Black Country Partnership NHS Foundation Trust

Quality Report

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Date of inspection visit: 16th – 20th November 2015
Date of publication: 26/04/2016

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

Summary of findings

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

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

Summary of findings

Ratings

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

Overall rating for services at this Provider	Requires improvement 
Are Mental Health Services safe?	**Requires improvement** 
Are Mental Health Services effective?	**Requires improvement** 
Are Mental Health Services caring?	**Good** 
Are Mental Health Services responsive?	**Good** 
Are Mental Health Services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We found that the Black Country Mental Health Partnership NHS Foundation Trust was performing at a level which led to a judgement of Requires Improvement.

The provider failed to consistently ensure that all people receiving a service were protected from potential harm due to poor environments at hallam street hospital and not consistently checking and maintaining equipment used by patients.

We found that systems to manage information governance were inconsistent; record keeping and archiving of patients files were of concern in some areas. We also found that training in the mental health act & mental capacity act was not a mandatory requirement on an ongoing basis.

The provider scored below the national average with regards to staff recommending the Trust as a place to work. Some of the staff that we spoke with felt disengaged from improvements that the leadership team are trying to embed. However, we saw evidence that the Trust is attempting to engage more effectively with staff by developing initiatives such as 20/20 events where staff were invited to participate in interactive workshops that focussed on the trusts strategic goals and objectives for the future.

We were impressed by the leadership at board level but identified that there was work required to ensure that the leadership at ward or team level was of a similar standard. The trust had implemented systems to monitor quality, safety and risk and the various committees and sub-committees which fed into the senior team enabled this. However, these processes were not fully embedded throughout the organisation.

The Trust can be proud of the caring culture within the staff group. We saw consistent evidence of people who use Trust services being treated with dignity, kindness and respect. We also saw some very good examples of services responding to the individualised and often complex needs of the patients.

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

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as Requires Improvement because:

- The wards at Hallam Street, Abbey ward, Charlemont ward and Friar Ward did not have clear lines of sight that allowed staff to observe all areas. There were blind spots that had not been mitigated in any way.
- Wards at Hallam Street were in a poor state. Walls and carpets were stained with damaged furniture and there was an unpleasant odour throughout the ward areas.
- In the child and adolescent mental health community services, toys were not regularly checked and cleaned.
- Cleaning records were not always available for staff to review or to check that areas had been cleaned at Lodge Road CAMHS service.
- Clinical equipment in patients' homes was not always maintained according to the manufacturer's service schedule.
- There were significant risks in relation to staffing levels in the Health Visiting Family Inclusion Team. However, the trust added additional resource to this service following our findings.
- Measures for summoning assistance were not robust across all the community mental health teams. Single Point of Referral had systems that were ineffective.
- Medication was not properly stored at Complex Care North. Fridge temperatures were not routinely checked. This could have led to harm to patients who used the services.

However :

- The MacArthur centre psychiatric intensive care unit and the acute wards had completed environmental risk assessments and all identified risks had been mitigated.
- Acute wards for adults of working age had introduced the first five stages of 'safe wards' in line with guidance from the Department of Health. This has resulted in greater collaborative working between staff and patients.
- Managers shared learning from incidents with staff in a number of formats including by email and through discussion at team meetings.
- Staff completed crisis plans for patients. They also had procedures for dealing with a sudden deterioration in people's health. When needed, they referred patients to the crisis team for an immediate assessment.

Summary of findings

Are services effective?

Requires improvement

We rated effective as Requires Improvement because:

- In the crisis and health based place of safety service, three out of nine care plans did not address the needs identified at the assessment stage and lacked clear guidelines on how staff should support patients to meet their needs.
- Health based place of safety teams records were not well organised and staff did not have access to information they needed because teams used different electronic record systems.
- Patients' confidential information was not kept secure. In two out of the three older people wards folders with patients' personal information such as name, date of birth, national health service numbers stored in glass cabinets in the dining/ lounge area.
- Managers did not ensure that all staff had an appraisal. Some wards/teams had good arrangements in place for regular appraisals of their staff and others did not.
- Health records arrangements were complicated and inconsistent across the trust and some patients had multiple files across different teams.
- In the acute wards and psychiatric intensive units, consent forms were filed with medication charts.
- Patients were regularly informed about their rights under the Mental Health Act and this was recorded in most patients' notes.

However:

- The trust monitored and audited outcomes for patients using its services. This included the monitoring of quality priorities such as medication administration errors, the reduction of restrictive interventions in learning disabilities inpatient units.
- There was a range of psychological interventions available. Therapy sessions took place regularly with individual based psychological interventions.
- Staff in the trust used a range of outcome measures. Health of the nation outcome scales were used to assess patients and formed part of patients reviews.
- Obtaining informed consent was variable and not always noted in care plans. We found that some patients had their views documented clearly in their care plans however; consent to treatment was not always recorded.

Are services caring?

Good

We rated caring as good because:

Summary of findings

- We observed examples of staff treating patients with kindness, compassion and communicating effectively. We saw staff engaging with patients in a kind and respectful manner throughout the trust.
- Patients and staff felt comfortable together and addressed each other by first names. Staff respected patients' privacy and dignity by knocking before entering patients' rooms, and speaking positively with them.
- In the CAMHS community service, young people were able to participate in skill or vocational based activities. Staff and patients worked together to integrate therapies into young people's educational commitments at school, which included a staff member picking up young people to ensure they attend the planned activities.
- Our team that inspected the children, young people and families' services found caring to be outstanding. People who used that service said the staff went the extra mile when they provided care. Staff empowered young people by providing them with appropriate information to support them to make decisions about the care they received. Staff went beyond their roles to overcome obstacles to ensure the needs of the child, family and carers were met.
- Information was provided to patients in the form of leaflets and welcome pack for patients that contained information to help patients orientate and provide them with information they might need whilst in hospital.
- Patients told inspectors about their involvement in the care they receive and staff documented patients' input to their care planning. Patients told us they were consulted about their care plans and felt involved in their care. Patients in the community learning disability service were always offered a copy of their care plan.
- In all of the services inspected, we saw examples of how patients were informed about how to access Independent Mental Health Advocacy (IMHA) services.
- Patients using the services of the mental health crisis and health based place of safety teams had their advance decisions recorded and taken into account when offered treatment.
- Patients in the acute wards and psychiatric intensive care units had patient centred physical intervention plans that guided the teams if physical interventions were required.
- Community meetings where patients were supported to contribute and voice their feedback on the service.

However:

Summary of findings

- Although we concluded that staff provided personalised care, this was not always reflected in most care plans.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The trust managed its beds effectively and therefore did not have difficulty in finding beds for its patients with out of area placement being rare.
- Patients on extended leave were always able to return to their own beds on their wards.
- Staff could access interpreters for patients and their families whose first language was not English. Information was provided in a range of languages if needed. Posters were displayed in a range of languages that asked patients to point to their language to assist staff in helping them.
- The community-based mental health services for older people had a treatment and recovery unit at Edward street hospital and had developed a cognitive stimulation group for those that use Punjabi as a fist language.
- The health visiting team at Ladies walk clinic had set up a monthly clinic operating between 5pm and 7pm so that the clinic services could be accessed by working parents. That was the best-attended health-visiting clinic across the trust.
- Gerry Simon clinic had access to spiritual leaders for patient support. Patients were supported to attend places of worship such as church or mosque.
- Dietary needs were catered for by the trust. Patients wanting halal or kosher meals had those provided for them.
- At Penn hospital, a health care assistant had worked with a local dental surgery to offer a service to patients at Brook and Dale wards. This ensured that dental treatment would be available to patients in hospital and when they were discharged.
- The forensic inpatient service used ‘shadow leave’ as positive risk taking with patients.
- There were leaflets on notice boards advertising the Patients Advisory and Liaison service, (PALS) and the Independent Mental Health Advocates (IMHA) service with contact details. There were compliments and complaints boxes placed around services.
- No complaints were referred to the ombudsman for any core service.

Summary of findings

- Patients and carers knew how to raise concerns and make a complaint and were confident that staff responded positively to them. Young people at the key team had raise concerns about the building décor and as a result, staff and patients started a project to paint the walls with murals.
- Lessons learnt from complaints and concerns were discussed at team meetings so that staff understood issues that caused distress to patients and carers. Learning lessons information was shared with trust staff through local meetings and through the trust learning lessons newsletter.

However:

- Patients in community-based mental health services for people with learning disabilities or autism had long waits for assessments. Sandwell, Dudley and Walsall teams were all above the 18-week target for assessment.
- There was no system in place in the single point of referral team to regularly monitor the list of people waiting to be assessed by the team.
- The specialist community mental health services for children and young people had long lists of patients waiting for assessments or interventions. Parents and carers, if they had concerns, were instructed to contact the services or attend their local accident and emergency department.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The trust have been slow to address the issues relating to potential ligature anchor points which had been highlighted in the environmental risk assessments
- Senior managers had not supported the health visitor family inclusion team with additional resources to manage a caseload that had significantly increased over the last 12 months. Staff were struggling to cope daily. We were not assured children and families were protected against abuse and avoidable harm. Senior managers were aware of the significant issues threatening delivery of safe and effective care.
- The paediatric physiotherapy service held 979 items of equipment in patients' homes within the Dudley borough and approximately 50% of this equipment had not been serviced within the recommended manufacturer timescale.

However:

- The board had a clear strategy for the future direction of the trust.

Summary of findings

- Staff were able to describe the trust's vision and values. Staff felt positive about the senior management team and felt heard by them.
- There had been opportunities for engagement with senior managers through walk arounds and through the 20/20 consultations meetings.
- Governance arrangements enabled managers to ensure patients were being kept safe and their staff were being trained, appraised and supervised.
- The trust had a clear structure of relevant committees and sub-committees. Across the core services, teams and wards were well managed with relevant recorded meetings in place.
- There were policies and procedures in place to help and guide staff in their work.
- Morale was mostly good and staff described their managers as approachable and responsive. There was consistent level of front line staff's knowledge and awareness of the trust's vision and strategy.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Oliver Shanley, Deputy Chief Executive Officer, Hertfordshire Partnership University NHS Foundation Trust

Team Leader: James Mullins, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Kenrick Jackson, mental health hospitals, CQC The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers, support staff and a variety of specialists and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

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

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about Black Country Partnership Foundation NHS Trust and asked other organisations to share what they knew.

We carried out an announced visit 16th to 20th November 2015. We also carried out an unannounced visit on 3rd December 2015.

We inspected all mental health inpatient services across the trust including adult acute services, the older people's wards and specialist wards for people with learning disabilities and children and adolescents. We inspected the trust's place of safety under section 136 of the Mental Health Act and the crisis services. During the inspection visit, we:

- Visited most of the trust's hospital locations and many of the bases from which it provides its community healthcare and community mental health services.
- Held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists.
- talked with 378 staff
- talked with 145 people who used services and with 78 carers and/or family members
- observed how people were being cared for and attended community treatment appointments
- Reviewed 328 care or treatment records of people who use services.

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

Summary of findings

Information about the provider

Black Country Partnership Foundation NHS Trust provides mental health, learning disability care and community health services to people predominantly living in the boroughs of Sandwell, Dudley and Walsall. The trust has a staff complement of around 2060 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 £98.4 million. Corporate staff work from Delta House, the current Trust Headquarters building.

The trust provides:

- Mental health and specialist health 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

What people who use the provider's services say

Patients and carers were complimentary about the care received from the older adult wards at Edward Street and Penn Hospital. People were positive about staff who they felt had a good understanding of their patients and demonstrated a caring nature.

Feedback from a parent using the Family Nurse Partnership when talking about the family nurse who visited her included, “She is like a best friend, mother, counsellor and therapist, all rolled into one. Absolutely amazing.” Feedback from a parent whose child was being cared for by the Palliative Care See Saw Team stated that they would, “Rate the service 10 out of 10.”

Patients of the acute and psychiatric intensive units were complimentary of staff. They said they had been treated with dignity, respect and felt that the staff cared about them. One carer told us that the service had included them and that they felt happy that their relative was being cared for by the trust.

Patients who used the community mental health services for adults told us staff treated them with kindness, compassion and in a respectful manner. They were polite, non-judgemental and they spoke to them as if they were a person. Patients told us they attended their review meetings and were encouraged to involve their relatives if they wished to. Relatives told us they felt included.

All patients who used the forensic wards praised the psychology team at the clinic.

We received a number of negative comments from patients relating to the quality of food provided. These all came from the MacArthur Centre.

There were also five negative comments relating to the environment at Hallam Street Hospital. Patients said that the building was too small and did not have enough space. There was also a complaint that patients at Hallam Street had to go to the recovery centre for meals regardless of inclement weather.

Summary of findings

Good practice

At Penn hospital a health care assistant (HCA) had worked closely with a local dentist surgery to offer a service to the patients at Brook and Dale wards. This linked with external services to ensure that dental treatment would be available to patients when they were discharged. This project had been such a success that the same HCA was now in the process of approaching local opticians to negotiate a similar service.

The development of a sensory processing group within Sandwell CAMHS service. This was developed by occupational therapists because of long waiting times for OT interventions.

Staff across all children, young people and family services were committed to empowering young people through providing them with the right information and support to enable them to make decisions around the care they received.

The Health Visitor Inclusion team, See Saw Palliative Care team and Health Visitor Ladies Walk team worked beyond to provide child centred, flexible appointments and involved children, young people and family members in decision making where possible.

A nurse who spoke four Asian languages had been recruited to the team. She acted as a lead in the team for black and minority ethnic (BME) communities.

The treatment and recovery unit at Edward street hospital had developed cognitive stimulation groups for those that use Punjabi as a first language. The team had also developed a programme in partnership with West Bromwich Albion football club. This was aimed at engaging particularly male patients and recognised the important role football had played in their lives.

Staff on the forensic inpatient/secure wards used of collaborative risk assessment and risk management planning. Patients participated in training staff in relational security and risk assessment and risk management.

The speech and language therapists at Ridge Hill, together with Dudley Library and Dudley leisure centre, developed a communication strategy to help people with learning disabilities to communicate to the best of their ability with support. This strategy consisted of ten standards of communication that were going to be adopted by a good range of other agencies.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must ensure that all areas visited by patients for their clinical reviews have emergency equipment such as automated external defibrillators and oxygen on site.
- The trust must ensure that management of potential risk from ligature risks do not compromise patient's privacy and dignity unless this is unavoidable.
- The trust must also ensure that an environmental risk assessment to include ligature risk is carried for flats used as crisis beds at 'P3'.
- The trust must ensure that risk assessments are completed for patients and regularly reviewed and updated.
- The trust must ensure that there are appropriate arrangements for the safe management of medicines. They must have proper arrangements for safe storage of medicines and safe and secure transportation of medicines. Medicines stocks must be consistently checked.
- The trust must ensure that there are clear systems of records management so that records are well-organised and different team members can access patients' records when needed
- The trust must ensure they store all care records securely.
- The trust must ensure that emergency equipment is available and accessible at all locations.
- The trust must ensure there are suitable numbers of qualified staff to meet the needs of children and families across all CYPF services.

Summary of findings

- The trust must ensure all equipment is serviced as per manufacturer's service schedule.
- The trust must ensure that where toys are available for the use of young people that those toys are regularly cleaned and records are maintained of this process.

The trust must ensure that all ward environments are clean, well maintained and free of unpleasant odours

Action the provider SHOULD take to improve

- The trust should ensure that portable appliance tests are carried out to all electrical equipment used to ensure they are safe to use.
- The trust should ensure that the kitchen area at Hallam street 136 suite does not have open access to boiling water from the instant water boiler fitted to the wall.
- The trust should ensure that staff receive training in Mental Health Act (MHA) and the Code of Practice. Staff in charge of the place of safety should receive special training for that role.
- The trust should ensure that there are arrangements in place to monitor adherence to the MHA and Mental Capacity Act to ensure that it was being applied correctly.
- The trust should ensure that all teams have information leaflets specific to their teams on how the services are run.
- The Trust should review its Seclusion policy in line with the MHA CoP (2015).
- The trust should ensure that there are effective systems to monitor high referrals and waiting times in the Single Point of Referral team.
- The trust should ensure that the legal status of patients is recorded on prescription charts in line with the code of practice requirements. Ensure that when appropriate the T2, T3, Form 4a or CTO12 capacity to consent to treatment forms are with the prescription charts.
- The trust should ensure that MHA paperwork copies are available in all patients' notes. To ensure clarity regarding the legalities of the CTO and its application.

Black Country Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

The trust had systems and processes in place that was monitored and audited by the Mental Health Act office to ensure good application of the Mental Health Act and the MHA code of practice. We found that most patients had received their rights under section 132 of the mental health act and that staff regularly repeated this information.

MHA paperwork was regularly monitored and most of the paperwork we looked at was correctly completed. Patients had been given copies of their section 17 leave authority and were clear about the type of leave that was being authorised with the number of the escorts required.

Information was displayed throughout the trust informing patients of how to contact the independent mental health advocate (IMHA).

Not all staff had received training in the MHA. However, those staff we talked to had a good understanding of the mental health act and how to apply it in their work with patients.

All T2 and T3 forms relating to medication and the use of a second opinion doctor were in place and complete

Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff we met and spoke to had an understanding of their responsibilities under the MCA and DoL safeguards. However, we found that some staff had not received training in the mental capacity act and deprivation of liberty safeguards.

Most wards had when needed had made appropriate DoLS applications. We saw that best interest assessments had taken place for patients who lacked capacity.

Independent mental capacity advocacy (IMCA) was available through a partnership with Voice ability. Staff were aware of the independent mental health advocacy team and knew how to contact them on behalf of their patients.

Requires improvement

Are services safe?

Detailed findings

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

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

Summary of findings

Our findings

Safe and clean care environments

- The trust scored 91% overall in the 2015 PLACE assessments, for privacy, dignity and wellbeing, which was similar for other trusts nationally.
- There were cleaning schedules available that showed regular cleaning took place. Most of the wards and services we visited were well maintained and kept people safe. The infection control committee within the trust oversaw infection control. Staff received infection control practice as part of mandatory training. We found good levels of completion for this training. Regular trust-wide cleanliness audits were undertaken. In the children, young people and families' service there were regular hand hygiene audits carried out. We saw evidence of issues highlighted during the audits and escalated to the trusts infection control committee with actions being implemented to address those issues. However in our inspection of the acute wards and psychiatric intensive care units we found at Hallam street hospital wards that had poor environments with dirty walls, stained carpets, furniture that was ripped and there was an unpleasant odour through the ward areas.
- Fire procedures and equipment were in place at all services. Staff had received fire safety training, and were aware of what to do in an emergency.
- Most wards and services had alarm systems. However, the interview rooms at Lodge road CAMHS did not have alarms fitted in the interview rooms. There were personal alarms available for staff if requested but may not be heard in all rooms that meant that staff and patients were at risk. In the community mental health services, not all locations had access to alarms. The single point of referral team assessed patients in GP surgeries. The interview rooms were not fitted with panic alarms. Staff were aware of the risks and conducted interviews in pairs when there were concerns.
- There was no evidence seen of regular auditing or any system to ensure that toys in use by young people visiting the Gem centre. Toys in use at Lodge road were old and in poor condition. There were foreign objects found in one toy box in use by a young person during the inspection. The box also contained broken toys and scraps of paper.
- We found that not all the layout of the wards generally allowed clear lines of sight for staff to observe patients. The trust had not installed observation mirrors in some areas to reduce the risk. Wards used staff observation to mitigate this risk. At the Gerry Simon clinic the circular layout of the unit, mean that corridors curved so it was not possible to see very far without physically moving and following the curve of the corridor. There were poor lines of sight with blind spots at Hallam street hospital on Abbey ward, Friar ward and Charlemont ward. None of these blind spots was mitigated by the use of mirrors. All three wards had blind spots in the stairwells, the stairs had a landing half way up that turned 180 degrees and this prevented clear view from top to bottom of the stairs. There was not mitigation by way of mirrors to this risk area. At the MacArthur centre, there were good lines of sight and blind spots were mitigated by the use of mirrors and increased levels of observation. CCTV was been fitted at the MacArthur centre during the inspection.
- On the majority of wards, there were clear arrangements for ensuring that there was single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice.
- All clinic rooms we visited appeared clean and were fit for purpose. Clinic rooms were well with equipment that was checked regularly to ensure they were in good working order so that they could be used in an emergency.
- The trust carried out ligature and environmental audits across all of its wards and units. Where ligature risks were identified there was arrangements in place to

mitigate those risks such as by observation for patients deemed to be at risk of self-harm. There were ligature risks in the bathroom at the 136 place of safety in Penn hospital that had not been identified by the ligature and environmental audit. These risks were taps on the washbasin in the toilet and door handles. When staff were asked about those risks, they said patients at risk were managed through maintaining observation when patients were using the facilities. The crisis and resolution home treatment tam used flats owned by a voluntary organisation as its crisis beds. There were several potential ligature points such door and window handles, taps and curtain rails. No risk ligature risk assessments had been completed prior to patients been placed in those crisis beds.

- The kitchen area at Hallam street hospital had open access to boiling water from the instant hot water boiler fitted to the wall. The ward manager was aware of this risk and had reported to senior managers four months earlier but no action had been taken.

Staffing

- The trust reviewed staffing levels for all inpatient areas and community areas. The trust monitored and reported on shift fill rates for the wards. In the information provided to CQC by the trust for the three months between April 2015 and June 2015 shifts were filled as follows; 1281 shifts for registered nurses. 2687 shifts for health care support workers. 176 shifts for registered nurses and 96 for health care support workers for the three months were not filled as planned however, it was noted that ward managers had been able to maintain safe staffing levels.
- Across the Trust, there were 105 WTE vacancies for qualified nurses and 45 WTE vacancies for qualified nursing assistants. This was X% and Y% of all qualified nurse and nursing assistant posts respectively.
- At the time of our inspection in November 2015, we found that staffing was generally sufficient on the wards. However, in children, young people and families' services health visiting family inclusion team there were significant risks to children and their families because of low staffing levels. The team had one full time health visitor, one community nursery nurse working part time and 0.1 support from administrative staff for a caseload of one hundred complex cases. Following our findings, the trust added additional resource to this service.
- The acute wards and psychiatric intensive care wards had high numbers of vacancies mainly for band 5 registered nurses. This meant they (wards) had to use bank and agency staff to support regular staffing levels. The highest use of bank or agency staff was by Macarthur ward where temporary staff worked 710 shifts between July and October 2015. To maintain consistency wards had a preferred list of bank and agency staff who knew the wards and patients.
- Ward and team managers confirmed that processes were in place to request additional staff where required.
- Medical cover was generally good across most inpatient and community services. From information received from the trust there were two middle grade vacancies that were covered by locums.
- The Trust provided details of 11 mandatory training courses across 149 MH departments. The target completion rate for all courses is 95% and the one which had met its target was 'Paediatric Basic Life Support'. Some completion dates were in the future. Records for March 2015 showed that 85.3%, of staff had attended mandatory training.

Track Record on Safety

- Black Country Partnership NHS Foundation Trust reported 1,987 incidents to National Reporting and Learning Systems (NRLS) between 1 April 2014 and 31 August 2015.
- The majority of incidents resulted in no harm (61%) or low harm (36%) to the patient. 10 incidents were categorised as deaths, all of which occurred mainly within the adult mental health speciality.
- There were 26 National Reporting and Learning Systems incidents categorised as deaths during the period, which accounted for 1.0% of all the incidents reported.
- 59 incidents were reported to STEIS (Strategic Executive Information System) between 1 July 2014 – 30 June 2015. Ten of these involved the death of a patient. The trust reported there were no never events. The top three incident types reported were the seven unexpected death of community patient in receipt of care.
- 56 Serious Incidents Requiring Investigation (SIRI) were reported by the trust.

Learning from incidents

- The trust had a system in place to capture incidents and accidents and to learn from them when things went wrong. Staff were able to explain the process they used to report incidents through the trust's reporting system.
- Staff were aware of how to complete incident reports and their responsibilities in relation to reporting incidents. An on-line incident form was completed on the trusts Datix system following any incident. Temporary staff were unable to use the Datix system to report incident however. They passed the information to regular staff that would complete the Datix forms on their behalf.
- The trust had a weekly telephone meeting to discuss risks, incidents and to ensure action had been taken to reduce the potential for similar incidents to happen. That information gathered at the weekly telephone meeting was shared with on-call managers working at weekends to ensure awareness of ongoing risks or potential risks.
- A quality safety group meeting chaired by a non-executive director reported all serious incidents to the trust board.
- All serious incidents are thoroughly investigated using a root cause analysis methodology.
- Monthly updates from the trust called 'learning lessons' were sent to all staff. Lessons learned were discussed weekly in the team meetings and monthly divisional meetings.
- Following incidents de-brief sessions were offered to all staff. Some wards had appointed de-brief leads to take the lead in organising the de-brief sessions.

Safeguarding

- The trust had policies in place relating to safeguarding and raising concerns, (whistleblowing procedures). Staff were aware of the safeguarding policy and most was aware of the trust safeguarding leads. We were told that the trust is internal and the local authorities' safeguarding teams were accessible and available to staff for additional advice.
- Managers and staff told us of occasions where they had raised urgent issues of concern and held joint meetings with other service providers. We heard about a number of positive actions because of this.
- Safeguarding training targets were set at 95%. Not all core services had achieved that level of compliance. The community mental health teams had achieved 100% for training in both adult and children safeguarding. The acute wards for adults of working age and psychiatric intensive care units had compliance for level 2 safeguarding at 15% and level 3 at 26%.
- The trust had recognised the shortfall in safeguarding training and had prioritised training. A number of staff had been trained in safeguarding and they would be providing training across teams. Most staff were able to describe situations that would constitute abuse and could demonstrate how to report concerns.
- A governance process was in place that looked at safeguarding issues at both a trust and at directorate levels on a regular basis.
- Where a complaint related in whole or in part to an incident that could potentially be considered a serious incident or be subjected to duty of candour, the complaints department ensured that was reported to the Governance Team. Complaints that met duty of candour were also reported to the Governance Team to ensure duty of candour has been met and linked on the Datix system

Assessing and monitoring safety and risk

- We saw that risk assessments were completed on admission and updated regularly within the inpatient wards. Risk assessments were variable in the community teams. The community mental health teams had comprehensive risk assessments that were updated regularly and utilised historical and current risks in contingency plans.
- Risk assessments for young people using the services were not always completed. Following initial referral and assessment, we found that young people did not always have a risk assessment completed.
- There were a range of risk assessments implemented with children, young people and families' services.
- Crisis plans were in place in the health-based place of safety and learning disability community teams where we saw routine use of crisis plans or advance decisions for patients. The complex care teams had systems in place to respond to deterioration in a person's health. People confirmed they had been able to access the services quickly.

- The trust had a small pharmacy team that provided a clinical and advisory service to in-patient wards and had oversight of medicines use in the trust. The supply of

medicines was externally sourced; each pharmacist covered two to three wards each day. Any concerns or advice about medicines was written directly onto the person's medicine records.

- The Pharmacy Department at both Hallam and Penn sites were situated at central locations to increase the accessibility to the Pharmacy Team. All members of the pharmacy team wore burgundy clinical tops. This made it easy to quickly identify who the pharmacy team were around the trust and in particular on the wards.
- In response to the NHS England and MHRA patient safety alert: Improving medication error incident reporting and learning (March 2014) the trust had appointed a Medicine Safety Officer (MSO). Arrangements were in place to ensure that medicine incidents were documented and investigated. The learning from medicine related incidents was shared with staff via staff team meetings.
- Arrangements were in place to check that medicines were stored securely but not that they were within safe temperature range as audits that were carried out only checked on staffs compliance with monitoring.

Potential risks

- The trust had lone working polices and arrangements in place measures had been put in place to reduce the risk of lone working across teams. The crisis teams had a system of signing in and out with expected return times so that staff location was known at all times. Staff in the children, young people and families' teams had logbooks where appointments were recorded and they had mobile telephones with a tracking application installed in order for their location to be traced.

Requires improvement

Are services effective?

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

Summary of findings

Our findings

Assessment and delivery of care and treatment

- The trust proportion of admissions to acute wards gate kept by the CRHT Team was 100% The trust constantly remained at 100% and therefore above the England average.
- The trust delivered 66% of its memory clinics as part of the wider community mental health teams for older people as opposed to a stand-alone clinic. In the last 12 months, memory clinics each assessed an average of 544 patients and saw an average of 1206 patients in total, a near fourfold increase since 2010/11.
- 49% people diagnosed with dementia over the last 12 months were in the early stages of the condition.
- The majority of care plans were personalised and included patients' views. They covered the full range of patients' problems and needs. For example, in the learning disabilities service, we looked at 27 patients' care records and all but one showed that patients' needs were assessed and care was delivered in line with their individual care plans.
- In the crisis and health based place of safety service we saw three out of nine care plans we reviewed were not holistic and recovery orientated. They did not address the needs identified at the assessment stage and lacked clear guidelines on how staff should support patients to meet their needs.
- In-patients had a physical healthcare check completed on admission and their physical healthcare needs were being met. Medical staff following the patient's admission to the ward documented physical health examinations and assessments. Ongoing monitoring of physical health problems was taking place. Most patients had a care plan that showed staff how to meet these physical healthcare needs.
- Physical health checks were completed and where needed ongoing healthcare was provided. There were clear arrangements were in place for partnership working around physical healthcare needs with colleagues in primary care.
- In the community learning disabilities service, we saw a specialised team that promoted access to mainstream health services such as hospital and general practitioners. Hospital passports had been developed and when patients were admitted to an acute hospital it described likes, dislikes, current medication and how they wanted to be addressed.
- Most teams stored information and care records securely in locked cupboards and secure computers. The acute wards securely stored paper notes in nursing offices within dedicated cupboards. When patients moved between teams, there was an effective system to ensure that notes went with them.
- However, in the crisis and health based place of safety teams records were not well organised and staff did not have access to information they needed because each team used different electronic record systems.
- In two out of the three older people wards we saw folders with patients personal information such as name, date of birth, national health service numbers stored in glass cabinets in the dining/lounge area.

Best practice in treatment and care

- The trust were asked to provide the number of delayed discharges over the last 6 months but provided percentage figures instead. Between December 2014 and May 2015 Newton, Salter Ward and Suttons Drive had no delayed discharges whilst Penrose had the most at 25%. Between December 2014 and May 2015, there were 220 re-admissions within 90 days. Ridge Hill had the highest proportion of re-admissions at 53% whilst Daisy Bank, Gerry Simon, Newton, Penrose, Pond Land and Suttons Bank had none.
- Outcomes for patients using the services were monitored and audited by the trust. This included the monitoring of quality priorities such as medication administration errors, the reduction of restrictive interventions in learning disabilities inpatient units. The

trust monitored and reported on progress against these indicators and priorities. Commissioners met with the trust to review the progress they made against their quality priorities. A range of outcome measures was in use by the trust. Health of the nation outcome scales were used to assess patients and formed part of patients reviews. We reviewed 12 sets of notes in the crisis and health based place of safety. All had up to date health of the nation's outcome scales which meant the service was using standard ways to monitor changes in patients' presentation.

- There was a range of psychological interventions available. For example, we saw that psychologists were an integral part of the acute wards and psychiatric intensive care wards. Therapy sessions took place regularly with individual based psychological interventions.
- The child and adolescent mental health services were using the national institute for health and care excellence guidelines on managing challenging behaviours and continence with young children with learning disabilities.
- Regular audits were carried out across the trust. An example seen was the auditing of clinical notes. The audit showed that 20% of the records within the audit had a current risk assessment or evidence of review. 10% of records did not have a care plan.
- The second national audit of schizophrenia saw the trust score 89% against the standard of service users who report positive outcomes from the care they received over the past 12-months.88% of service users reported in the audit that their experience of care over the past 12 months had been positive.

Skilled staff to deliver care

- The necessary skills to deliver care were available across the trust. All the staff in the learning disabilities service were trained in the skills to work with that client group. In the community, child and adolescent teams there were staff from different discipline to enable them to care for children and young people.
- Staff working in the community-based teams for adults of working age were trained in talking therapies such as dialectical behavioural therapy, cognitive behavioural therapy and solution focussed therapy.
- There was a good induction process in place for new staff in the crisis and health based place of safety teams.
- All teams had access to a wide range of mental health disciplines to meet the needs of patients. As an example, we saw that all the staff at the Gerry Simon clinic were trained and experienced in working with people who had learning disabilities.
- In information provided to us by the trust, they showed that 94% of non-medical staff had received an appraisal. Mental health community and specialist child, young people and families had the lowest at 84%. Mental health wards, learning disability and forensic had the highest at 95%.
- Appraisal was variable across the trust. Some teams had good arrangements in place for regular appraisals of their staff and others did not. In the acute and psychiatric intensive care wards, there was monthly supervision ongoing for staff whilst in the community mental health services for children and young people we could not find evidence that staff were getting regular supervision. Managers told us they provided supervision but could not provide evidence to support.

Multi-disciplinary working

- Teams worked effectively between themselves and with agencies external to the trust. There were examples of teams working with other agencies such as the community children and young people service providing in partnership with the local authority a multi-agency group that focussed on working with families and children who had been taken into care.
- There were weekly referral meetings held in community teams that involved the multi-disciplinary team meeting, discussing, and allocating new referrals for assessment and treatment.
- There were good working relationships between the home treatment team, the approved mental health practitioner teams and the crisis teams.
- Multi-disciplinary working across all community children, young people and family services was robust, proactive and well planned.
- Psychologists supported teams and offered some team's monthly supervision.
- We saw a limited involvement in multi-disciplinary meetings, of clinical pharmacists due to limited capacity of the small team and geographical spread of the Trust.

Information and Records Systems

- The trust had an information governance policy that had been developed and embedded over the last year

since the appointment of the information governance manager. There was a good escalation process from ward to the information governance steering group to the quality and safety board. The information governance team made site visits to audit compliance with information governance across the trust. The team is not a large one but to cover the geographical area of the trust it divided itself into two to ensure the audits were completed. The information governance lead had responsibility for information governance across the trust, by collating data and presenting to the information governance steering group. Staff were provided with support, training, systems and easy access to the information governance team. The staff information governance training had recently been refreshed by the trust.

- Health records arrangements were complicated and inconsistent between geographical locations. The trust had approximately 250,000 records held in archives across its sites. Live records for patients open were kept on the wards. Discharged patient files were kept on site for two years. After two years, the files were archived at an onsite library, of which there were six. Patients had multiple files across site and there was a project to store patient files together. The trust had been running a project on retention and destruction and had identified 9000 files for destruction. There was no consistent electronic health record. All inpatients wards uses paper files. The Wolverhampton based teams used care notes. Individual teams used their systems consistently but not between teams outside their core service. This meant that information could become lost or misinterpreted.

Consent to care and treatment

- Obtaining informed consent was variable and not always noted in care plans. We found that some patients had their views documented clearly in their care plans however; consent to treatment was not always recorded. In the acute wards and psychiatric intensive units, we found that consent forms were filed with medication charts. Patients were regularly informed about their rights under the mental health act and this was recorded in most patients' notes.
- Staff received Mental Capacity Act training as part of their safeguarding training however given that safeguarding training was low across the trust this meant that not all staff were up to date with Mental Capacity Act.

Good

Are services caring?

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

Summary of findings

Our findings

Dignity, respect and compassion

- The trust's 2015 overall score during their patient led assessment of the care environment assessments for dignity, privacy and respect was 90.6%, which was about the same as the England average of 90.7%. The trust scored 88.2% overall for food which was just below the England average of 89%. Heath Lane hospital scored 88.6%, Hallam street hospital scored 84.4%, Edward street hospital scored 91.1%, and Penn hospital scored 89.4%.
- Results of the Friends and Family test showed 71% of staff would recommend the trust as a place to receive care. This score was below the national average for similar mental health trusts.
- The CQC's Community Mental Health Patient Experience Survey showed the trust scored the same as other mental health trusts.
- We observed examples of staff treating patients with kindness, compassion and communicating effectively. We saw staff engaging with patients in a kind and respectful manner throughout the trust. For example, we saw staff attending to a patient who was in pain, and was experiencing emotional distress. The staff were caring, kind and mindful of the patients' needs. Staff demonstrated good personalised care that was not always reflected in most care plans.
- We saw that patients and staff felt comfortable together and we heard them addressing each other by first names. We observed that staff knocked before entering patients' rooms, and speaking positively with patients.
- In the CAMHS community service, we observed a cooking and music group. Young people were able to participate in skill or vocational based activities. Staff and patients told us that they made every effort to integrate therapies into young people's educational commitments at school, which included a staff member picking up young people to ensure they attend the planned activities.
- Our team that inspected the children, young people and families' services found caring to be outstanding. People who used that service said the staff went the extra mile when they provided care. Staff empowered young people by providing them with appropriate information to support them to make decisions about the care they received. There were many examples seen during the inspection of staff going beyond their roles to overcome obstacles to ensure the needs of the child, family and carers were met.

Involvement of people using services

- Most patients and their carers told us that they were orientated to their ward on admission and were shown around by staff. They had received information leaflets relating to the trust. Welcome pack for patients was available in most wards that contained information to help patients orientate and provide them with information they might need whilst in hospital.
- Where possible learning disability patients visited the ward with their relative or carer before admission.
- We received good feedback from patients about their involvement in the care they receive. Documented evidence of patients having input to their care plans was consistent. Patients told us they were consulted about their care plans and felt involved in their care. Patients in the community learning disability service told us they were always offered a copy of their care plan.
- Information was displayed on the wards and in the community services about advocacy services and specifically the Independent Mental Health Advocacy (IMHA) service for patients detained under the MHA. Most staff was familiar with the role of advocates and they knew how to contact them on behalf of patients.
- Patients in the mental health crisis and health based place of safety service told us their advance decisions were recorded and taken into account when treated. We saw that all patients in the acute wards and psychiatric

Good

Are services caring?

intensive care units had patient centred physical intervention plans in their notes. This was an agreed approach to planning if physical interventions were required.

- We observed community meetings where patients were supported to contribute and voice their feedback on the service.

Good

Are services responsive to people's needs?

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

Summary of findings

Our findings

Planning and delivery of services

- Information received from the trust showed that the bed occupancy in the learning disability service had been consistently below the national average for the last 12 months with the exception of Q3. The mental health bed occupancy was consistently below the national average for the last 12 months. Gerry Simon had the highest rate at 97% and Penrose had the lowest rate at 53%.
- We were not aware of any out of area placements at the time of our inspection. The trust did not have difficulty in finding beds for its patients and an out of area placement would be rare.
- When patients go on extended leave, their beds are not allocated to new patients, which meant on return they had a bed to return to.
- The trust was below the national average in regard to percentage (96%) of patients on CPA who were followed up within seven days after discharge over three four quarters of 2014/15, and was at 98% for quarter 4.
- The total number delayed patients had risen over the past year with peaks in December 2014, April 2015 and July 2015. There was a dip in delays in February 2015 The trust has consistently had a lower number of delayed days than the England national average. The cause of the peak in December 2014 and dip related to patients needing non-acute care.
- Referral to assessment and assessment to treatment targets in assertive outreach teams were 134 days and 28 days respectively. Sandwell older adults' referral to assessment was 21.6 days and 15.6 days from assessment to treatment.
- We found long waits in community learning disabilities services. Sandwell, Dudley and Walsall teams were all above the 18-week target for assessment.

Diversity of needs

- Dudley, Walsall and Wolverhampton present a large geographical area across what is known as the Black Country due to its industrial heritage. All three areas have large ethnic populations from the black and Asian community. There has been a growth in people from central Europe such as the polish community
- Staff could access interpreters for patients and their families whose first language was not English.
- Staff told us they could access information in a range of languages if needed. We saw posters in a range of languages that asked patients to point to their language and let the receptionist know.
- There was a range of leaflets in different languages in the community mental health teams for adults. This meant that non-English speaking/reading patients were able to get information in the languages they understood. Staff told us they had access to a range of leaflets in various languages through the trust's intranet translation services.
- Community mental health team for older adults had a treatment and recovery unit at Edward street hospital and had developed a cognitive simulation groups for those that use Punjabi as a fist language. The group recognised the different early life experiences of the patients using services.
- Patients and carers who had used the services of the complex care team north had made adjustments to the building. The south team had raised concerns that wheelchair users could not access the building easily.
- The health visiting team based at Ladies walk clinic had implemented a monthly clinic running between 5pm and 7pm so that the clinic could be accessed by working parents. That was the best-attended health-visiting clinic across the trust.
- Patients in the Gerry Simon clinic had access to spiritual leaders for support. Some patients were supported to attend places of worship such as church or mosque.
- Dietary needs were catered for by the trust. Patients wanting halal or kosher meals had those provided for them.

Good

Are services responsive to people's needs?

- At Penn hospital, a health care assistant had worked with a local dental surgery to offer a service to patients at Brook and Dale wards. This ensured that dental treatment would be available to patients in hospital and when they were discharged.

Right care at the right time

- Bed occupancy levels at the MacArthur centre meant that a bed was always available at the psychiatric intensive care unit. The trust had robust links with neighbouring trust that would ensure, if required, a psychiatric intensive care bed was available and sufficiently close for patients' families to maintain contact.
- Patients of the older adult's community service treatment and recovery unit and the groves day centre were seen with a week of referral for an assessment. Urgent referrals were responded to on the same day. The older adults' home treatment team responded quickly to referrals on the same day and dealt quickly and sensitively to patients phone calls.
- The crisis team response to referral was different across the geographical area of the trust. In Wolverhampton, the referral and assessment service gate kept all new referrals and in Sandwell, the crisis and resolution home treatment team received referrals. Both operated a triage service with a response based on level of urgency. Patients in Wolverhampton with an urgent referral were seen between 6 and 48 hours whilst emergencies would be seen within six hours. In Sandwell, urgent referrals were seen within 24 hours and routine referrals within seven days and non-urgent within 28 days.
- Within the community based mental health services for adults all referrals were received through a single point of referral. Referrals were accepted from general practitioners and other healthcare professionals. Self-referrals were not accepted by the service. Referrals went through a screening process by a duty worker and if risk was evident and urgent referral to the crisis, team was sent that same day. Non-urgent referrals would be assessed by a single point of referral worker who would send a letter to inform the patient and give them a telephone number with which to contact the team if they needed to whilst waiting for their assessment. A routine assessment could take between six to 20 weeks although the service target was between 4 – 8 weeks. There was no system in place to regularly monitor the list of people waiting to be assessed by the team.
- The community mental health services for children and young people held waiting lists for assessments or interventions for long periods. The team monitored waiting times but the risk to young people waiting was not. Parents and carers were told if they had concerns, they should contact the services or attend accident and emergency.
- The forensic inpatient service used 'shadow leave' as positive risk taking with patients. Shadow leave was where staff followed a patient on section 17 leave at a distance. This was to monitor the patients' ability to stay safe when out on leave and report to the multi-disciplinary team. If there was a concern, the staff member would intervene to ensure the patient and the public was safe.
- We saw that assessments for children and young people took place at appropriate time across all services. The key contact stages for the healthy child programme were included in the community children, young people and family services key performance indicators.

Learning from concerns and complaints

- There were leaflets on notice boards advertising the Patients Advisory and Liaison service, (PALS) and the Independent Mental Health Advocates (IMHA) service with contact details. There were compliments and complaints boxes placed around services.
- 155 complaints were received by the trust In 2012/13. In 2013/14, there was slight increase to 161 but the number that was upheld had fallen by 31%. All aspects of clinical treatment were the most common complaint category in both 2012/13 and 2013/14, although this increase in the second year compared to the first.
- The number of received complaints for attitude of staff total remained broadly the same but the number of upheld complaints fell.
- Learning Disabilities in-patient wards had the lowest proportion of upheld complaints at 25% whilst community based older people service had the highest proportion of upheld complaints at 100%.
- One complaint had been upheld by the health service ombudsman in the previous 12 months for community based mental health services for adults of working age.
- Most patients and carers knew how to raise concerns and make a complaint. They felt they would be able to raise concerns should they have one and were confident that staff would respond positively to them.

Good

Are services responsive to people's needs?

- Staff told inspectors and we saw that complaints, concerns and lessons learnt were discussed at team meetings.
- On the day of our inspections, we observed staff supporting a patient to make a complaint.
- The community learning disabilities services had not received any complaints in the past twelve months but patients knew how to complain and where to seek help to complain through an advocate.
- The majority of carers in the community mental health services for children and young people said that they knew the complaints procedure. They said they would approach staff with their concerns if they had them. Young people at the key team had raise concerns about the décor and as a result, staff started a project to paint the walls with murals. Young people were able to participate in the project by inputting their thoughts that was displayed on the mural.
- Learning lessons information was shared and discussed by ward and team managers in local meetings and shared within a trust newsletter.

Requires improvement

Are services well-led?

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

Summary of findings

Our findings

Vision, values and strategy

- The trust's strapline was our community: you matter, we care. To work with local communities to improve health and well-being for everyone. This was shared with staff across the trust.
- The trust's values were 'Valuing people as individuals, providing high quality innovative care, working together for better lives, openness and honesty and exceeding expectations'
- The trust's strategic goals were to; Nurture a culture, which provided safe, effective, caring, and responsive and well led services. Involve and listen to patients, carers and family's experience to continually improve services. To be a leading provider of specialist mental health, learning disability and children's services, proactively seeking opportunities to develop services building partnerships with others, to strengthen and expand the services provided. Attract and retain a well-trained, diverse, flexible, empowered and valued workforce and use resources effectively, innovatively and in a sustainable manner.
- The trust's vision and values were on display in the trust and were available on the trust's intranet. There was consistent level of front line staff's knowledge and awareness of the trust's vision and strategy.
- The trust has held 20/20 events where staff were invited to participate in interactive workshops that focussed on the trusts strategic goals and objectives for the future. The outcomes from the various workgroups were shared at relevant meeting to gather feedback for other staff.
- Staff across the trust were familiar with executive team and board members.
- Trust board members interviewed were clear about the trust's vision and strategy. Senior clinicians were clear about their role and the trusts direction.

Good governance

- Quality and safety is led throughout the trust by the quality and safety steering groups. The quality and safety committee monitors all quality, safety, safeguarding, mental health act, complaints/ compliments and patient experience. The lead for quality at board level are the medical and nursing directors.
- There was a board assurance framework in place to hold the executive team to account and monitor progress against the strategic objectives and operational delivery. Risk registers were also in place and held at divisional levels of the trust.
- During the inspection, we found that board members had a good understanding of the issues faced by the trust in delivering and continuing to deliver services. The board held staff to account whilst allowing the executive team to manage the delivery of services.
- The clinical director of each division chairs the quality and safety steering group. The group meets each month and monitors the divisions' performance in safety, audits, patient experience and workforce. The group considers all serious incidents, with themes considered. Themes identified are disseminated trust wide via the learning lessons bulletin.
- Most staff demonstrated they were aware of the governance process and their responsibilities. Staff had access to performance information and meeting minutes. Staff said they were able to escalate risks through their teams and up through the divisional structures and they would be placed onto the divisional risk register.
- There was evidence staff were taking part in clinical audits in a meaningful way with teams learning from the audits and using them to inform developments to the service.
- Training was monitored across the trust. Safeguarding training was below the trusts minimum standards and a plan had been formulated to improve using internal trainers and with periods for the training of all staff to be completed.

Requires improvement

Are services well-led?

- The local teams owned complaints management and they referred the issues to the patient advice and liaison team for resolution. Themes were collected to gather any trust wide or systemic issues and the learning was disseminated through the learning lessons bulletin.

Leadership and culture

- Morale was found to be good in the trust and staff told us this was because of recent changes that had taken place and improved engagement. Some staff felt engaged by the trust and had participated in the 20/20 process. Staff told us that the senior managers were visible. Staff in Meadow ward told us about previous low morale but senior managers responded by setting up a turnaround team. The team had set up an improvement plan and staff said how much improved working on that ward was sickness levels had fallen and staff who had thought about leaving had changed their mind.
- Average sickness rates at the trust 5.4% for the past year. There was a staff turnover rate in the trust of 17.4%.
- In the 2014 NHS staff survey, the trust scored better that the average for two key measures. These were receiving health and safety training in the past 12 months and having equality and diversity training in the past 12 months.
- The trust scored worse than the national average and were in the worse 20% of trusts nationally in eight areas. These included feeling secure, raising concerns about unsafe clinical practice; fairness and effectiveness of incident reporting procedures and staff recommending the trust as a place to work.
- To consider staff's views, the trust has held 20/20 vision events that detailed the trust's priorities against the national priorities. This formed the basis of discussion with staff about the visions and values of the trust.
- Because of a poor result staff survey, whistleblowing and a feeling from staff that the trust did not listen to them. The trust had been working with the royal college of nursing on improving the culture of the organisation and staff interface. The trust has been working on developing better and 'less clunky' systems that allow teams and services to focus on working together, improve quality, and deliver safe services.
- Staff knew their immediate senior managers and most felt they had a good working relationship with them. Staff were aware of the directorate management structure and felt supported by them.
- Staff were aware of how to report concerns and understood their role in monitoring and assessing risks. They said that line manager would be supportive when they reported their concerns.

Fit and Proper Person Requirement

- We were assured by the trust's chair and members of the senior leadership team regarding the implementation of the fit and proper person's test that all directors had received the appropriate clearance.
- We reviewed executive members' personnel files and found the appropriate documentation had been completed.
- The trust undertook a self-assessment and completed checklists on all board members.

Engaging with the public and with people who use services

- There were limited processes in place for consultation with patients and carers regarding service provision. There were several patient representative groups geographically dispersed across the trust.
- A carers' Team gave carers the chance to have their own caring, physical, and mental health needs considered. The team gave support to people caring for someone aged 18-65, living in or on the boundaries of Sandwell by carrying interventions such as care assessments, to providing health screening for carers, to organising social events for carers to meet one another.
- The Trust developed a mental health initiative called, The Recovery College. Its aim was to support people on their journey to recovery. The college aimed to support people to become experts in their own self-care, and enable family, friends, carers and staff to better understand mental health so that they can best help people towards recovery. Courses were co-produced with users, carers and professionals working in partnership.
- Patients in the forensic wards collaborated with psychologists in the assessment and management of their risks. Forensic ward patients attended and participated in staff training. Feedback received showed that this led to learning for the staff and for the patients.
- There is a 'Listen and Action' group across the learning disability services on how to engage and support patients and carers.
- The trust had a small patient experience team that were there to ensure that service users, carers and families

were involved in trust developments and feel confident and supported in raising any issues. They covered: patient advice and liaison service, dealing with formal complaints, receiving concerns and compliments about services, volunteering, implementing the patient Friends and Family Test, and overseeing the system and development for the Trust to involve service users and carers.

Quality improvement, innovation and sustainability

- The MacArthur Centre was a member of the national association of psychiatric intensive care units. The acute wards were preparing to undertake Accreditation for Inpatient Mental Health Services accreditation via the royal college of psychiatrists.
- Data collected in the acute wards was fed into national improvement programmes.
- The physical intervention training team were members of national restraint reduction programmes and had started their own regional restraint reduction group, collaborating with their opposite numbers from other trusts in the west midlands.
- The acute wards and psychiatric intensive care unit underway with the implementation of safe wards and this was directing change on all acute wards. There was development of new strategies to encourage collaborative working with patients'. Wards were developing their own strategies to aid with de-escalation and staff were enthusiastic about the work they were undertaking.
- Child and adolescent mental health community services had recently been inspected as part of the West Midlands Quality Review Service. The West Midlands Quality Review Service (WMQRS) is a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based quality standards, carrying out developmental and supportive quality reviews.
- We saw new methodology in the children, young people and families services was shared locally between trust services and with external organisations to help drive wider health improvements. Staff told us that they were encouraged to suggest ways to improve services, however found that if the initiative required additional resources there were often lengthy delays in approval and implementation of the initiative. We saw excellent local strategic leadership in relation to services for vulnerable children including robust procedures and female genital mutilation.
- The older adults' community services treatment and recovery unit had developed links with West Bromwich Albion football club in order to provide an innovative cognitive stimulation group. The treatment and recovery unit were developing a reminiscence room and had raised funds through charitable donations to facilitate this.
- Across the community learning disabilities, services there were good examples of research taking place. Current research included sex offender treatment programs for males with a learning disability and dialectic behaviour therapy for females with a learning disability. The psychologists had received a national award for their work with dementia care within learning disabilities.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9: HSCA (RA) Regulations 2014 Person-centred care** · Black Country Partnership Foundation Trust must ensure that the care and treatment of patients are appropriate to meet their needs and reflect their preferences. Patients did not have care plans that were up to date, personalised, holistic or recovery orientated. Patients did not actively participate in care planning. Health checks were not carried out and physical health needs were not monitored. Regulation 9 (1) (a,b,c) (3) (b,c,d,e,f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10: HSCA (RA) Regulations 2014 Dignity and respect** · Patients must be treated with respect and dignity. The management of potential risks from ligature points in the health based place of safety did not respect patient's privacy and dignity. Regulation 10 (10) (2) (a) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Safe care and treatment Care and treatment must be provided in a safe way for service users. · Environmental risk assessments including ligature risks had not been carried out for flats used as crisis beds at P3. · Identified ligature risks at Orchard Hills had not been mitigated and ligature cutters were not accessible to all staff · Risk assessments were not always carried out and regularly reviewed for patients. There were no appropriate arrangements for the safe management of medicines at Quayside house. · Blind spots in the acute wards had not been mitigated · The trust must ensure temperatures of the medicines fridges are completed, recorded consistently. · The trust must maintain accurate, complete and detailed records in respect of each person using the service. Regulation 12 (1) (2) (a,b,d,f,g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment · The trust must ensure that all equipment used in patients homes are properly maintained and serviced according to manufacturer's service specification · The trust did not operate cleaning schedules appropriate to the care and treatment being delivered from premises. · Toys used by young people were not regularly cleaned or replaced when broken. · Cleaning audits were not always available to be reviewed.

This section is primarily information for the provider

Requirement notices

· Emergency equipment was not available and accessible at all community locations.

· The trust must ensure that all ward environments are clean, well maintained and free of unpleasant odours

Regulation 15 (1) (e,f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance · The trust must ensure that there are robust systems and methods in teams to effectively monitor quality, safety and ongoing performance. · The trust must ensure that they assess, monitor and mitigate risks relating to service users on waiting lists held by community teams. · The trust must ensure records are secure, well organised and accessible to staff when needed. Regulation17 (2) (a,b,c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing · The trust must provide sufficient and suitably qualified competent skilled and experienced person in order to meet the needs of patients and the trusts regulatory obligations. Staff were not receiving regular training for the mental health act and the mental capacity act. · The trust must ensure that there are adequately staff across services to meet the needs of patients to protect them from abuse and avoidable harm.

This section is primarily information for the provider

Requirement notices

Regulation 18 (1) (2) (a,b)