients who had not responded to either telephone calls or letters.
- Between June and August 2016, services follow up 97% of patients' on the Care Programme Approach (CPA) within seven days of discharge from psychiatric inpatient care from this trust. This was slightly above the national average of 96.8% and above the trust target of 95%. In the previous three quarters, the trust was below the England average in two out of three quarters.

The facilities promote recovery, comfort, dignity and confidentiality:

Good

Are services responsive to people's needs?

- The majority of the trust's services had the quantity and range of rooms and equipment needed to support treatment and care.
- In relation to food, PLACE data (self-assessments undertaken by NHS and private/ independent health care providers) for Birmingham and Solihull Mental Health NHS trust was 98.1%. This was 6.2% more than the national average. Eighteen of the 21 sites scored higher than the national average; of which, 11 sites scored 100%.
- All services were effective in displaying information at main receptions and notice boards around buildings. Information included details of patient rights, how to complain and support services available.

Meeting the needs of all people who use the service:

- The trust had patient information leaflets in English for people who use services. Staff showed inspectors that when a leaflet was needed in another language, they were able to print in the required language. However, in some services, information for patients who did not speak English as a first language was also displayed in English. Staff in the hubs had a list in a variety of languages which patients and carers could point to and identify the language they would find most useful. Staff could then access leaflets in the required language. Some teams had staff who spoke more than one language.
- All services had access to interpreters and staff could describe how to access these when required.
- Patients could access hot drinks and snacks 24/7 on the all wards. Food and menu choices also reflected the diversity of the trusts catchment area and catered for religious and dietary requirements.
- Most inpatient wards and community team environments were fully accessible to people with physical disabilities. Patients' had access to faith rooms though not always on the ward they were on. Staff told us that they proactively supported patients' to access faith centre on hospital site or in the community to meet their spiritual needs.
- Almost all rooms were private and appeared to be comfortable. However, consulting rooms used by the East Hub had poor soundproofing, which meant that conversations could be overheard. The consulting rooms at the North Hub had glass panels in the doors. These rooms were situated on a busy corridor and during the inspection, we saw people looking in at the windows.
- Across all wards and teams, there was accessibility for people with mobility issues or disabilities.

Listening to and learning from concerns and complaints:

- The trust managed complaints through a team that included the patient experience team, complaints and patient advice and liaison service (PALS). A team of staff trained in root cause analysis to undertake investigations underpinned this approach. A report was submitted to the Trust Board in public each month which detailed the number, type of complaints received by the trust. The organisation learnt lessons from complaints through a process that included the circulation of a learning lessons newsletter to all staff and through team meeting discussions. We undertook an audit of four completed complaints during our inspection. Our findings showed the trust followed robust processes.
- Between December 2015 and November 2016, the trust received 165 complaints. Of the 165 complaints received, 100 (61%) were upheld with 15 fully upheld. The trust referred two complaints to the ombudsman, one of which was partially upheld.
- The trust listened to and learnt from complaints. Patients generally said they knew how to complain formally and said they were happy to raise issues at community meetings or directly with individual staff. Inpatient wards had various information leaflets readily available on how to make a complaint or compliment, and advocacy details. Patients' we spoke with in various services shared examples of historical complaints or concerns, which the trust had listened to and acted on, resulting in refurbished waiting areas and revised practices.
- Staff we spoke with across all services were knowledgeable and confident when discussing the complaints procedure. The majority of staff told us that they would first try and resolve complaints locally and informally in the first instance before escalating then within the organisation. All staff were aware of the trust's policy.

Good

Are services responsive to people's needs?

- Before our inspection, the trust received 19 compliments in the 12 months from December 2015 to November 2016.

Requires improvement

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 Birmingham and Solihull Mental Health NHS Trust as **Requires Improvement** for well led because:

- The trust had not implemented the Equality Delivery System (EDS2). The executive team lead for equality and diversity was unaware that implementation of EDS2 was a legal requirement. Equality analyses were not completed for all major decisions or policies.
- The Board Assurance Framework did not focus on strategic risks and instead was an extension of the corporate risk register.
- Staff groups in several areas reported feeling under-valued and as being unheard with regards to key decisions and service re-design
- The Allied Health Professional (AHP) group lacked identified leadership.
- In seven of the nine services we inspected we found the safe domain required improvement.

However:

- Staff received mandatory training and the trust had an overall compliance rate of 94%.
- Processes for assuring that directors were 'fit and proper' were clear and consistent. We reviewed four director files and found all checks and declarations had been completed.
- Services were well led at local level and staffing was sufficient to provide patients with good care and treatment.

Our findings

Vision, values and strategy

- The trust's vision was:
  - The service integration to be a fully and successfully implemented, holistic approach to care by working in partnership with other agencies and partners
  - To attain excellent, deserved and recognised reputation with all stakeholders.
  - To be providers of choice for an increased range of commissioners and services
  - Staff are proud to work for the organisation and will hold themselves to account for service experience
  - a refreshed and built upon reputation for providing excellent services and care
- The trusts values were to 'put service users at the centre of everything we do' by displaying:
  - **Honesty and openness;** keep each other well informed through regular communication. Have honest conversations and explain decisions.
  - **Compassion:** bring compassion to all our dealings with service users and carers and expect it in our colleagues.
  - **Dignity and respect:** respect all those whom we deal with at work, especially our service users and staff and take action to address those who do not.
  - **Commitment:** commit to help our colleagues provide the best care services that we can. We will do what we say we will.
- Most staff knew and agreed with the organisation's values.

Good governance:

- The trust provided their Board Assurance Framework (BAF). This detailed risks that scored 15 or above ie high risks. It identified gaps in the risk controls which affected strategic ambitions. The four strategic ambitions outlined by the trust were as follows; Quality, Safety, Experience and Effectiveness; Achieve long-term financial stability by being top quartile for productivity, consolidation and protection of current business, growth by acquisition or merger FRR of 4, discipline and rigour; Develop strong, effective, credible, sustainable relationships with key stakeholders, building the Trust's reputation; To have a workforce that is innovative, empowered, engaged, fairly rewarded and motivated to deliver the strategic ambitions of the Trust. We reviewed

the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR). We spoke with relevant Directors regarding the Trust's approach to managing strategic and operational risk. We also observed the Board meeting on 29th March 2017 where discussions took place about external developments and the risks for the trust. The BAF appeared not to focus on the four strategic ambitions and instead appeared to develop the operational risks present on the CRR, which meant that whilst the Board understood the operational risks, they did not have a clear view of the trusts strategic risks.

- The majority of staff across trust services had received their mandatory training. For the twelve months 05 January 2016 to January 2017, the trust's overall compliance was 94.5%. Four of the nine core services had a compliance rate below the trust average, with Community Mental Health Services for Children and Young People having the lowest of 87.1%. Long Stay/ Rehabilitation Wards for Adults of Working Age achieved the highest rate of 98.3%
- We found at the time of inspection that the staffing was generally sufficient to provide safe care. The overall vacancy rate at the end of the reporting period (December 2015 to November 2016), was 3.4% higher than at the start of the period, which correlated with a drop in the overall number of substantive staff.
- The proportion of non-medical staff who received regular supervision or who had had an appraisal varied across services that we inspected. Most staff in the organisation also received regular management and clinical / caseload supervision. However, not all teams recorded formal supervision, so it was difficult to assess the effectiveness of this.
- The majority of Mental Health Act paperwork was completed and stored correctly. Regular audits ensured that staff applied the Mental Health Act (MHA) correctly and there was evidence of learning from these audits. However, the Mental Health Act associate managers were aware of the issue of renewals and reviews taking place after the end of the original date of detention but had not taken action to address this at the time of inspection. The application and understanding of the Mental Capacity Act varied and was poorly applied within the wards for older people with mental health problems and in the specialist community mental health teams for children and young people.
- Performance data and an escalation and de-escalation system of reporting and monitoring risk informed the trusts risk register. Risks rated less than eight sat on the teams risk register, risks rated between eight to 12 were highlighted on the directorates risk registers and all risks rated over 12 (the highest possible risk) were included at an executive / board level. This system enabled close monitoring at all levels and accountability and responsibility.
- The trust audited and monitored outcomes for patients' using services. This included the monitoring of key performance indicators such as mental health outcomes, physical health, preventing suicide, health records, medicines management, and consent to treatment process, and care plans.
- The trust had clear policies and processes for the responding to and reporting of serious incidents. This involved weekly incident reviews at a senior level and monthly discussions at the clinical governance committee. The trust shared all key findings of incidents across the organisation, themes and learning points through bulletins and learning lessons, and discussed within staff supervisions.
- The Trust' equality governance arrangements sat across the workforce committee and integrated quality committee. With most legally required frameworks not being discussed in sub-committees to enable the delivery of the equality strategy, the governance framework for equality was not deemed to be effective. A quarterly report on equality and diversity was received by the quality committee and reported to the Board monthly via the People Plan report where issues for escalation were identified. An annual report on equality and diversity was presented to the Board and/or its delegated sub -committee. There was no evidence of the trusts implementation of the Equality Delivery System (EDS2) and the senior staff member we spoke with was not aware that implementation of EDS2 was a contractual requirement. There was also a lack of evidence to demonstrate that equality analyses were routinely undertaken for all major decisions in the trust and this was not captured in the trust's risk register indicating the board's awareness of this as a risk to the

organisation. The majority of papers going to the board inspected suggested that there were no equality related implications, despite clear equality related risks resulting from the decisions agreed and recorded. Without adequate training for managers and for the board about their duty to undertake equality, the leads may not have been aware of their equality responsibilities. Some Black and minority ethnic (BME) staff interviewed during inspection were negative about the trust and reported that they felt progression within the trust was difficult for staff from a BME background. However, other staff gave positive feedback and were particularly appreciative of the listening into actions programme, about the 'Dear John' initiative and other work the trust had undertaken.

- From the inspection of policies and interviews undertaken during the week of inspection, the organisation had sound systems, processes and controls in place concerning information governance and records. The organisation operated an electronic record system at the time of Inspection. The trust trained all staff to access all systems to reduce possible risks of not being able to access information when needed at the point of admission or crisis.
- During our inspection, we met with a variety of partner organisations working with the trust including Clinical Commissioning Groups, Local Authority, and NHS England. All spoke positively about partnerships with the trust and found the trust to be open minded, supportive and recovery focused.
- The trust approach to its programme of audit incorporated national, mandatory and trust priorities for audit activity. Staff were involved in a range of clinical audits to monitor the effectiveness of the service provided.

Fit and proper persons test:

- Healthcare providers are required to ensure that all directors are fit and proper persons for their senior roles within healthcare organisations. The CQC requires trusts to check that all senior staff met the stated requirements upon appointment and set up procedures and policies to give continuous assurance that senior remained fit for role throughout their employment.
- The trust had a robust fit and proper person approach that was detailed in the trusts human resource recruitment policy. The policy outlined the process for recruitment, appointment and continually evidencing the fitness of Directors in trust employment.
- We reviewed four board members personnel files. All four of these files evidenced consistent processes undertaken to evidence fitness with external agencies, annual self-declarations regarding fitness for a board level role within the organisation and annual appraisals. All of the files had evidence of current disclosure and barring service (DBS) checks and held evidence of references.

Leadership and culture:

- The trust recorded 20 key findings, which scored below the average for mental health trusts in the 2016 NHS staff survey. In comparison to the trust's results in the 2015 survey, four key findings were worse and 28 did not change. No key findings had improved from the previous survey. The trust has no key findings that were recorded as being above the average for mental health trusts.
- Staff morale varied across the services in the trust. Some groups of staff felt less visible and less valued than other staff groups and were concerned about their professional voice and influence at a senior level. Administrative and clerical staff felt they were not highly regarded and they did not feel consulted on organisational changes. Medical staff, both consultant and trainees that we spoke to during inspection, expressed concerns regarding communication and their inability to influence in the trust. Consultants told us that they were engaged in discussions but not heard. They gave examples of where discussions about changes in the community mental health teams had taken place; however, the implementation resulted in services feeling undermined. We found through focus groups and interviews that allied health professional (AHP) staff echoed the concerns related to increased generic working, specifically in acute wards and psychiatric intensive care units, lessening the impact of allied health professionals' impact on patients' recovery journeys. Most allied health professional staff we spoke with were positive about the director of nursing and their inclusive views. However, all shared concerns that the AHP workforce structure remained without

professional leadership. They felt this negatively affected staff recruitment and retention. Staff felt that if they wanted to progress further they would need to take management positions that did not support the retention of clinical expertise and maturity to benefit the quality of care that patients received. Staff highlighted the current lack of an AHP lead that prevented a strong voice at a senior level. Psychologists we spoke to during the inspection told us that they were particularly concerned about the professional recognition of the psychologists in the Trust and in particular a sense of not being able to contribute their expertise to the service provision. Much of their concern related to New Dawn initiative. The psychologists had been invited to lead on the development of new pathways putting psychological therapy at the heart of the pathway including working to NICE guidance. They felt that the New Dawn strategy resulted in organisation redesign but did not embrace the focus on psychological therapies, which was the core of the proposition.

- Staff sickness rates across the trust, at November 2016 were 4.3%. Child and Adolescent Mental Health Wards had the highest average sickness rate of any core service with 8.5% and Crisis Services and Health Based Places of Safety the lowest with 4.2%.
- Staff experiencing bullying or harassment in the twelve months prior to inspection was above the national average.
- The organisation promptly and effectively addressed poor staff performance across the organisation. Team leaders and managers in services across the organisation demonstrated when and how to escalate concerns and knew how to access support from human resources or occupational health teams.

Engagement with the public and with people who use services:

- The organisation had encouraged service users through the 'See Me' project and the listening into action forums for staff and service users' to influence care and engage in developments. Significant work had been completed in respect lesbian, gay, bisexual, transgender (LGBT) groups but there was a lack of robust initiatives relating to other protected characteristics.
- The trust was starting to re-establish staff for disability and BME networks with strong sponsorship at board level to ensure they have a voice and engage them in a meaningful way.

Quality improvement, innovation and sustainability

- The Trust had established a Recovery College and had recruited twelve peer support workers. A peer support worker is someone who has had personal experience of mental illness and was now using that experience to support other patients on their journey of recover.
- RAID plus was a project to reduce the incidence and intensity of mental health crisis and to scale proven innovations beyond the Birmingham and Solihull area. The RAID Plus Test Bed project is initially focused in Birmingham and Solihull where 1.3million people are resident and around 25,000 people experience a mental health crisis every year. The RAID Plus project seeks to test the combination of predictive analytics, online support tools and visual demand and capacity management systems, with the introduction of a mental health urgent care co-ordination centre and training unit to assess whether patients experiencing mental health crisis and their support networks, benefit more than current practice. This project will aim to build on and improve existing, established services.
- Safe wards had been introduced across all inpatient wards and there was evidence that this, coupled with other individualised violence reductions strategies, had reduced the amount of physical restraint being used across the Trust when compared with levels the previous year.
- The trust had introduced an initiative called 'Dragons Den' whereby staff could approach the trust to request funding for special projects or improvements. We saw several examples where staff had used this process to undertake projects to improve the health or quality of life of patients across the forensic services.
- The memory assessment service was an accredited member of the Royal College of Psychiatrists' Centre for Quality Improvement Memory Service National Accreditation Programme (MSNAP). The Memory Services National Accreditation Programme works with services to assure and improve the quality of memory services for people with dementia or memory problems and their carers. It engages staff in a comprehensive

Requires improvement

Are services well-led?

process of review, through which good practice and high quality care are recognised. The programme also supports memory services to identify and address areas for improvement.Accreditation of the programme aims to assure staff, service users and carers, commissioners of the service being provided. The service was in the process of applying to be re-accredited which was due in April 2017.

- Reservoir Court had received the accreditation for inpatient mental health service (AIMS) in December 2015.
- All of the wards for older people with mental health problems had received Accreditation for Inpatient Mental Health Services (AIMS).

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The provider had blanket restrictions in place for searches of patients returning from section 17 leave with no recording of individualised risk assessments within patients care records. This was a breach of Regulation 9 (1) (a) & 9 (3) (a)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • Patients' dignity and respect was not maintained while in seclusion. This was a breach of regulation 10 (1) (2) (a).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • Patients were given medication covertly for physical health reasons without a mental capacity or best interests meeting having been undertaken for that medication. • Staff had not fully completed capacity to consent to treatment forms and where they had they were not decision specific.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 11(1)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • · New bridge House, Eden PICU, Eden Acute and George Ward had potential ligature points that had not been fully managed, mitigated, or addressed · New bridge House, Eden PICU, Eden Acute and George Ward wards had poor lines of sight. Staff could not easily observe patients. · Staff had not routinely recorded fridge temperatures on all wards. · Staff did not record routine searching of patients in care plans and risk assessments and applied this as a blanket restriction to all patients rather than based on individual need. · Fridge temperatures were consistently recorded over the normal temperature range. No Action taken to manage the situation {C}· Staff did not document the allergy status for all patients on prescription charts {C}· Staff did not sign and date all prescription charts

This section is primarily information for the provider

Requirement notices

{C}· Information on the level of medication for self-administering patients was not with prescription chart. Information concerning risk assessments, patients compliance or audits in relation to self-medication was not available

{C}· The service did not ensure that there were effective processes in place for the safe and secure handling of medicines.

{C}· Some teams had out of date medication.

{C}· Two clinic rooms were dusty and cluttered.

{C}· There were no stock lists of medication held on site.

{C}· The pharmacy team did not carry out regular monitoring of the safe and secure handling of medicines across the service.

· The trust did not have a process in place to record relevant details of prescription stock control.

{C}· Staff had not completed the allergy status of patients on all prescription charts.

{C}· Staff did not use lockable cases to transport medications between crisis resolution home treatment bases and patients homes.

{C}· We found that clinical equipment was out of date and recording of temperatures and daily checks had not been undertaken or recorded in some areas

This section is primarily information for the provider

Requirement notices

{C}· We also found oxygen bottles and clinical equipment such as needles, tongue depressors, clinical trays, biohazard kits and urinalysis sticks that were out of date

This was a breach under Regulation 12 (1)(2)(a) (b) (c)(d) (e) (g) (i)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • Staff at the health-based place of safety did not have access to personal alarms. • The alarm triggers in use at the psychiatric decisions unit had not been effectively checked or maintained. • Shower facilities at the health-based place of safety did not have an accessible alarm point. This was a breach under Regulation 15 (1) (e) Premises and equipment.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • · We found that patients were being transferred to access seclusion facilities on another ward. This ward was registered for the care and treatment of adolescent service users.

This section is primarily information for the provider

Requirement notices

This was a breach under regulation 17 (1) (a)(b)(c)

{cke_protected_1}· Staff had not completed fully section 17 leave paperwork and made this accessible to patients

· Staff had not reviewed section 62 paperwork and made timely referrals to SOAD.

This was a breach of Regulation 17 (2)(c)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Regulation 18 HSCA (RA) Regulations 2014 Safe Staffing • Caseloads in the community mental health team hubs were high. Some staff reported that they worked in their own time to complete essential case recording. This was a breach of Regulation 18 (2)(a) • Healthcare assistants did not receive MHA or MCA training which meant they could not fully support patients in this area. This was a breach off Regulation 18 (1) (2) (a)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment · Patients subjected to blanket restrictions when ordering food from takeaways.

This section is primarily information for the provider

Requirement notices

All patients subjected to searches when returning to wards after any period of leave.