

# Black Country Partnership NHS Foundation Trust

## Inspection report

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall rating for this trust

Requires improvement 

Are services safe?

Requires improvement 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

# Summary of findings

## Background to the trust

Black Country Partnership Foundation NHS Trust provides a range of inpatient and community mental health services to working age adults, older people and children. The trust provides services for people who live predominantly in the boroughs of Sandwell and Wolverhampton, with smaller services offered in Dudley and Walsall.

The trust was part of plans to merge with two other NHS organisations in 2017. The planned organisation was known as Transforming Care Together (TCT). Following two delays to the merger, a final decision was taken by the three boards not to progress with the merger in February 2018. Black Country Partnership Foundation NHS Trust found itself without a substantive leadership team. With the support of NHSI moved to appoint interim executives and trust chair.

The trust provides:

- Mental health and specialist learning disabilities services to people of all ages in Sandwell and Wolverhampton
- Specialist learning disability services in Walsall, Wolverhampton and Dudley
- Community healthcare services for children, young people and families in Dudley

The trust provides the following core services:

- Specialist community mental health services for children and young people
- Acute wards and psychiatric intensive care units
- Community mental health services for adults of working age
- Forensic/secure wards
- Wards for older people with mental health problems
- Community mental health services for older people
- Mental health crisis services and health based places of safety
- Wards for people with learning disabilities or autism
- Community mental health services for people with learning disabilities or autism
- Children, Young People and Families community services

The trust has a staff complement of more than 2000 whole time equivalent (WTE). The trust serves a population of approximately one million people from a variety of diverse communities across the Black Country. The trust has an annual income of about £100 million. Corporate staff work from Delta House, the current trust headquarters building.

The trust was inspected in November 2015 as part of the CQC comprehensive inspection programme and all core services were inspected. We re-inspected the trust in October 2016 to understand if the trust had acted upon the issues we raised as part of the inspection in November 2015. At the time of the October 2016 inspection, Black Country Partnership Foundation NHS Trust did not comply with Regulation 12, Safe care and treatment; Regulation 17, Good governance and Regulation 18, Staffing. During this inspection, we found the trust had not complied with the following regulations; Regulation 9, Person centred care; Regulation 10, Dignity and respect; Regulation 12, Safe care and treatment; Regulation 15, Premises and equipment; Regulation 18, Staffing.

# Summary of findings

## Overall summary

Our rating of this trust went down since our last inspection. We rated it as **Requires improvement**



## What this trust does

Black Country Partnership Foundation NHS Trust provides community services for children, young people and families; inpatient and community mental health services for adults and older people; and community and inpatient learning disability services.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected six complete core services:

- Specialist community mental health services for children and young people
- Community mental health services for people with learning disabilities or autism
- Wards for people with a learning disability or autism
- Mental health crisis services and health-based places of safety
- Acute wards for adults of working age and psychiatric intensive care units
- Wards for older people with mental health problems

These were selected due to their previous inspection ratings or because our ongoing monitoring had identified that an inspection at this time was appropriate to understand the quality of the service provided. Four provided mental health services and two provided learning disability services. Four of the services that we inspected had been rated as good. The other two services were rated as requires improvement at the time of the inspection.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed Is this organisation well-led?

## What we found

# Summary of findings

## Overall trust

Our decisions on overall ratings take into account factors including the relative size of services and we use our professional judgement to reach a fair and balanced rating

Our rating of the trust went down. We rated it as requires improvement because:

- Not all trust properties were clean, well-furnished and fit for the purposes of modern mental health care services. Not all staff always followed infection control procedures. Staff at Pond Lane had poor working conditions. They worked in an untidy, unclean environment with no ambient temperature control.
- Staff were not consistent in following best practice in the use of restrictive practices. Staff on Dale Ward carried out blanket searches which were not in line with the trust policy. Patients on the psychiatric intensive care unit were only able to smoke at set times.
- Staff did not manage medicines consistently well in two services. They did not store or keep them at the correct temperatures.
- Staff in some services did not follow good practice in the development and use of care plans. They did not review care plans regularly and some care plans in wards for people with learning disabilities or autism, did not pay sufficient regard to the monitor of physical healthcare needs of patients relating to diet and weight gain.
- Not all staff across services received regular managerial and clinical supervision or had an identified clinical supervision supervisor.
- We found issues of staff knowledge in the Mental Capacity Act and Gillick Competence in some services. Staff working with children and young people in the Early Intervention Service did not have a clear understanding of Gillick Competence or understand where and why this would be applied.
- In parts of the trust, clinical staff had to use three different electronic recording systems – together with keeping paper notes. This meant that notes were cumbersome and difficult to navigate for people who do not work regularly in the service. However, staff we spoke with were always able to find the information we requested. The trust had plans to implement an electronic patient records system.
- We did not find evidence of a robust recruitment process for all executive directors. When the planned TCT merger ended the trust found itself without a substantive leadership team and with support from NHSI interim appointments were made from amongst senior managers within the trust.
- The governance systems from ward to board were not sufficiently strong to have identified and rectified a number of risks. These included environmental risk assessments which were not always location specific, actions on the risk register that had not been taken and the problems with information governance. We concluded that this was a legacy of the aborted merger. During the period when work was under way to create Transforming Care Together, governance was led by the acquiring trust. When plans to merge ended, this left Black Country Partnership Foundation NHS Trust without a substantive governance lead to direct and develop new systems. The trust had since taken action to strengthen their governance structure by making a senior appointment to lead governance and improve its systems.
- The trust used root cause analysis approach to review serious untoward incidents and mortality lacked consistent challenge at the executive level before reports were signed off. The trust had action plans in place to address this issue.
- The role of Freedom to Speak Up Guardian was held by a trust board member and that could lead to a conflict of interest for the post holder. This had been reviewed and new plans were in place to seek an external solution.

However:

# Summary of findings

- We concluded that the trust board was re-establishing its control of performance following the aborted merger. The trust board operated collaboratively, that meant executives and non-executive directors shared responsibility and liability for decision-making. Apart from the lapses we identified on this inspection, the board had a reasonable understanding of performance, which appropriately covered and combined people's views with information on quality, operations, and finances.
- The trust board were visible across the trust. We observed meetings chaired by the chief executive and heard from staff that they knew who the leaders of the trust were.
- The trust's vision and values pre-dated the previous plans to merge. The trust planned to refresh them with staff engagement. Staff had an understanding of the vision and values in relation to local services.
- The trust had an equality strategy in place which they were refreshing in collaboration with patients and staff for collaborative ownership and effectiveness.
- The trust communicated well with patients, carers, staff and stakeholders. The majority of staff groups felt they knew what was happening in the organisation. Families and carers described a varied experience of communication with staff in the trust but were praising of the support they received from the carers team.
- The trust strived to improve quality and innovation, for example, the epilepsy improvement group to ensure that all inpatients with epilepsy had a care plan to manage the condition with standard documentation across all learning disability units.
- The trust were proactive in attempts to employ people across many of the core services but recruitment of staff remained a challenge.
- The trust recognised its staff in a number of ways, through a simple thank you to formal awards.
- There was a culture of learning and research across the trust.

## Are services safe?

Our rating of safe went down. We rated it as requires improvement because:

- Not all wards were clean, well-furnished and fit for purpose. In particular, the acute wards at Hallam Street Hospital were dirty and poorly maintained. A clinic room was littered, dirty and the ward environments were unclean. Staff at Pond Lane had poor working conditions. They worked in an untidy, unclean environment with no ambient temperature control.
- Risk assessments of the physical environments in which patients received care did not cover all areas, including patient areas. Furnishings in consultation rooms where staff met with patients at Edward Street and Pond Lane were not of a good standard. Consultation rooms were dark, cluttered and uninviting.
- Staff training compliance rates for fire safety and information governance were below 75%.
- The use of restrictive interventions did not consistently follow best practice. Staff on Dale Ward carried out blanket searches which were not in line with the trust policy. Patients on the psychiatric intensive care unit were only able to smoke at set times.
- Staff had not followed the medicines management policy regarding action to take when temperatures go above or below guidelines in two services. Staff were unsure of what actions to take when temperatures were out of range. Staff at Pond Lane did not take appropriate action when medicine storage temperatures exceeded specified ranges.
- Staff within the Early Intervention Service team had not received regular management supervision in line with the trust policy.

# Summary of findings

- Staff did not always follow infection control procedures. For example, on Friar ward they had left wet bedding left in a patient shower cubicle for several hours. The shower cubicle was locked and not accessible to patients.
- We found examples where security of confidential information was not maintained. At two sites we visited, Edward Street and Pond Lane, staff had positioned computers in a way that would allow unauthorised people to view computer screens that might contain personal patient information. Staff rectified this when we raised it as an issue on inspection. We found that one patient care plan had been shredded as one member of staff thought this was procedure. The trust investigated this following inspection, after which we were assured that it was an isolated incident and not systemic practice.

However:

- Every ward for adults of working age had an up to date ligature risk assessment in place, which included photos of all risks to easily identify them. The document contained individual plans telling how to manage risks.
- The wards complied with guidance on mixed-sex accommodation and had areas specifically for male and female patients.
- The environments in child and adolescent mental health services at the Gem Centre and Lodge Road were comfortable and inviting for young people using the service. All rooms at the Lodge Road were identically themed to support with consistency for young people who might struggle with changes to environments. Environmental risk assessments were in place at the Gem centre and included consideration of patient areas.
- Most of the trust's services had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Wards for adults of working age had adequate staffing to meet the needs of patients. Staff in the wards for people with learning disability completed mandatory training and had access to specialist training if required. The trust had implemented the safe wards programme.
- Staff completed person centred physical intervention protocols for all patients who were restrained or had a history of restraint. These aimed to reduce the need for future restraint.
- Learning disability wards had low usage of rapid tranquilisation and only used restraint on patients as a last resort. We saw staff using de-escalation techniques on the wards. Each patient had a positive behaviour support plan which detailed trigger points and explained how to support them if they became distressed.
- Staff received feedback from investigations at handovers and monthly meetings. We found evidence of changes to working practice as a result of this feedback.
- There was a system in place to provide staff with a debrief after serious incidents. This was provided by psychologists attached to each team

## Are services effective?

Our rating of effective went down. We rated it as requires improvement because:

- Not all patients had an up-to-date care plan. Of the 36 patient records reviewed in the Community Mental Health services for people with learning disabilities or autism, 60% of the records did not have a collaborative, personalised or holistic care plan detailing their treatment aims or recovery goals. We found three records within Early Intervention Service and one record in Child and Adolescent Mental Health Services did not contain an up-to-date care plan. Staff had not removed old copies of care plans and reports from patient files at Penrose House which made the files cumbersome and difficult to navigate.

# Summary of findings

- Some patients did not receive a range of treatments based on best practice to support their physical health and encouraged them to live healthier lives. Staff at Daisy Bank had not adequately monitored physical healthcare needs of patients relating to diet and significant weight gain. (The trust completed their plans to close Daisy Bank in September 2018 as part of the national Transforming Care Programme).
- Staff working with children and young people in the Early Intervention Service did not have a clear understanding of Gillick Competence or understand where and why this would be applied.
- Not all staff received regular managerial and clinical supervision or had an identified clinical supervision supervisor. Staff within the Early Intervention Service and staff at Penrose were not receiving regular management supervision.
- Mental Health Act audits were completed but did not show evidence of lessons learnt or actions that had been taken. This had not affected patient care but could do so in the future without improvements.
- In 31 records reviewed in the acute wards doctors had undertaken a routine mental capacity assessment. These assessments were not specific and were being applied to patients for which it would have been reasonable to assume capacity.

However,

- Most staff provided care and treatment based on national guidance and pathways were in line with National Institute for Health and Care Excellence. Staff followed guidelines for a range of issues including best practice in administration of medication, psychological, family and behavioural therapies and interventions in mental health conditions.
- Staff provided a range of care and treatment interventions suitable for the patient group. Patients had access to clinical psychologists and occupational therapists. Staff in the Promoting Access to Main Stream Health Services team were proactive in ensuring that patients' physical healthcare needs were being met. The trust had trained some staff to deliver solution focused training to new staff. This meant staff could offer a consistent therapeutic approach to patients.
- Staff were skilled, experienced and qualified in their area of work. Staff we spoke with demonstrated they had the right skills and knowledge to meet the needs of the patient group. They were up to date with mandatory training. Penrose House and The Larches had access to a wide range of health professionals to support patients. These included speech and language therapists, occupational therapists and psychologists who provided a range of therapies to suit the needs of each patient.
- Staff understood safeguarding and appropriately reported issues. Staff had received training in safeguarding for both adults and children. They knew who to contact at the trust for advice.
- Staff monitored physical health needs appropriately and routinely liaised with children and young people GP to ensure physical health needs were met. Ward staff developed good relationships with staff in community teams.
- Staff engaged in clinical audits and findings were discussed at quality meetings attended by service leads. Good practice was routinely shared and actions from audits were fed back to teams through team meetings and addressed in supervision. Staff participated in benchmarking and quality improvement initiatives.

## Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Staff demonstrated a sensitive, caring and compassionate attitude in their work with young people. They acted in a respectful and discreet manner and were responsive to people who needed emotional support and advice. We found that staff treated patients with care and compassion and permanent staff knew individual patients and their needs well.



# Summary of findings

- Staff supported patients to participate in planning their care. They used easy read information with words and pictures to support patients to understand the care they received. Patients were assessed for a communication passport to be developed on admission to the ward. Staff encouraged family and carers to be involved as much as possible and with the consent of the patients. Apart from protected mealtimes families and carers could visit when they wanted to.
- Staff took person-centred approach in their responses to people using the service. They demonstrated understanding of individual children and young people's personal, cultural, social and religious needs. Staff used a range of methods suitable across age groups and abilities to find effective ways to communicate with young people about their care.
- Most patients had access to regular community meetings on their wards. Wards had "you said we did" noticeboards. Carers were involved in patient care, ward meetings and activities where appropriate. Staff routinely enabled families and carers to give feedback on the service they received and made changes and improvements to the service based on their feedback. Most patients and their relatives gave positive feedback about the wards.
- Hallam Street Hospital had an expert by experience service development volunteer role. This meant patients had the opportunity to work alongside staff on time specific projects to support the development of services and review documents; policies and procedures that affected the experience of patients at Hallam Street Hospital.
- Patients had good access to independent advocacy. Staff ensured patients were referred and made information available to patients on the wards. Staff directed patients to other services and supported them to access those services.

However:

- Staff did not routinely provide carers with information about how to access a carer's assessment.

## Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- The trust had set target times from referral to triage and then to admission for crisis services. All services we inspected were compliant with these targets. The crisis and liaison teams were able to respond very quickly to urgent referrals, usually within one hour. Staff within Child and Adolescent Mental Health Services achieved their target of 18 weeks for referral to assessment. Crisis, Home Treatment and Early Intervention Service met their targets for responding to referrals, there were no young people waiting to access treatment within these teams.
- Staff actively engaged with people who did not attend appointments, found it difficult or were reluctant to engage with the service. They offered flexibility when offering appointments were dynamic and compassionate in their approach to engaging children and young people.
- There were a range of rooms and facilities available across services. These included clinics attached to both health-based places of safety that were fully equipped to deliver care. Equipment was easily available and where required was checked in line with national guidance.
- All services we checked had a range of information available to patients. Information provided was in a form accessible to the patient group for example in easy-read form for people with learning disability.
- Patients knew how to make a complaint and stated that they would feel able to follow the process if required. Staff were well equipped to handle complaints appropriately and within trust policy.
- Staff knew how to access interpreters for patients who required this service.



# Summary of findings

- The trust was part of the West Midland MERIT vanguard, this was a group of neighbouring trusts working together to enable patients access to local beds and reduced the need for patients to travel significant distances for a bed. Most patients had their own bedrooms although some were expected to sleep in bed bays or dormitories.
- Patients had access to a wide range of activities to support recovery in most services.

However:

- There were delayed discharges at Penrose House and Daisy Bank. These occurred due to a lack of suitable accommodation being available for patients with complex needs. (The trust completed their plans to close Daisy Bank in September 2018 following inspection).
- Some patients referred to speech and language or physiotherapy were waiting longer than expected to receive an assessment.
- The liaison team had lost their allocated interview rooms in the hospital where they were based. This meant that they were conducting assessments and interviews in rooms that were unsuitable.

## Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- Although we identified some lapses in governance and the overall trust rating had moved from Requires Improvement to Good, we concluded that the trust board's ability to focus on day to day governance had been hampered because of flux around the proposed merger but we saw evidence that they were picking up the reins again, which demonstrated good leadership.
- The trust board operated collaboratively, that meant executives and non-executive directors shared responsibility and liability for making decisions.
- There was a rounded understanding of performance, which suitably covered and combined people's views with information on quality, operational services and finances.
- The trust board were very visible across all services of the trust. Many staff told us that they knew and saw the executive team visiting services. The chief executive held regular meetings across the trust for staff to come and share their experiences working within their services.
- The trust understood the challenges to quality and sustainability, and identified the actions required to address them. This aligned to the wider health and social care economy of the Black Country. There was good leadership at trust board and its input into the sustainability and transformation partnership level.
- The trust had retained its vision and values for the organisation. The strategy and priorities of the trust aligned to its vision and values. Staff had an understanding of the vision and values in relation to local services.
- Staff told us they could influence change within the organisation. Staff had been consulted on changes to the structure of wards for people with learning disabilities and had the opportunity to contribute to strategy and design. Staff felt able to report concerns and incidents and knew how to do this.
- Staff we spoke to felt respected and listened to by their managers and senior managers within the trust. They stated that they felt a sense of pride in their role and the trust in general. The trust recognised staff and volunteers' staff in a number of ways, through a simple thank you to annual achievement awards.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems. Managers had access to systems to support them with their role, including access to data and dashboards showing service and staff performance information.

# Summary of findings

- The trust had an equality strategy in place which they were refreshing in collaboration with patients and staff for collaborative ownership and effectiveness.
- Staff, patients, and their families had access to up to date information about the trust. The trust communicated well with patients, carers, staff and stakeholders. The majority of staff groups felt they knew what was happening in the organisation. Families and carers described a varied experience of communication with staff in the trust but were praising of the support they received from the carers team.
- There were arrangements in place to identify, record and manage risks. Patients mental and physical health was assessed, and care and treatment planned.
- The trust worked hard to improve quality and innovation, for example, the epilepsy improvement programme to ensure that all patients with epilepsy had a comprehensive plan for the management of the condition.
- Recruitment of staff was a challenge to the trust but they were proactive in attempts to employ people across many of their services.

However:

- We did not find evidence of a robust recruitment process for all executive directors. When the planned TCT merger ended, the trust found itself without a substantive leadership team and with support from NHS Improvement, interim appointments were made from amongst senior managers within the trust.
- Governance systems from ward to board provided performance management information to make decisions needed further strengthening. Including environmental risk assessments, risk register actions and information governance. During the TCT process, governance was led by the acquiring trust. When plans to merge ended, it left the Black Country Partnership Foundation NHS Trust without a substantive governance lead to direct and develop new systems. The trust had acted to strengthen their governance structure by making a senior appointment to lead governance and improve its systems.
- Actions identified on the risk register were not complete despite being signed as complete. Not all risks identified were on the risk register and some risks did not identify staff who were responsible and accountable for the actions identified. Environmental changes to Edward Street identified following an incident in February 2017 were not complete at the time of inspection in July 2018.
- There were three electronic recording systems being used alongside a system of paper notes. This also included different sets of notes for different disciplines within the team. This meant that notes were cumbersome and difficult to navigate for people who did not work regularly in the service. However, staff we spoke with were always able to find the information we requested. The trust had plans to implement an electronic patient records system.
- The trust used a root cause analysis approach to review serious untoward incidents. The review of mortality lacked consistent challenge at an executive level before reports were signed off. The trust had action plans in place to address these issues.
- We found a lack of maintenance and cleanliness at Hallam Street Hospital and Pond Lane. We raised our concerns with the trust and they took action to improve. The chief executive informed us of improvements they had made and that their recent Patient Led Assessment of the Environment (PLACE) had given Hallam Street 100% for cleanliness and over 99% trust wide.
- The role of Freedom to Speak Up Guardian role was carried out by a member of the trust board and could lead to a conflict of interest for the post holder. This had been reviewed and new plans were in place to seek an external solution.

# Summary of findings

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice in the following core service:

- Specialist Community Mental Health Services for Children and Young People.

## Areas for improvement

We found areas for improvement including five breaches of legal requirements that the trust must put right. We found 20 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

## Action we have taken

We issued five requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of five legal requirements in four core services. For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

We found the following outstanding practice:

### **Specialist Community Mental Health services for Children and Young people**

- Staff used technology to support children and young people in their treatment. Staff issued young people and their families with information regarding online therapy programmes and tools they could access outside of the treatment environment. Child and Adolescent Mental Health Services had its own service user designed website that contained information for young people and their carers. The website contained interactive material and age appropriate information presented in an engaging way.

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

# Summary of findings

## Action the trust MUST take to improve

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

### Specialist community mental health services for children and young people:

- The Trust must ensure all areas are clean and meet infection control standards.
- The Trust must ensure office risk assessments are completed and action is taken to ensure office areas are clean, safe and tidy environments to enable staff to carry out their duties safely. This must include ensuring the temperature of the office is controlled and enables staff to work in a healthy environment.
- The Trust must adhere to their policy on medicine storage. This includes monitoring storage temperatures and taking appropriate action when these exceed specified ranges.
- The Trust must ensure staff working with children and young people have a clear understanding of Gillick Competence and understand where and why this would be applied.
- The Trust must ensure actions identified on the risk register are completed in a timely manner to ensure patient and staff safety and accurately reflects the present situation before being signed as complete. Risk registers must clearly identify staff responsible and accountable for actions identified.

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

- The trust must ensure that patients are supported in the least restrictive way, staff follow the trust guidance on blanket restrictions and all restrictions on patients are individually assessed and care planned.
- The trust must ensure that all wards are well maintained and clean.
- The trust must ensure that all infection control procedures are followed.
- The trust must ensure that all emergency equipment is present and in order.
- The trust must ensure that staff follow safe medicines management.
- The trust must ensure that staff training compliance rates for fire safety and information governance meet or are above 75%.
- The trust must review doors on the psychiatric intensive care unit at Macarthur to ensure that they are anti barricade.
- The trust must ensure that staff assess mental capacity of patients in line with the Mental Capacity Act.
- The trust must ensure that all staff receive and record clinical and managerial supervision.

### Community mental health services for people with learning disabilities or autism

- The trust must ensure that care plans demonstrate that patients are receiving holistic and person-centred care. When a patient is seen across multiple disciplines, the trust must ensure that care plans are collaborative. The trust must ensure that patients' care plans are regularly reviewed.

### Wards for older people with mental health problems

- The provider must ensure that staff training for fire safety, information governance, moving and handling, safeguarding adults level 2 and 3 and safeguarding children level 2 meet the trust targets of 75%.
- The provider must ensure there is an exclusive female only lounge available on for female patients Chance Ward

## Action the trust SHOULD take to improve

# Summary of findings

## **Trust wide**

- The trust should ensure the governance systems are further strengthened to ensure clear communication from ward to board.
- The trust should ensure consistency of challenge at the executive level before mortality reviews and serious untoward incidents are signed off as complete.
- The trust should ensure that all locations are clean and well maintained.

## **Wards for people with learning disabilities:**

In line with the National Transforming Care Programme the trust completed their plans to close Daisy Bank in September 2018 a short time following this inspection,.

- The trust should ensure there are enough staff available to provide clinical supervision at Penrose House for all staff and for qualified staff at Daisy Bank.
- The trust should ensure that old care plans and reports are archived appropriately to improve the patient files at Penrose House.
- The trust should ensure activity programmes take place at Penrose House and Daisy Bank and that there are adequate staffing levels to support this.
- The trust should ensure that they continue to work closely with commissioners to find suitable placements for patients whose discharge has been delayed.
- The trust should ensure that Daisy Bank has adequate management cover while they are still providing care to patients.

## **Specialist community mental health services for children and young people:**

- The Trust should ensure environmental risk assessments cover all areas of the building, including those used by patients. These documents should be live and changing with environmental changes. Actions from issues arising should be clearly documented and the responsible person clearly named. These should be updated and kept in a place where staff can access them if needed.
- The Trust should adhere to information and communication technology principles, as set out in the trust's own policy and ensure computer screens are not in public view. The Trust should ensure staff are aware of protocols in place to access and use personal alarms provided.
- The Trust should ensure furnishings are of a good standard.
- The Trust should ensure all patients have an up-to-date risk assessment.
- The Trust should ensure all patients have an up-to-date care plan that shows involvement of the child or young person.
- The Trust should ensure all staff receive regular management supervision.

## **Acute wards for adults of working age and psychiatric Intensive care units:**

- The trust should ensure that staff accurately monitor visitors to and from wards.
- The trust should ensure that staff always record patient observations accurately and in line with trust policy.
- The trust should ensure that signage on locked doors clearly explains the rights of informal patients to leave the ward.

# Summary of findings

- The trust should ensure that all staff document and review all incidents in a timely manner.
- The trust should ensure that all staff are aware of the need to keep patient document in line with trust policy.
- The trust should ensure that all payphones on wards are in working order and offer privacy.

## **Community mental health services for people with learning disabilities or autism**

- The trust should implement a formal caseload management system.
- The trust should ensure that patients are routinely offered a copy of their care plan.
- The trust should ensure staff are documenting when a best interests meeting has occurred and document details of the meeting.
- The trust should ensure that the service continues to decrease waiting times for some services.
- The trust should continue to implement the new electronic records system to ensure the service improves its current record keeping system.

## **Wards for older people with mental health problems**

- The provider should ensure that patients experiencing mobility difficulties on Meadow Ward have access to a lift to be able to attend tribunals and access other parts of the hospital if required.

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

The trust was part of plans to merge with two other NHS organisations in 2017. The planned organisation was known as Transforming Care Together (TCT). Following two delays to the merger, a final decision was taken by the three boards not to progress with the merger in February 2018. Black Country Partnership Foundation NHS Trust found itself without a substantive leadership team. With the support of NHSI, it appointed interim executives and a trust chair.

Our rating of the trust remained the same. We rated it as good because:

Our rating for the trust took into account the previous ratings of services not inspected this time.

- Although we identified some lapses in governance and the overall trust rating has gone from RI to Good we concluded that the trust board's ability to focus on day to day governance had been hampered because of flux around the proposed merger but we saw evidence that they were picking up the reins again, which demonstrated good leadership.
- The trust board operated collaboratively, that meant executives and non-executive directors shared responsibility and liability for making decisions.
- There was a rounded understanding of performance, which suitably covered and combined people's views with information on quality, operational services and finances.

# Summary of findings

- The trust board were very visible across all services of the trust. Many staff told us that they knew and saw the executive team visiting services. The chief executive held regular meetings across the trust for staff to come and share their experiences working within their services.
- The trust understood the challenges to quality and sustainability, and identified the actions required to address them. This aligned to the wider health and social care economy of the Black Country. There was good leadership at trust board and its input into the sustainability and transformation partnership level.
- The trust had retained its vision and values for the organisation. The strategy and priorities of the trust aligned to its vision and values. Staff had an understanding of the vision and values in relation to local services.
- Staff told us they could influence change within the organisation. Staff had been consulted on changes to the structure of wards for people with learning disabilities and had the opportunity to contribute to strategy and design. Staff felt able to report concerns and incidents and knew how to do this.
- Staff we spoke to felt respected and listened to by their managers and senior managers within the trust. They stated that they felt a sense of pride in their role and the trust in general. The trust recognised staff and volunteers' staff in a number of ways, through a simple thank you to annual achievement awards.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems. Managers had access to systems to support them with their role, including access to data and dashboards showing service and staff performance information.
- The trust had an equality strategy in place which they were refreshing in collaboration with patients and staff for collaborative ownership and effectiveness.
- Staff, patients, and their families had access to up to date information about the trust. The trust communicated well with patients, carers, staff and stakeholders. The majority of staff groups felt they knew what was happening in the organisation. Families and carers described a varied experience of communication with staff in the trust but were praising of the support they received from the carers team.
- There were arrangements in place to identify record and manage risks. Patients' mental and physical health was assessed, and care and treatment planned.
- The trust worked hard to improve quality and innovation, for example, the epilepsy improvement programme to ensure that all patients with epilepsy had a comprehensive plan for the management of the condition.
- Recruitment of staff was a challenge to the trust but they were proactive in attempts to employ people across many of their services.

However:

- We did not find evidence of a robust recruitment process for all executive directors. When the planned TCT merger ended, the trust found itself without a substantive leadership team and with support from NHS Improvement, interim appointments were made from amongst senior managers within the trust.
- Governance systems from ward to board provided performance management information to make decisions needed further strengthening. This included environmental risk assessments, risk register actions and information governance. During the TCT process, governance was led by the acquiring trust. When plans to merge ended, it left the Black Country Partnership Foundation NHS Trust without a substantive governance lead to direct and develop new systems. The trust had acted to strengthen their governance structure by making a senior appointment to lead governance and improve its systems.



# Summary of findings

- Actions identified on the risk register were not complete despite signed as complete. Not all risks identified were on the risk register and some risks did not identify staff responsible and accountable for the actions identified. Environmental changes to Edward Street identified following an incident in February 2017 were not complete at the time of inspection in July 2018.
- There were three electronic recording systems being used alongside a system of paper notes. This also included different sets of notes for different disciplines within the team. This meant that notes were cumbersome and difficult to navigate for people who do not work regularly in the service. However, staff we spoke with were always able to find the information we requested. The trust had plans to implement an electronic patient records system.
- The trust used root cause analysis approach to review serious untoward incidents and mortality lacked consistent challenge at the executive level before reports were signed off. The trust had action plans in place to address this issue.
- We found a lack of maintenance and cleanliness at Hallam Street Hospital and Pond Lane. We raised our concerns with the trust and they took action to improve. The chief executive informed us of improvement they had made and that their recent Patient Led Assessment of the Environment (PLACE) had given Hallam Street Hospital 100% for cleanliness and over 99% trust wide.
- The role of Freedom to Speak Up Guardian was carried out by a member of the trust board and could lead to a conflict of interest for the post holder. This had been reviewed and new plans were in place to seek an external solution.

## Ratings tables

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

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

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

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ Dec 2018	Requires improvement ↓ Dec 2018	Good →← Dec 2018	Good →← Dec 2018	Good →← Dec 2018	Requires improvement ↓ Dec 2018

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

### Ratings for community health services

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

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

## Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓↓ Dec 2018	Requires improvement ↓ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Requires improvement ↓ Dec 2018	Requires improvement ↓ Dec 2018
Forensic inpatient or secure wards	Requires improvement ↔↔ Feb 2017	Good ↔↔ Feb 2017	Good ↔↔ Feb 2017	Good ↔↔ Feb 2017	Good ↔↔ Feb 2017	Good ↔↔ Feb 2017
Wards for older people with mental health problems	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018
Wards for people with a learning disability or autism	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018
Community-based mental health services for adults of working age	Good ↔↔ Feb 2017	Good ↔↔ Feb 2017	Outstanding ↔↔ Feb 2017	Good ↔↔ Feb 2017	Good ↔↔ Feb 2017	Good ↔↔ Feb 2017
Mental health crisis services and health-based places of safety	Good ↑ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018
Specialist community mental health services for children and young people	Requires improvement ↓ Dec 2018	Requires improvement ↔↔ Dec 2018	Good ↓ Dec 2018	Good ↔↔ Dec 2018	Requires improvement ↓ Dec 2018	Requires improvement ↓ Dec 2018
Community-based mental health services for older people	Good ↔↔ Feb 2017	Good ↔↔ Feb 2017	Good ↔↔ Feb 2017	Outstanding ↔↔ Feb 2017	Outstanding ↔↔ Feb 2017	Outstanding ↔↔ Feb 2017
Community mental health services for people with a learning disability or autism	Good ↔↔ Dec 2018	Requires improvement ↓ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018	Good ↔↔ Dec 2018

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

# Specialist community mental health services for children and young people

Requires improvement  

## Key facts and figures

The trust offers Child and Adolescent Mental Health Services in Sandwell and Wolverhampton. Teams assess and treat severe behaviour and mental health disorders in children and young people up to the age of 18. The service offers support and guidance to families, carers and parents.

The trust has a Crisis Intervention and Home Treatment Team covering Sandwell and Wolverhampton and offer specialist services to those children and young people whose needs cannot be met by core child and adolescent mental health services. The service operates seven days a week, 8am-8pm, with on-call access out of hours with the aim of reducing the frequency of admission to hospital for children and young people.

The Early Intervention Service work with young people and adults aged 14-35 who are going through a first episode of psychosis, or who seem at risk of going through a first episode of psychosis.

The Inspire team are based at the Gem Centre in Wolverhampton and provide targeted and specialist support for children and young people with mild, moderate or severe learning disabilities and mental health problems. We did not inspect this service.

We inspected five teams over four sites:

- The Sandwell crisis intervention and home treatment team based at Lodge Road, West Bromwich and The Gem Centre, Wolverhampton
- The Early Intervention Team based at Pond Lane, Wolverhampton and Edward Street, West Bromwich
- The Sandwell Child and Adolescent Mental Health Service based at Lodge Road, West Bromwich.
- The Wolverhampton Child and Adolescent Mental Health Service based at the Gem Centre, Wolverhampton.

Our inspection was announced at short notice to enable us to observe routine activity.

During the inspection visit, the inspection team:

- visited three teams in Sandwell and two in Wolverhampton
- looked at the quality of the environment
- observed how staff supported children and young people
- received feedback from eight carers and two young people, and reviewed feedback from patient surveys and feedback forms
- spoke with the managers of the four teams visited
- spoke with 21 other staff members; including psychiatrists, nurses, clinical psychologists, psychotherapists, occupational therapists and administration staff
- reviewed 27 patient records.

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

# Specialist community mental health services for children and young people

- There were concerns regarding the environment at Pond Lane and Edward Street. Staff within the Early Intervention Service at Pond Lane worked in an untidy and unclean environment. There were concerns around infection control and medication storage temperatures at Pond Lane.
- Environmental risk assessments were not completed for all sites. Where actions were identified within completed risk assessments, these were not always completed to ensure office areas were clean, safe and tidy environments to enable staff to carry out their duties safely.
- Staff did not adhere to their own policy on medicine storage. Medicines were not stored at an appropriate temperature at Pond Lane and staff did not take appropriate action when these exceed specified ranges.
- Staff within the Early Intervention Service did not have a clear understanding of Gillick competence and understand when and why this would be applied. This could have led to competent young people not being appropriately involved in their care.
- The service did not ensure actions identified on the risk register were completed. Actions identified where signed as completed when they had not been.

However:

- Child and Adolescent Mental Health Services and Crisis and Home Treatment teams had suitable premises to see young people. Environments had been decorated with children and young people at the centre. Staff had used their knowledge of young people and feedback from people using the service to create a suitable therapeutic environment.
- Staff managed medication well. They had good support from the pharmacists and ensured medication was administered in a safe way to young people.
- Staff provided care and treatment based on national guidance and care pathways were in line with the recommendations of the National Institute for Health and Care Excellence. Staff followed guidelines for a range of issues including best practice in administration of medication, psychological, family and behavioural therapies and interventions in mental health conditions.
- Staff across the service treated young people with respect, care and compassion. Young people and their families spoke positively about the care and treatment from staff and the service.
- Staff had good relationships and worked well with each other to achieve good outcomes for young people. Managers and senior staff at a local level were visible, supportive and approachable.

## Is the service safe?

**Requires improvement**  

Our rating of safe went down. We rated it as requires improvement because:

- The office area at Pond Lane was untidy and unclean with no ambient temperature control. Environmental risk assessments did not cover all areas of the building, including patient areas there was no environmental risk assessment in place at Pond Lane. Consultation rooms were dark, cluttered and uninviting.
- Medicines and emergency equipment were not stored appropriately. At Edward Street and Lodge Road, staff did not display appropriate signage to indicate where the emergency bag and oxygen cylinder were kept. The emergency bag at Edward Street did not have a tamper proof seal. Staff at Pond Lane did not take appropriate action when medicine storage temperatures exceeded specified ranges. The trust did not act quickly to rectify concerns about the temperature fluctuations in the office at Pond Lane.

# Specialist community mental health services for children and young people

- The service did not adhere to the policy on information and communication technology principles, as set out in the trust's own policy, and ensure that computer screens are not in public view. We found three instances at two sites we visited, Edward Street and Pond Lane, where computer screens used by staff could have been viewed by unauthorised people. We raised this issue with managers during our inspection and they responded to it.

However:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse. Most staff were up-to-date with mandatory training. There were vacancies within the core service that was being managed well by the trust and posts had been created and recruited to under a service redesign. There was appropriate use of bank and agency staff to cover vacancies and staff absence.
- The environment in Child and Adolescent Mental Health Services at the Gem Centre and Lodge Road was comfortable and inviting for young people using the service. All rooms at the Lodge Road were identically themed to support with consistency for young people who might struggle with changes to environments. Environmental risk assessments were in place at the Gem Centre and included consideration of patient areas.
- Staff mostly adhered to infection control principles, including handwashing, had access to alcohol gel, and participated in hand hygiene audits. Staff kept equipment used in the community clean and ensured they were in date.

## Is the service effective?

**Requires improvement**   

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff within Early Intervention Service could not clearly describe Gillick competence and how this applied to their work with young people. Staff told us they routinely asked parent's permission in decisions about young people's care. This could lead to competent young people not being appropriately involved in their care.
- Staff within the Early Intervention Service were not receiving regular management supervision.

However:

- Staff were skilled, experienced and qualified in their area of work. Staff we spoke with demonstrated they had the right skills and knowledge to meet the needs of the patient group. Staff within Child and Adolescent Mental Health Services and Crisis services had received supervision and yearly appraisal.
- Staff provided care and treatment based on national guidance and pathways were in line with the recommendations of the National Institute for Health and Care Excellence. Staff followed guidelines for a range of issues including best practice in administration of medication, psychological, family and behavioural therapies and interventions in mental health conditions.
- Staff understood their roles and responsibilities under the Mental Health Act and the Mental Capacity Act. They knew how to support young people experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff monitored physical health needs appropriately and routinely liaised with children and young people's GP to ensure physical health needs were being met.

# Specialist community mental health services for children and young people

- Staff engaged in clinical audits and findings were discussed at quality meetings attended by service leads. Good practice was routinely shared and actions from audits were fed back to teams through team meetings and addressed in supervision.
- Staff used technology to support children and young people in their treatment. Children and young people had access to a tablet in reception at Lodge Road, staff used online tools to support with treatment and Child and Adolescent Mental Health Services had its own service user designed website that contained information for young people and their carer's.
- All teams had excellent links with both internal and external services and worked collaboratively with them to achieve the best outcomes for young people. Staff shared information within the multidisciplinary team and handed over between shifts effectively.

## Is the service caring?

Good  

Our rating of caring went down. We rated it as good because:

- Staff demonstrated a sensitive, caring and compassionate attitude in their work with young people. They acted in a respectful and discreet manner and were responsive to people who needed emotional support and advice.
- Staff took person-centred approach in their responses to people using the service. They demonstrated understanding of individual children and young peoples' personal, cultural, social and religious needs.
- Staff involved young people and their families in decisions care and communicated with them in a way that helped them to understand their treatment. Staff used a range of methods suitable across age groups and abilities to find effective ways to communicate with young people about their care.
- Staff routinely enabled families and carers to give feedback on the service they received and made changes and improvements to the service based on their feedback.

However:

- Staff did not routinely inform people using the service how they could access independent advocacy.

## Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- The service met targets for referral to assessment within Child and Adolescent Mental Health Services. Wolverhampton had an average waiting time of seven weeks and Sandwell had an average waiting time of 11 weeks. Crisis, Home Treatment and Early Intervention Service met their targets for responding to referrals, there were no young people waiting to access treatment within these teams.
- Staff actively engaged with people who did not attend appointments, found it difficult or were reluctant to engage with the service. They offered flexibility when offering appoints were dynamic and compassionate in their approach to engaging children and young people.



# Specialist community mental health services for children and young people

- Both Child and Adolescent Mental Health Services and Early Intervention Service bases were accessible for people using the service. The flooring to the entrances was flat or had ramp access and there was access to a disabled toilet. There was information available in languages used by the local population and the service had access to interpreting services if required.
- Staff supported people who wanted to make a complaint to the service. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

However:

- At Pond Lane Early Intervention Service base, if young people needed to use the toilet, they needed to be escorted by a member of staff through locked doors as toilets were not in the waiting area.

## Is the service well-led?

**Requires improvement**  

Our rating of well-led went down. We rated it as requires improvement because:

- Governance arrangements within the service were not robust. Concerns identified on the risk register were not actioned in a timely manner to ensure staff and patient safety. There were risks identified on the risk register regarding security against violence and aggression and patient confidentiality for the reception area of Edward Street. Identified actions to improve the environment, such as providing staff alarms, addressing the visibility of reception area and improving the security of staff offices, had not been commenced and implemented in a timely manner. There were no identified completion dates in place despite managers signing to say this had been checked. Not all risks were identified on the risk register and some risks did not identify staff responsible and accountable for the actions identified.
- Computers in reception at both Edward Street and Pond Lane were in direct line of sight of visitors, these had not been moved to protect potential breaches of confidentiality and this had not been identified as a risk on the risk register. Ongoing concerns over medication storage at Pond Lane had not been identified on the risk register and measures had not been taken to rectify fluctuating temperatures in the office despite this being identified by staff in September 2016.

However:

- The trust had a vision and values of what it wanted to achieve. All staff we spoke with could discuss and demonstrate how they worked in line with the values of the trust.
- Managers within the core service were visible and accessible. Leaders had a good understanding of the services they managed. They were clear about the direction of the service and the strategy going forward within the service restructure.
- Staff could influence change within the organisation. Staff had been consulted on changes to the structure of Child and Adolescent Mental Health Services and were given the opportunity to contribute to strategy and design.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Managers had access to systems to support them with their role, including access to data and dashboards showing service and staff performance information.
- Staff, children and young people and their families had access to up to date information about the trust. People using the service had opportunities to feedback on the service they received.

# Specialist community mental health services for children and young people

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Wards for people with a learning disability or autism

Good   

## Key facts and figures

We inspected three wards for people with a learning disability based across three sites

- Penrose House is a specialist acute assessment and treatment in-patient service for adults with a learning disability and additional complex health needs. These needs can include autistic spectrum disorders, behaviour problems, and mental health difficulties. It supports both male and female patients. It is based at the Heath Lane hospital site in West Bromwich. It has 10 beds and at the time of the inspection five of these were in use.
- The Larches provides a hospital-based 'step-down' service for people with learning disabilities and complex needs. It supports someone's transition to the community from hospital. The service is for men aged 18 to 70. The ward is based on the Hallam Street hospital site in West Bromwich. It has 14 beds. At the time of the inspection eight beds were in use and two were allocated to patients on extended leave from the ward
- Daisy Bank is for people with a learning disability, with additional needs who require a period of admission to a specialist assessment and treatment unit. This could be because they are at risk in their current situation or because they require a period of treatment and rehabilitation. It supports both male and female patients. The ward is based on the Orchard Hills site in Walsall. They provide eight beds but currently have two patients. The trust completed their plans to close this ward in September 2018 as part of the national Transforming Care Programme.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected all five domains in this core service as part of our planned inspection programme.

Daisy Bank was last inspected in March 2018. This was a responsive inspection following concerns raised by commissioners. The team found there were no breaches. We did not rate this ward at that time.

All wards were part of a follow up focussed inspection in October 2016. The inspection team looked at the safe domain and rated the wards as good. Some of the wards inspected have now closed in line with the planned reduction in inpatient beds as part of the Transforming Care Programme.

All wards were inspected as part of a comprehensive inspection in November 2015 and were rated as good overall and in all domains. Some wards in this inspection are no longer being used,

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team

- spoke with eight patients and two carers
- visited all three wards and spoke to the ward managers, acting ward managers and their deputies
- spoke with 16 other staff members including doctors, nurses, healthcare assistants, occupational therapists, psychologists, speech and language therapists and activity coordinators
- observed a discharge planning meeting
- reviewed 13 sets of patient records, 4 sets of Mental Health Act paperwork and 16 prescription charts

# Wards for people with a learning disability or autism

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- All wards had detailed risk assessments and used these to keep patients safe. Ligature risks were managed well by staff who used detailed plans to manage patients care. Rooms were clean and well maintained and the clinic room was fully equipped to meet the needs of patients.
- Staff managed medication well. They had good support from the pharmacists and ensured medication was administered in a safe way to patients.
- Staff used national guidance including that set out by the National Institute for Health and Care Excellence to provide care for patients. Staff ensured care plans had been completed with input from patients and had updated them on a regular basis as patient needs changed.
- Staff treated patients with compassion and patients we spoke to said that staff looked after them and helped them. Staff ensured patients had good access to advocacy. They made referrals or encouraged patients to refer themselves where possible.
- Patients always had their own bed to return to following a period of leave. Managers kept beds open for patients during the transition phase to new placements to ensure this was a smooth process for patients.
- Patients had access to an excellent range of easy read materials. We saw these were completed in both pictures and written language depending on the needs of each individual patient. Medication leaflets had a photograph of the medication box and medicines to support patients to understand what they had been prescribed and why.
- Staff felt supported in their roles. Staff reported that managers and senior staff at a local level were supportive and approachable. Managers used a dashboard to monitor staff performance including mandatory training and supervision.

However:

- Levels of clinical supervision for staff were low for qualified staff and healthcare assistants at Penrose House and for qualified staff at Daisy Bank due to staff sickness and there was no one available to provide this.
- Staff stored old copies of care plans and reports in patient files at Penrose House which made the files cumbersome and difficult to navigate.
- The activity programmes at Penrose House and Daisy Bank were limited and staff needed to ensure these were taking place.
- The wards did not complete audits of the Mental Capacity Act and actions in the Mental Health Act audits had not been completed. Staff had completed paperwork appropriately and this had not directly impacted on patients but had the potential to do so if not improved.
- Daisy Bank and Penrose House had delayed discharges at the time of the inspection. These were due to issues outside of their control such as suitable placements not being available for patients with complex needs. We saw that staff did what they could to keep the process moving for patients. As part of the Transforming Care Programme, overseen by NHS England, Daisy Bank closed post-inspection that meant they had no delayed discharges.
- Daisy Bank had not had permanent leadership over a period of 18 months and this had impacted on morale of the staff and patient care however the trust made the decision to close this ward in September 2018.

# Wards for people with a learning disability or autism

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- The wards were clean and clinic rooms were fully equipped and well maintained. Wards had the right equipment to support the needs of patients in their care.
- Managers used the same bank and agency staff where possible. This ensured some continuity for patients. The medical cover on the wards both day and night was good and patients had access to a local GP if needed.
- Staff completed mandatory training and had access to specialist training if required. The mandatory training was above the trusts compliance rate of 85%.
- Wards rarely used rapid tranquilisation and only used physical restraint on patients as a last resort. We saw staff using de-escalation techniques on the wards. Each patient had a positive behaviour support plan which detailed trigger points and explained how to support a them if they became distressed.
- Staff understood safeguarding and how to report issues. Staff had received training in safeguarding for both adults and children. They knew who to contact at the trust for advice.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Staff completed assessments for patients soon after their admission to the wards. Patient records were holistic, person centred, recovery orientated and up to date.
- Staff used national guidance such as that from the National Institute of Health and Care Excellence to support patients and Health of the Nation Outcome Scales to monitor patients' progress.
- Penrose House and The Larches had access to a wide range of health professionals to support patients. These included speech and language therapists, occupational therapists and psychologists who provided a range of therapies to suit the needs of each patient.

However:

- Levels of clinical supervision for staff were low for qualified staff and healthcare assistants at Penrose House and for qualified staff at Daisy Bank due to staff sickness and no other staff available to provide this however this was no longer an issue for Daisy Bank because it was closed in September 2018.
- Staff had not completed audits relating to the Mental Capacity Act for several months. Issues with staffing at the trust had meant these had not taken place. However, the trust had revised the record keeping audit to include Mental Capacity Act and these showed audit was taking place from June 2018. Mental Health Act audits had been completed but did not show evidence of lessons learnt or actions that had been taken. This had not impacted on patient care but could do so in the future if improvements have not been made.
- Staff had not removed old copies of care plans and reports from patient files at Penrose House which made the files cumbersome and difficult to navigate.

# Wards for people with a learning disability or autism

- Carers felt that staff at Daisy Bank had not adequately monitored physical healthcare needs of patients relating to diet and significant weight gain. However, records showed that physical healthcare had been monitored. The trust closed Daisy Bank in September 2018 as part of the Transforming Care Programme.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- We found that staff treated patients with care and compassion and permanent staff knew individual patients and their needs well.
- Staff supported patients to participate in planning their care. They used easy read information with words and pictures to support patients to understand the care they received. All patients were assessed for a communication passport to be developed on admission to the ward.
- Patients had good access to independent advocacy. Staff ensured patients were referred and made information available to patients on the wards.
- Staff encouraged family and carers to be involved as much as possible and with the consent of the patients. Apart from protected meal times, families and carers could visit when they wanted to.

## Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- Staff provided all information in an easy read version using pictures and words tailored to the needs of each individual patient. This included medication leaflets, activity boards and easy read care plans.
- Patients were discharged at a pace to suit their needs. Wards worked on discharge plans with patients to help keep them informed of progress being made. Staff supported new placements by encouraging new staff to visit and shadow on the wards to ensure a smooth transition for the patient. A patient's bed was kept open for two weeks following the discharge so that any concerns could be addressed with the new placement if needed.
- Patients had access to suitable spiritual support. This was provided by a team from the trust. Staff knew who to contact to arrange for visits and spoke about the team visiting the wards.

However:

- Penrose House and Daisy Bank offered limited amounts of activities. Patients had individual activity plans but these could be disrupted by staff shortages and the needs of the patients. At the time of inspection both wards had low numbers of patients so this meant activities were cancelled less often. This could change as the number of patients increased.
- Penrose House had one delayed discharge and Daisy Bank two. These occurred due to a lack of suitable accommodation being available for patients with complex needs. Staff maintained discharge plans for patients whilst they waited for decisions to be taken to discharge them. The decisions were outside of the control of staff working on the wards. As part of the Transforming Care Programme, overseen by NHS England, Daisy Bank closed post-inspection that meant they had no delayed discharges.

# Wards for people with a learning disability or autism

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- Staff knew the vision and values of the trust and used these to set key objectives for staff. Issues with staff performance were addressed through supervision and in line with the trusts human resources policy. Managers used a dash board to effectively manage the wards.
- Managers added items to the trust's risk register to ensure that the wards continued to make improvements and keep patients safe.
- Staff said they were supported by managers at a local level. Some staff had worked within the same teams for many years and this meant the wards had a good culture where staff supported each other.

However:

- Daisy Bank had been without a permanent manager for 18 months which impacted on staff morale and patient care. Qualified staff had stepped up to cover the ward management roles but this had been affected by staff sickness. This ward was closed in September 2018.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.



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

Requires improvement  

## Key facts and figures

The acute wards for adults of working age and psychiatric intensive care units (acute wards or PICU) service at Black Country Partnership Foundation NHS Trust consisted of five acute wards and one psychiatric intensive care ward. They provided support and treatment for adults of working age that required inpatient care for their mental health. Abbey Ward, Charlemont Ward and Friar Ward were located at Hallam Street Hospital and are mixed gender services with nine beds for women and nine for men. All three wards were laid out in the same way. Patients could access the resource centre at Hallam Street Hospital to take part in recovery focussed and therapeutic activities. The resource centre was in another building a short walk from the wards. There was no covered walkway to access the resource centre.

Brook and Dale wards were at Penn Hospital. Brook Ward is a 20-bed ward for men; Dale Ward is an 18-bed ward for women. They were in the same building and share therapy rooms that were situated in a corridor just off the main ward areas.

The Macarthur Centre is a 12-bed psychiatric intensive care unit for males that is located at Heath Lane Hospital. It had two outside areas, therapy rooms, a dining area, a practice kitchen and two lounge areas located in the ward area.

Any women that required psychiatric intensive care services had to go out of county, as the trust had no provision for a female psychiatric intensive care ward.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We visited all five acute wards and the psychiatric intensive care unit. Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team;

- visited all five of the wards and the psychiatric intensive care unit (PICU) at three hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 18 patients and received feedback from three carers
- spoke with all ward managers from each of the wards
- spoke with the operational manager for the Penn Hospital
- spoke with 30 other staff members; including doctors, nurses, healthcare assistants, occupational therapists, psychologists, housekeepers and nursing students
- observed one shift handover
- checked six clinic areas and in the process reviewed 49 medication charts
- reviewed 31 patient care records

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

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

- The ward environments at Hallam Street Hospital were not always clean and staff did not always follow infection control procedures. The wards had numerous blind spots and ligature risks, the wards were over two floors which meant staff used increased patient observation levels. Staff told us they were challenging environments to manage acutely unwell patients.
- Staff did not always ensure that emergency equipment was in kept order. On two wards we found that the emergency equipment bag was not in order and staff did not document that medical equipment was routinely maintained and cleaned.
- Staff did always follow safe medicine management procedures. Staff were unsure of the procedures to follow when the temperature of the clinical rooms were above recommended range.
- One door on the psychiatric intensive care unit was not anti barricade, which meant that patients could barricade themselves in the room. Following an incident this room was no longer used by patients.
- Staff on Dale Ward carried out searches on all patients; regardless of the level of risk. This blanket approach to searching patients was not in line with trust policy.
- Staff mandatory training compliance did not always meet the trust target of 85%. Information governance and fire safety training compliance levels were below 75%.
- Staff did not assess patients' mental capacity in line with the Mental Capacity Act. We saw evidence that Mental Capacity Act documentation was not completed appropriately and that patients' assessments were not decision specific.
- Not all staff had regular clinical supervision and one third of staff on the psychiatric intensive care unit did not have an identified clinical supervisor.

However:

- The ward environments at Penn Hospital and Macarthur Unit were clean and well maintained.
- The wards complied with guidance on mixed-sex accommodation and had areas specifically for male and female patients.
- Staff completed a risk assessment for every patient on admission and updated these as needs changed or incidents occurred. We saw evidence for this in the 31 care and treatment records we reviewed.
- Patients had appropriate access to physical healthcare. Nursing staff and doctors monitored patients' physical health throughout admission.
- Staff attitudes and behaviours showed that they treated patients with dignity and respect.
- Staff were supported to take care of well-being whilst at work. The trust recognised staff and volunteers' success within the service through annual achievement awards.

## Is the service safe?

**Inadequate**   

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

- Staff on the acute wards at Hallam Street Hospital were unable to observe all parts of the wards as they were two storeys high. Staff mitigated these risks by increasing patient observation levels. The acute wards at Hallam Street Hospital had blind spots and ligature risks. Staff told us this and the ward being over two floors made observations challenging and increased patient observation levels were needed to ensure patient safety. However, we found that staff did not always record patient observations.
- The psychiatric intensive care unit at Macarthur had one door which was not anti-barricade. There had been an incident prior to the inspection where a patient had barricaded themselves into the room.
- Three acute wards at Hallam Street Hospital were dirty and poorly maintained. We found one clinic room that was shared with the health based place of safety, was littered and dirty, and three ward environments were unclean.
- Staff did not always follow infection control procedures. We observed wet bedding left in a patient shower cubicle for several hours. The shower cubicle was locked and not accessible to patients.
- Staff did not always ensure that emergency equipment was in order.
- Staff did not always store medicines within the correct temperature range and were unsure of what actions to take when temperatures were out of range.
- Staff training compliance rates for fire safety and information governance were below 75%.
- Signage on the acute wards did not clearly spell out the rights of informal patients to leave the ward.
- We were not assured that staff recorded incidents in sufficient detail or timely manner.
- We found that one patient care plan had been shredded as one member of staff thought this was procedure. The trust investigated this following inspection, after which we were assured that it was an isolated incident and not systemic practice.
- We found examples of blanket restrictions on two wards. Staff on Dale Ward carried out blanket searches which was not in line with the trust policy. Patients on the psychiatric intensive care unit were only able to smoke at set times.
- Staff did not always ensure that visitors recorded their time of entry and exit of the ward.

However:

- Staff completed a risk assessment for every patient on admission and updated these as needs changed or incidents occurred. We saw evidence for this in the 31 care and treatment records we reviewed.
- Staff completed person centred, physical intervention protocols for all patients on whom they used physical restraint or had done so in the past. These aimed to reduce the need for future restraint.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Every ward had an up to date ligature risk assessment in place, which included photos of all risks to easily identify them. The document contained individual plans telling how the risks should be managed.
- The wards complied with guidance on mixed-sex accommodation and had areas specifically for male and female patients.
- Staff and patients had access to alarms and call systems. We saw that staff responded to alarms in a calm and timely manner.
- Staff attitudes and behaviours showed that they treated patients with dignity and respect.

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

## Is the service effective?

**Requires improvement**  

Our rating of effective went down. We rated it as requires improvement because:

- Not all staff received regular managerial and clinical supervision or had an identified clinical supervision supervisor.
- In 31 records reviewed, doctors had undertaken a routine mental capacity assessment on every patient admitted to the wards. These assessments were not specific and were being applied to patients for which it would have been reasonable to presume capacity.
- The trust had not undertaken any Mental Capacity Act/ Deprivation of Liberty Safeguards audits.

However:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Staff provided a range of care and treatment interventions suitable for the patient group. Patients had access to psychology and occupational therapy.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. All registered nurses and health care assistants had received training in solution focused therapy and the trust had trained some staff to deliver solution focused training to new staff. This meant staff could offer a consistent therapeutic approach to patients.
- Patients had appropriate access to physical healthcare. Nursing staff and doctors monitored patients' physical health throughout admission.
- Staff participated in clinical audits.
- Ward staff developed good relationships with staff in community teams.

## Is the service caring?

**Good**   

Our rating of caring stayed the same. We rated it as good because:

- Staff attitudes and behaviours showed that they treated patients with dignity and respect.
- Patients described the staff as caring, supportive and non-judgemental. Patients felt staff listened to them and provided them with appropriate emotional and practical support.
- Most patients and their relatives gave positive feedback about the wards.
- Most patients had access to regular community meetings on their wards. Wards had “you said, we did” noticeboards.
- Carers were involved in patient care, ward meetings and activities where appropriate.
- Hallam Street hospital had an expert by experience service development volunteer role. This meant patients had the opportunity to work alongside staff on time specific project to support the development of services and review documents; policies and procedures that impacted upon the experience of patients at Hallam Street Hospital.

However:

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

- Staff did not routinely provide carers with information about how to access a carer's assessment.

## Is the service responsive?

**Good** ● ➡ ➡

Our rating of responsive stayed the same. We rated it as good because:

- The wards had a wide range of useful information displayed for patients on physical health, mental health conditions, complaints, activities and advocacy.
- There was appropriate space for activities and access to outside areas.
- A range of meal choices were available and food and drinks could be provided flexibly
- The trust were part of the West Midland MERIT vanguard, this was a group of neighbouring trusts working together to enable patients access to local beds.
- Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories.
- Patients had access to a wide range of activities to support recovery.
- Patients had access to outside space.
- Patients had access to their own mobile phones or office phones.

## Is the service well-led?

**Requires improvement** ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- Ward systems were not robust or effective enough to ensure staff delivered safe and effective care. There were lapses in medicine management practice, infection control and cleanliness, staff supervision, recording of patient observations and inappropriate assessment of capacity.
- Staff on Dale Ward did not adhere to the search policy.
- The trust had not completed Mental Capacity Act audits.
- The trust had not implemented a consistent approach to a smoke free environment across the hospital sites. Staff told us there was not enough staff trained in smoking cessation to support a cross trust smoke free environment.

However:

- The trust had implemented the safe wards programme.
- Ward managers were visible on the wards. Staff knew who the senior managers within the trust were.
- Staff felt able to report concerns and incidents and knew how to do this
- Managers dealt with poor performance when needed. Examples discussed showed how this was done in a positive and supportive manner.
- Staff were supported to take care of wellbeing whilst at work.

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

- The trust recognised staff and volunteers' success within the service through annual achievement awards.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Mental health crisis services and health-based places of safety

Good   

## Key facts and figures

The crisis resolution and home treatment teams were based at Quayside House in Oldbury and Penn Hospital in Wolverhampton. These services were for people experiencing severe mental health crisis. The team at Quayside House operated 24 hours, seven days a week. The team at Penn hospital operated between the hours of nine a.m. and ten p.m. The Liaison team then provided cover throughout the night. The teams provided assessment and short-term interventions. They were responsible for receiving referrals and would carry out a triage; assessment and provided care and treatment. The teams worked using a multidisciplinary approach to support patients in their own homes to reduce inpatient admissions and facilitate early discharge from hospital.

The Liaison team was based at Penn Hospital but provided specialist mental health support and assessment services at a number of locations including police stations and New Cross Hospital.

The health-based places of safety, also known as section 136 suites, were based at Penn Hospital and Hallam Street Hospital. Patients were brought to this place of safety by a police officer because they were concerned that the patient had a mental disorder and should be seen by a mental health professional. Patients were kept in the suite under section 136 of the Mental Health Act so that they could be assessed to see if they required treatment. The health-based places of safety were managed by staff from the crisis resolution and home treatment team and staff from the adjoining acute wards. Both teams worked with the street triage services. A qualified mental health professional worked alongside the police to provide an immediate assessment of anyone that presented as possibly having a mental health problem.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During our inspection we: -

- visited the health-based places of safety at Hallam Street Hospital and Penn Hospital. We also visited the crisis teams at Penn Street Hospital and Quayside House and the Liaison Team at New Cross Hospital.
- spoke with four managers, four psychiatrists, four health care assistants, five qualified nurses and one psychologist.
- spoke with four patients and two carers.
- observed three patient visits in the community by the crisis services and two patient interviews by the liaison service
- looked at 30 prescription charts, 24 care records and a range of documentation relating to the service.
- attended two handover meetings and one multidisciplinary team meeting.
- undertook two tours of health based places of safety.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:



# Mental health crisis services and health-based places of safety

- There were high levels of experienced staff who had undertaken a complete mandatory training programme. Regular monthly meetings ensured that staff received feedback after serious incidents and were kept up to date about improvements to the service. Care records were up to date and contained holistic and individualised information relating to care.
- All records we checked contained comprehensive assessments including an assessment of physical health. Staff followed best practice guidance issued by national organisations such as the National Institute for Health and Care Excellence. There was a full range of mental health disciplines available to patients across the service. Staff had good knowledge of the Mental Health Act and Mental Capacity Act and how they were relevant to their service users.
- We observed care being delivered by staff who were professional and knew their patient's needs. They were able to tailor care delivery to the specific needs of the individuals and were aware of a wide range of impact factors such as history, culture, gender and individual ability. Where possible patients were involved in the development of their own care. Where appropriate families and carers were also involved.
- All services we inspected were compliant with targets set by the trust in relation to referral to treatment times. The crisis and liaison services could respond quickly to urgent referrals. Information about this service and local services to support patients was available in a range of languages. Patients we spoke to were aware of how to make a complaint and felt that they would be comfortable to do so if they needed to.
- Staff understood their roles and how they related to the trusts core values. Managers were visible and well respected. Staff felt well respected and valued by the trust. All staff we interviewed stated that they were proud of the work that they did and felt that the trust supported their development.

However

- Some of the environments we inspected presented risks. The electronic and paper recording systems were cumbersome and difficult to navigate.
- There had been some issues with communication with teams outside of the trust.
- The liaison team had lost its specialist interview rooms at the local hospital where they were based. This meant that they were conducting interviews and assessments in rooms more suited to physical health care delivery.

## Is the service safe?

**Good**  

Are services safe? We rated safe as good because:

- There were high levels of experienced staff in the teams and new starters were mentored by staff that were well established in the service.
- Staff completed a mandatory training programme. Training compliance was 88% in all subjects which is above trust targets.
- Staff received feedback from investigations at handovers and monthly meetings. We found evidence of changes to working practice as a result of this feedback.
- There was a system in place to provide staff with a debrief after serious incidents. This was provided by psychologists attached to each team.
- Care records were up to date and contained information that was holistic and individualised.

# Mental health crisis services and health-based places of safety

However,

- The outer wall at the Hallam Street health based place of safety could be climbed over. Staff were aware of this and the risk was being managed with ongoing risk assessments and staffing.
- There were two separate electronic record keeping systems in place alongside a paper system. This made it difficult to navigate and find information. Staff were always able to find what they were looking for.

## Is the service effective?

**Good** ● → ←

Are services effective. We rated effective as good because:

- Patients had comprehensive assessments which included and assessment of their physical health. These were created in collaboration with the patient where possible.
- Staff followed best practice guidance in a range of areas including the administration and transport of medication.
- Staff were experienced and qualified for their roles and there was an induction and training system in place for new starters. There was access to a full range of mental health disciplines in the service including psychologists, psychiatrists, social workers and occupational therapists
- Communication between staff was good and there were systems in place to ensure the transfer of information between teams. This included multi-disciplinary teams and handovers.
- Staff received training in and had good knowledge of both the Mental Health Act and Mental Capacity Act. They were also knowledgeable about the code of practice and the five guiding principles of the Mental Capacity Act.

However;

- There had been communication issues between the liaison team and staff at the hospital where they were based. This meant the liaison team may not have been in receipt of relevant risk information however, the services were working together to improve communication.

## Is the service caring?

**Good** ● → ←

We rated caring as Good because:

- We observed staff interacting with patients. They were supportive and encouraging and had developed good working relationships with the patients they cared for.
- Patients were actively involved in the development of their own care where possible. Staff tailored their communications in a way that took into account patients understanding of their condition.
- Where appropriate families and carers were involved in care. There was also a provision of support for carers.

## Is the service responsive?

**Good** ● → ←

# Mental health crisis services and health-based places of safety

We rated responsive as good because:

- The trust had set target times from referral to triage and then to admission. All services we inspected were compliant with these targets. The crisis and liaison teams were able to respond very quickly to urgent referrals, usually within one hour.
- There were a range of rooms and facilities available across the service. This included clinics attached to both health based places of safety that were fully equipped to deliver care. Equipment was easily available and where required was checked in line with national guidance.
- All services we checked had a range of information available to patients. This was available in a range of languages.
- Patients knew how to make a complaint and stated that they would feel able to follow the process if required. Staff were well equipped to handle complaints appropriately and within trust policy.

However

- The liaison team had lost their allocated interview rooms in the hospital where they were based. This meant that they were conducting assessments and interviews in rooms that were more suited to the delivery of physical health care.

## Is the service well-led?

Good   

We rated Well Led as good because:

- Staff understood their roles. Managers had worked in the service for a long time and understood the challenges faced by their staff. There was a clear strategy across all services we inspected and this was in line with the trusts visions and values.
- Staff knew who their direct managers were and spoke very highly of them. They also knew who the most senior leaders were within the trust.
- Staff could explain how the trusts visions and values linked to the delivery of high quality care.
- Staff we spoke to felt respected and listened to by their managers and senior managers within the trust. They stated that they felt a sense of pride in their role and the trust in general. Staff were recognised for their achievements including staff award schemes.

However

- There were three electronic recording systems being used alongside a system of paper notes. This also included different sets of notes for different disciplines within the team. This meant that notes were cumbersome and difficult to navigate for people who do not work regularly in the service. Staff we spoke with were always able to find the information we requested.

# Community mental health services for people with a learning disability or autism

Good   

## Key facts and figures

The Black Country Partnership Foundation NHS Trust provides community mental health services for adults with learning disabilities or autism across Sandwell, Dudley, Walsall and Wolverhampton. At this inspection, we visited Quayside House based in Sandwell, Orchard House based in Walsall and Ridge Hill based in Dudley.

The aim of these teams is to deliver specialist health services for people with a learning disability and additional complex health needs. These health needs can include autistic spectrum disorders, mental health difficulties and behaviour problems. A team of specialist health staff from different professions provide a range of in-patient, outpatient and community treatments and interventions. The community learning disability teams consisted of specialist community nurses, clinical psychologists, psychiatrists, occupational therapists, speech and language therapists and physiotherapists. The service offered access to behavioural support and a promoting access to mainstream services (PAMHS) team.

During this inspection visit, the inspection team:

- visited each team in Sandwell, Walsall and Dudley and looked at the quality of the environment
- observed six community visits, during which we spoke to seven patients and one carer
- spoke to three carers over the phone
- spoke with the service manager and the four principal leads
- spoke with 26 other staff members; including one occupational therapist, two speech and language therapists, 12 specialist nurses, three psychiatrists, three behavioural support staff, one physiotherapist, one clinical psychologist, and three administration staff
- reviewed 36 care records of patients, and
- attended one allocation meeting.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care. Clinical premises where patients were seen were safe and clean. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- The teams included or had access to the full range of specialists required to meet the needs of patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with services outside the organisation. Patients were able to see a psychiatrist in a timely manner and were seen urgently if required.
- Staff ensured that patients received any necessary assessment of their physical and mental health needs and provided a range of care and treatment interventions suitable for the patient group. Staff in the promoting access to main stream health services team (PAMHS) were proactive in ensuring that patients' physical healthcare needs were being met and supported patients to live healthier lives.

# Community mental health services for people with a learning disability or autism

- Staff used the Mental Capacity Act appropriately to determine if a patient had the capacity to make a specific decision. Staff gave patients every possible assistance to ensure they had the capacity to consent to treatment before they assumed that the patient lacked the mental capacity to make this decision.
- Staff attitudes and behaviours when interacting with patients showed that they were respectful and responsive. Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Staff informed and involved families and carers appropriately and provided them with support when needed.
- All information provided was in a form accessible to the patient group. Staff provided patients with easy-read documentation to understand their treatment. Staff knew how to access interpreters for patients who required this service.
- Patients received responsive care from the service. The teams followed up with patients who did not attend appointments and supported them to attend in the future. Patients knew how to complain or raise concerns, and staff knew how to handle complaints appropriately.
- Leaders had the skills, knowledge and experience to perform their roles. Leaders had a good understanding of the services they managed, were visible in the service and staff found them approachable. Staff knew and understood the trust's vision and values. Staff felt respected, supported and valued. Staff spoke highly of the service manager. Staff felt positive and proud about working for the trust and their team.
- The provider had a comprehensive schedule of meetings and reporting systems to ensure good governance of the service. Staff had access to up to date information about the work of the services they used. Staff participated in benchmarking and quality improvement initiatives and had opportunities to participate in research.

However:

- Staffing levels could not be increased to accommodate an increase in caseload or acuity of the patient group. This meant that some staff were managing high caseloads. Staff caseloads were not formally reviewed and the service did not use a caseload management tool.
- More than half of the records reviewed did not contain a holistic, person-centred care plan that demonstrated the patient's goals, treatment aims or detailed involvement across the multidisciplinary team. Patients were not routinely offered a copy of their care plan.
- Staff were not fully documenting when a best interests meeting had taken place for a patient who lacked capacity to make a decision.
- Staff did not routinely inform people using the service how they could access independent advocacy.
- Some patients referred to speech and language or physiotherapy were waiting longer than expected to receive an assessment.

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- All sites were clean, tidy and were fit for purpose. Staff adhered to infection control principles. In Ridge Hill, where patients were seen on site, there were adequate rooms and facilities to support the needs of the patient. The manager completed a regular health and safety checklist and ensured actions were completed in a timely manner. Staff prompted patients to use good hand hygiene techniques.

# Community mental health services for people with a learning disability or autism

- Patients were able to see a psychiatrist in a timely manner and were seen urgently if required.
- Staff responded promptly to sudden deterioration in a patient's health
- The manager had been proactive in filling vacant staff posts, utilising agency and fixed-term contracts where appropriate.
- Most of the records reviewed had a current risk assessment.
- Staff were knowledgeable in safeguarding principles and understood their safeguarding responsibilities.

However:

- Current commissioning arrangements meant that staffing could not be increased immediately when required, for example if caseloads increased. An increase in staffing levels would require the trust to submit a business case to local commissioners, or they can employ bank or agency staff, but this would take time.
- We could not find a formal tool used for caseload management at the time of this inspection. However, the trust reported post-inspection that they had piloted a context of care safe staffing tool within two community teams. We have not seen the impact of this pilot on community teams.

## Is the service effective?

**Requires improvement** ● ↓

Our rating of effective went down. We rated it as requires improvement because:

- Of the 36 patient records reviewed, 20 had an up to date care plan. Records contained a copy of patient's assessment where appropriate for example a physiotherapy or occupational therapy assessment however in over 60% of the records reviewed the patient did not have a collaborative, personalised or holistic care plan detailing their treatment aims or recovery goals. Patients were not routinely offered a copy of their care plan. The service planned to implement an integrated person-centred care plan, which detailed an individual's goals, and would be collaboratively written with the individual and the teams they were receiving treatment from.
- Staff were not fully documenting when a best interests meeting had taken place for a patient who lacked capacity to make a decision. Staff were not fully documenting the discussions held in the best interests meeting. Some staff were not using the proper form developed by the trust to clearly document evidence of a best interest meeting taking place, the options discussed and the outcome of the meeting.

However:

- Staff ensured that patients received any necessary assessment of their physical and mental health needs. Staff provided a range of care and treatment interventions suitable for the patient group. Staff in the Promoting Access to Main Stream Health Services team (PAMHS) were proactive in ensuring that patients physical healthcare needs were being met and supported patients to live healthier lives.
- Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Patients had access to a full range of specialists required to meet their needs.
- Staff used the weekly single point of referral (SPOR) meeting to ensure effective multidisciplinary team working.
- Staff used the Mental Capacity Act appropriately to determine if a patient had the capacity to make a specific decision. Staff gave patients every possible assistance to ensure they had the capacity to consent to treatment before they assumed that the patient lacked the mental capacity to make this decision.

# Community mental health services for people with a learning disability or autism

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff attitudes and behaviours when interacting with patients showed that they were respectful and responsive.
- Staff provided patients with easy-read documentation to understand their treatment.
- Staff directed patients to other services and supported them to access those services.
- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs.
- Staff informed and involved families and carers appropriately and provided them with support when needed.

However:

- Staff did not routinely inform people using the service how they could access independent advocacy.

## Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- The service had clear criteria for which patients would be offered a service.
- The team followed up with patients who did not attend appointments and supported them to attend in the future.
- Patients had access to a range of rooms and equipment to support their treatment and care at the Ridge Hill site in Dudley.
- All information provided was in a format accessible to the patient group for example, in easy-read language for people who had difficulty reading.
- Staff knew how to access interpreters for patients who required this service.
- Patients knew how to complain or raise concerns, and staff knew how to handle complaints appropriately.

However:

- In some teams, patients were waiting longer than the 18-week trust target to receive an assessment. In Walsall, patients had waited more than 18 weeks for a communication assessment. This was because patients who required a dysphasia assessment had been prioritized. The physiotherapy team in Sandwell had 32 patients who had been on the waiting list for more than 18 weeks.

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:



# Community mental health services for people with a learning disability or autism

- Leaders had the skills, knowledge and experience to perform their roles. Staff felt respected, supported and valued. Staff spoke highly of the service manager.
- Managers were visible in the service and staff found them approachable. Leaders had a good understanding of the services they managed.
- Staff felt positive and proud about working for the trust and their team. Staff knew and understood the trust's vision and values. Teams worked well together and cohesively.
- The provider had a comprehensive schedule of meetings and reporting systems to ensure good governance of the service.
- Staff had access to up to date information about the work of the services they used. For example, through the intranet or email bulletins.
- Staff had opportunities to participate in research. The service was part of a recent study conducted by the University of Bristol.

However:

- Due to a delay in changing from a paper based to an electronic records system, an integrated care plan had not been implemented.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Wards for older people with mental health problems

Good   

## Key facts and figures

The wards for older people with mental health problems at the Black Country Partnership Foundation NHS Trust were split across two sites. There are three wards in total providing support for older adults. Edward Street Hospital in West Bromwich had two wards, Chance and Salter. The hospital also had a dementia resource hub consisting of a café, hairdressers, dementia friendly kitchen and library. This was open to both inpatients and the wider community. Organisations also used this resource to hold groups such as carers groups. Chance ward on the ground floor of the building had 18 beds for males and females. They provided support for older adults experiencing mental health needs such as dementia. Salter ward on the first floor had 20 beds for both male and female older adults experiencing depression and anxiety. Both wards had limited space therefore some patients had to share bedrooms. Meadow ward was based at Penn Hospital in Wolverhampton. It had 16 beds for male and female patients experiencing dementia, depression and anxiety. This ward was purposely built and therefore a different layout from Chance and Salter wards. It was spacious had enough room for patients to have their own bedrooms with ensuite facilities.

Our inspection was unannounced therefore the service did not know we were coming. It allowed us to observe routine activity.

We visited all three wards for older people with mental health problems. Before the inspection we viewed information that we held about the service and asked the trust to provide information.

During the inspection visit, the inspection team:

- looked at the environment of all three wards
- spoke with 28 staff members including ward managers, doctors, cleaning staff, pharmacists, psychologists, health care support workers, occupational therapists and nurses.
- spoke to nine patients and six carers
- observed two handovers and one ward review
- Viewed 14 patient care records and 19 prescription charts

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The environments were clean and tidy. The ward layout meant staff did not find a good line of sight and there were ligature risks on all wards, staff mitigated these risks with good observation practice.
- Risk assessments were completed and updated when risks changed.
- Staff reported incidents using the trust's database. Lessons learnt were used to make improvements to services.
- Multi-disciplinary teams worked for the good of the patient. We saw the involvement of inpatient and community teams as well as other local hospitals working together to provide good care.
- Patients had access to a range of therapies provided by a range of staff employed by the trust.

# Wards for older people with mental health problems

- Staff cared for patients with respect and compassion. Their interactions with patients showed their understanding of the patient group and their needs. Patients and carers gave positive feedback about the staff and the wards. They gave feedback on the service.
- Staff involved patients in the planning of their care they involved carers and relatives if appropriate to support with care planning.
- Staff assessed and monitored patients' physical health throughout their admission. Patients had access to professionals specialising in aspects of physical care such as podiatrist.
- There was a range of rooms available for patient use for activities and access to a garden at both sites. Patients also used the facilities at the Lighthouse at Edward Street Hospital.
- Ward managers were always visible on the wards, staff said they were passionate, knowledgeable and supportive of the staff.
- All managers promoted a positive culture throughout the service, staff felt valued and appreciated by them.

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- The environment was clean and tidy. Chance and Salter ward layout meant they did not have good lines of sight and there were ligature risks on all wards; however, staff militated against the risks with observations.
- Staff demonstrated their awareness of how to manage clinic room temperatures that were above the normal range. They were aware of the trusts policies and procedures to make medicines safe for patient use during these circumstances.
- Staff reported incidents via the trust's database. Lessons learnt influenced changes such as having two staff to administer medication on the wards.
- Staff completed and updated risk assessments as and when changes occurred.

However:

- Chance ward did have an exclusive female only lounge. The designated room was used for other purposes and changed to a female only lounge on request.
- On Meadow ward not, all staff had access to the clinic and the emergency bag as the bag was moved temporarily to another room that only three staff had direct access
- Training for information governance, fire safety and moving and handling were below the trust target of 75%. Safeguarding training for adults level two and three and safeguarding children level two were below the trust target.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

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- Staff worked together in a multi-disciplinary way for the good of the patient. It involved inpatient and community teams and other local hospitals working together to provide good care.
- Staff used recognised tools to assess patient need. Physical health was assessed and monitored throughout the patients' admission. Patients had access to professionals specialising in aspects of physical care such as a podiatrist.
- Patients had access to both occupational and physiotherapists. Staff provided therapies and treatments suitable for the client group within the ward and in the lighthouse at Edward Street Hospital.
- The trust provided healthcare support workers with development training through the Trainee Nurses Associate. Courses were available to support interventions to assess physical health care such as phlebotomy courses.

However:

- The trust was unable to provide ongoing audits of Mental Capacity Act or Deprivation of Liberty Safeguards as the lead post was vacant.

## Is the service caring?

Good  ➡ ➡

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with respect and compassion. Their interactions with patients showed their understanding of the patient group and their needs.
- Staff involved patients in the planning of their care they involved carers and relatives if appropriate to support with care planning.
- Staff documented whether patients had copies of care plans and if they were able to sign the document.
- Staff invited carers/relatives to ward reviews and encouraged active participation. They provided support to both relative and patient.
- Patients and carers gave positive feedback about the staff and the wards. They were frequently invited to give feedback on the service.

## Is the service responsive?

Good  ➡ ➡

Our rating of responsive stayed the same. We rated it as good because:

- There was a range of rooms available for patient use for activities and access to a garden at both sites. Patients also used the facilities at the Lighthouse at Edward Street Hospital
- Staff displayed useful information for both staff and carers / relatives such as advocacy, carers groups, complaints and physical health
- Patients had access to support for their spiritual needs and a multi faith room was available at both sites
- Patients had a good choice of food. The service catered for religious, health and cultural needs.
- Patients could use mobile phones and rooms were available for privacy when making calls.

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However:

- Not all patients had rooms of their own. On Chance and Salter wards, patients had to share in dormitories of four patients. The structure of the building did not allow space to provide single rooms, therefore staff had to work within the confines of the building.
- On Meadow ward patients could not use the lift to attend tribunals or access other parts of the hospital. The lift was previously for patient use. Following a faulty alarm, it was turned into a “goods only lift”.

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- Staff were aware of the Freedom to Speak Up Guardian and knew how to report issues of bullying and harassment. They felt able to report concerns without fear of retribution.
- Some staff knew who senior managers were and said they had attended the wards.
- Ward managers were always visible on the wards, staff said they were passionate, knowledgeable and supportive of the staff.
- All managers promoted a positive culture throughout the service, staff felt valued and appreciated by them.
- Managers supported staff in difficult situations. Staff received debriefs following incidents and ongoing support from managers.
- The trust had good policies and procedures in place for staff to follow when clinic rooms were above normal limits and medicines management.
- The trust organised an annual achievement awards ceremony to celebrate the achievements of staff, carers and volunteers.
- The service was part of a group with NHS Improvement to reduce falls on the wards. Staff were involved in replacing the current tool used for assessing patient falls.

However:

- Training figures for safeguarding adults and children were below the trust target. Fire safety, information governance, and moving and handling were also below the trust completion rate.
- Not all staff were aware of the trust’s visions and values and were not involved in conversations concerning what the visions and values should be.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

#### Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulated activity

#### Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulated activity

#### Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulated activity

#### Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulated activity

#### Regulation

This section is primarily information for the provider

## Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing



# Our inspection team

Kathryn Mason, Head of Hospitals Inspection led the well-led inspection of the trust. Two executive reviewers, supported our inspection of well-led for the trust overall.

The team included three further inspectors, two executive reviewers and three specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.