Herefordshire Council

Agenda

Health, Care and Wellbeing Scrutiny Committee

Date:	**Monday 25 March 2024**
Time:	**2.00 pm**
Place:	**Conference Room 1 - Herefordshire Council, Plough Lane Offices, Hereford, HR4 0LE**

Notes: Please note the time, date and venue of the meeting.

For any further information please contact:

Ben Baugh, Democratic Services Officer
Tel: 01432 261882
Email: ben.baugh2@herefordshire.gov.uk

If you would like help to understand this document, or would like it in another format, please call Ben Baugh, Democratic Services Officer on 01432 261882 or e-mail ben.baugh2@herefordshire.gov.uk in advance of the meeting.

Agenda for the meeting of the Health, Care and Wellbeing Scrutiny Committee

Membership

Chairperson	**Councillor Pauline Crockett**
Vice-chairperson	**Councillor Kevin Tillett**
	Councillor Jenny Bartlett
	Councillor Simeon Cole
	Councillor Dave Davies
	Councillor Mark Dykes
	Councillor Richard Thomas

Agenda

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES

To receive details of any councillor nominated to attend the meeting in place of a member of the committee.

3. DECLARATIONS OF INTEREST

To receive declarations of interest in respect of items on the agenda.

4. MINUTES 11 - 14

To receive the minutes of the meeting held on 29 January 2024.

HOW TO SUBMIT QUESTIONS

The deadline for the submission of questions for this meeting is 5.00 pm on Tuesday 19 March 2024.

Questions must be submitted to councillorservices@herefordshire.gov.uk. Questions sent to any other address may not be accepted.

Accepted questions and the responses will be published as a supplement to the agenda papers prior to the meeting. Further information and guidance is available at www.herefordshire.gov.uk/getinvolved

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive any written questions from members of the public.

6. QUESTIONS FROM MEMBERS OF THE COUNCIL

To receive any written questions from members of the council.

7. UPDATE ON OUTCOMES OF CARE QUALITY COMMISSION INSPECTION OF HEREFORDSHIRE AND WORCESTERSHIRE HEALTH AND CARE NHS TRUST 15 - 152

This report provides the Health, Care and Wellbeing Scrutiny Committee with the background and findings of the Care Quality Commission's (CQC) inspection of Herefordshire and Worcestershire Health and Care NHS Trust (the Trust). It also outlines the actions taken following the "Well Led" inspection.

8. WORK PROGRAMME 2024/25 153 - 158

To consider the draft work programme for the Health, Care and Wellbeing Scrutiny Committee for the municipal year 2024/25.

9. DATES OF FUTURE MEETINGS

Monday 20 May 2024 2.00 pm

/pto

Monday 29 July 2024 2.00 pm

Monday 30 September 2024 2.00 pm

Monday 25 November 2024 2.00 pm

Monday 27 January 2025 2.00 pm

Monday 31 March 2025 2.00 pm

The public's rights to information and attendance at meetings

You have a right to:

- Attend all council, cabinet, committee and sub-committee meetings unless the business to be transacted would disclose 'confidential' or 'exempt' information.
- Inspect agenda and public reports at least five clear days before the date of the meeting. Agenda and reports (relating to items to be considered in public) are available at www.herefordshire.gov.uk/meetings
- Inspect minutes of the council and all committees and sub-committees and written statements of decisions taken by the cabinet or individual cabinet members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting (a list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
- Access to a public register stating the names, addresses and wards of all councillors with details of the membership of cabinet and of all committees and sub-committees. Information about councillors is available at www.herefordshire.gov.uk/councillors
- Have access to a list specifying those powers on which the council have delegated decision making to their officers identifying the officers concerned by title. The council's constitution is available at www.herefordshire.gov.uk/constitution
- Access to this summary of your rights as members of the public to attend meetings of the council, cabinet, committees and sub-committees and to inspect documents.

Recording of meetings

Please note that filming, photography and recording of this meeting is permitted provided that it does not disrupt the business of the meeting.

Members of the public are advised that if you do not wish to be filmed or photographed you should let the governance support team know before the meeting starts so that anyone who intends filming or photographing the meeting can be made aware.

The reporting of meetings is subject to the law and it is the responsibility of those doing the reporting to ensure that they comply.

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Public transport links

The Herefordshire Council office at Plough Lane is located off Whitecross Road in Hereford, approximately 1 kilometre from the City Bus Station.

Bus maps are available here: www.herefordshire.gov.uk/downloads/download/78/bus_maps

Herefordshire Council

The seven principles of public life

(Nolan Principles)

1. Selflessness

Holders of public office should act solely in terms of the public interest.

2. Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty

Holders of public office should be truthful.

7. Leadership

Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

Guide to Health, Care and Wellbeing Scrutiny Committee

Committee membership

Scrutiny is a statutory role fulfilled by councillors who are not members of the cabinet.

The role of the scrutiny committees is to help develop policy, to carry out reviews of council and other local services, and to hold decision makers to account for their actions and decisions.

Council has decided that there will be five scrutiny committees. The committees reflect the balance of political groups on the council.

The Health, Care and Wellbeing Scrutiny Committee consists of 7 councillors.

Councillor	Party
Pauline Crockett (Chairperson)	Independents for Herefordshire
Kevin Tillett (Vice-Chairperson)	Liberal Democrats
Jenny Bartlett	The Green Party
Simeon Cole	Conservative Party
Dave Davies	Conservative Party
Mark Dykes	Liberal Democrats
Richard Thomas	Conservative Party

Scrutiny functions

The committees have the power:

(a) to review, influence policy or scrutinise decisions made, or other action taken, in connection with the discharge of any functions which are the responsibility of the executive,

(b) to make reports or recommendations to the authority or the executive with respect to the discharge of any functions which are the responsibility of the executive,

(c) to review or scrutinise decisions made, or other action taken, in connection with the discharge of any functions which are not the responsibility of the executive,

(d) to make reports or recommendations to council or the cabinet with respect to the discharge of any functions which are not the responsibility of the executive,

(e) to make reports or recommendations to council or the cabinet on matters which affect the authority's area or the inhabitants of that area,

(f) to review or scrutinise decisions made, or other action taken, in connection with the discharge by the responsible authorities of their crime and disorder functions and to make reports or recommendations to the council with respect to the discharge of those functions. In this regard crime and disorder functions means:

  (i) a strategy for the reduction of crime and disorder in the area (including anti-social and other behaviour adversely affecting the local environment); and

  (ii) a strategy for combatting the misuse of drugs, alcohol and other substances in the area; and

  (iii) a strategy for the reduction of re-offending in the area

(g) to review and scrutinise any matter relating to the planning, provision and operation of the health service in its area and make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised or to be consulted by a relevant NHS body or health service provider in accordance with the Regulations (2013/218) as amended. In this regard *health service* includes services designed to secure improvement

(i) in the physical and mental health of the people of England, and

(ii) in the prevention, diagnosis and treatment of physical and mental illness, and

(iii) any services provided in pursuance of arrangements under section 75 in relation to the exercise of health-related functions of a local authority.

(h) to review and scrutinise the exercise by risk management authorities of flood risk management functions or coastal erosion risk management functions which may affect the local authority's area.

(i) To track actions and undertake an annual effectiveness review

The remit of Health, Care and Wellbeing Scrutiny Committee

- Adult social care (including adult safeguarding)
- Health and wellbeing board
- Housing
- Adults mental and physical health and wellbeing
- Safe Herefordshire campaign
- Outbreak control plan
- New models of care accommodation
- Talk Communities
- Homelessness
- All ages whole system commissioning strategy
- Independent living services and assistive technology plan
- Adults and communities budget and policy framework
- Statutory health scrutiny powers including the review and scrutiny of any matter relating to the planning provision and operation of health services affecting the area and to make reports and recommendations on these matters

Who attends scrutiny committee meetings?

- Members of the committee, including the chairperson and vice-chairperson.
- Cabinet members, they are not members of the committee but attend principally to answer any questions the committee may have and inform the debate.
- Officers of the council to present reports and give technical advice to the committee.
- People external to the council invited to provide information to the committee.
- Other councillors can attend but can only speak at the discretion of the chairperson.

Herefordshire Council

Minutes of the meeting of the Health, Care and Wellbeing Scrutiny Committee held in Conference Room 1 - Herefordshire Council, Plough Lane Offices, Hereford, HR4 0LE on Monday 29 January 2024 at 2.00 pm

Committee members present in person and voting:	**Councillors: Jenny Bartlett, Simeon Cole, Pauline Crockett (Chairperson), Dave Davies, Mark Dykes, Richard Thomas and Kevin Tillett (Vice-Chairperson)**

Others in attendance: B Baugh (Democratic Services Officer), Carole Gandy (Cabinet Member Adults, Health and Wellbeing), L Good (Service Director - Communities), H Hall (Corporate Director Community Wellbeing), J Lilley (Community Wellbeing Communications Lead), E Lowe (Talk Community Development Lead), A Rees-Glinos (Governance Support Assistant) and D Webb (Statutory Scrutiny Officer)

19. APOLOGIES FOR ABSENCE

All committee members were present.

20. NAMED SUBSTITUTES

There were no named substitutes.

21. DECLARATIONS OF INTEREST

No declarations of interest were made.

22. MINUTES

The minutes of the previous meeting were received.

Resolved:

That the minutes of the meeting held on 20 November 2023 be confirmed as a correct record and be signed by the Chairperson.

23. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions had been received from members of the public.

24. QUESTIONS FROM MEMBERS OF THE COUNCIL

No questions had been received from councillors.

25. COMMUNITY BASED SUPPORT SERVICES

The Chairperson made opening comments about the value of the activities supported by volunteers in the county, the need to use limited resources effectively, and the formation of Talk Community to promote and foster partnerships to reach out to individuals and

communities. The Cabinet Member Adults, Health and Wellbeing invited the committee to input into the strategic review of Talk Community.

The committee received the presentation 'Strategic Review of Talk Community' (link to the presentation).

The Service Director Communities presented the slides:- *Strategic review of Talk Community*; *Aim and methodology*; *Strategic context*; *Need*; *Vision, aims and outcomes*; and *Delivery model*.

The Talk Community Development Lead presented the slides:- *We asked our community groups what Talk Community was to them*; *Talk Community hubs*; *Hub case study*; *Community debt centres*; *Debt centre case study*; *Community action network meetings*; *Funding delivery; Talk Community delivery*; *Additional projects*; *Talk Community brokers*; *Case study – youth*; *Case study – market town*; *Case study – funding*; and T*alk Community has supported*. The Service Director Communities presented the final slide, *Issues*.

The principal points of the discussion included:

1. The Chairperson suggested that the presentation should be shared with local partner organisations such as Hereford and Worcester Fire and Rescue Service, Herefordshire and Worcestershire Health and Care NHS Trust, NHS Herefordshire and Worcestershire Integrated Care Board, and West Mercia Police.

2. A committee member noted that the scrutiny activity that could be undertaken was limited as the strategic review was at an early stage.

3. A committee member expressed concerns about the implications of changes to the national funding structure. The Service Director Communities said that this was being worked through currently. The Corporate Director Community Wellbeing noted the cessation of some one-off sources of funding but emphasised that there was core funding to support the consistency and continuity of the Talk Community service. The Chairperson noted some of the challenges associated with short-term funding streams.

4. In response to observations made by the Vice-Chairperson, the Talk Community Development Lead advised that: data obtained from Community Debt Centres was clear, as reporting mechanisms had been established from the outset; data from Talk Community Hubs was difficult to pin down, due to differences in scale and ways in which they operated; the identified '25,000 visits per annum to a Talk Community Hub and being connected to support' related only to those hubs that had responded; the lack of granularity was recognised; and a further breakdown of the figures received could be shared.

5. The Service Director Communities reported that all 75 hubs across Herefordshire would be audited to understand the offer being provided, the spaces being used, and the level of engagement with Talk Community. It was noted that there had been a seed funding grant scheme to support the establishment of each community group/hub (e.g. for computer equipment) but there was no contractual relationship with the council. The committee was advised that the potential for a more systematic approach would be explored through the review.

6. In response to an anecdote about equipment not being used at a hub, the Chairperson commented on the need for assurance around value for money.

7. In response to comments by a committee member, the Corporate Director Community Wellbeing: explained that it had been envisaged that Talk Community would adapt to whatever structure worked for a particular community, resulting in varied approaches in different areas; and the risk of Talk Community becoming a 'jack of all trades', due to differing perceptions internally and externally, was acknowledged and this reinforced the need for the council to establish what it wanted from Talk Community, whilst continuing to work collaboratively with communities.

8. In response to a question, the Chairperson considered that a change of title or branding at this stage would result in additional confusion about the programme.

9. A committee member commented that: councillors could promote the Talk Community newsletter to parish councils and other local groups; the 'Talk Community Strategic Approach' report, considered by Cabinet on 24 September 2020 [minute 179 of 2020/21 refers], demonstrated that much had been achieved through Talk Community during the Covid-19 pandemic; there had perhaps been too much focus on the number of hubs subsequently; there was a need to develop a communications strategy; Talk Community should be aligned with the Joint Strategic Needs Assessment, and should underpin and create value for other council strategies; and the evolving, long-term strategy for Talk Community should be included in the work programme for the committee.

10. A committee member suggested that an index of services for each hub, depending on the volunteer resources available, could help to raise public awareness. The Service Director Communities said that the audit would provide the opportunity to reconsider the number of hubs needed, and to size and shape them appropriately.

11. The Talk Community Development Lead responded to questions, the key points included: in addition to regular training on the Talk Community Directory, other training opportunities were offered to Talk Community volunteers whenever possible; an overview was provided of the work of the Healthy Lifestyle Team which sat within Talk Community but was funded by Public Health; and the development officers provided ongoing support for the hubs which could include working with partner agencies or other organisations to assist individuals with more complex needs.

12. Whilst it was noted that information about Talk Community was being circulated to clerks, it was suggested that the review could consider opportunities to work more closely with parish and town councils. The Service Director Communities reported on work that was underway to develop a new charter between Herefordshire Council and local councils.

13. Questions were asked about performance and the merits of concentrating efforts through the larger or more active hubs. The Talk Community Development Lead said that: apart from the initial seed funding, there was no ongoing funding or associated assessment of performance; and the smaller hubs were often in very rural areas and, even if infrequent, these could be critical to some people in those areas and may help to reduce isolation.

14. In response to questions about alignment to the County Plan given that there was no plan beyond 2023/24 currently, the Corporate Director Community Wellbeing advised that the slide on *Vision, aims and outcomes* [agenda page 26] reflected the original purpose of the programme which would be assessed during the review and it was not considered that this would be out of kilter with the ambitions likely to come through as part of the new County Plan which was in development.

15. The Vice-Chairperson noted that one size did not fit all but, given that the branding was the same, questioned whether there were reputational risks if some hubs were not meeting the needs of particular communities. It was suggested that it would be useful to engage with groups that had not chosen to be part of Talk Community.

16. In response to a question, the Talk Community Development Lead acknowledged that 'Cost of Living Roadshows' had not been well attended, although had resulted in positive outcomes for some individuals. It was reported that this had led to the development of the 'Winter of Wellbeing' (WoW) programme, including signposting to cost of living advice and support, and events had been well attended and good feedback had been received.

There was a short adjournment to enable the committee to consider potential recommendations to the executive.

The meeting recommenced, draft recommendations were displayed and read out by the Statutory Scrutiny Officer, and the following resolution was agreed by the committee.

At the conclusion of the agenda item, the Cabinet Member Adults, Health and Wellbeing thanked the committee for the debate and commented on: the challenges around data and how a robust evidence base could support applications for external funding; the need to assess both the gaps and possible overlaps in provision; and the need to consider outreach opportunities to engage with vulnerable people who were unable to access a hub or other community group.

Resolved: That it be recommended to the executive that:

1. **Herefordshire Council works with partners to identify funding for community-based services.**

2. **The service further develops its management information concerning the activity and outputs of Talk Community hubs.**

3. **Talk Community develops a communications strategy to provide a clear understanding of the service's purpose.**

4. **Health, Care and Wellbeing Scrutiny Committee reviews the forthcoming draft strategy.**

5. **The draft strategy explicitly takes into account the extent to which Talk Community underpins other strategies.**

26. WORK PROGRAMME 2023/24

The committee noted the work programme for the remainder of the municipal year 2023/24. The Statutory Scrutiny Officer commented on arrangements being made to schedule meeting dates and to undertake work programming activity for 2024/25.

Resolved: That the work programme 2023/24 be noted.

27. DATE OF THE NEXT MEETING

The date of the next scheduled meeting was confirmed as Monday 25 March 2024, 2.00 pm.

The meeting ended at 4.11 pm **Chairperson**

Herefordshire Council

Title of report: Update on outcomes of Care Quality Commission Inspection of Herefordshire and Worcestershire Health and Care NHS Trust

Meeting: Health, Care and Wellbeing Scrutiny Committee

Meeting date: Monday 25 March 2024

Report by: Statutory Scrutiny Officer

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose

This report provides the Health, Care and Wellbeing Scrutiny Committee with the background and findings of the Care Quality Commission's (CQC) inspection of Herefordshire and Worcestershire Health and Care NHS Trust (the Trust). It also outlines the actions taken following the "Well Led" inspection.

Recommendation(s)

That:

a) The committee note the report and findings; and

b) Make recommendations to the Trust and to Herefordshire Council following scrutiny of the report.

Further information on the subject of this report is available from
Danial Webb, Tel: 01432 260659, email: Danial.Webb@herefordshire.gov.ukl

Alternative options

1. For scrutiny to not consider the outcome of the Commission led inspection. This is not recommended. The inspection has moved the Trust from being in a good to an inadequate position. The Health, Care and Wellbeing scrutiny committee has the responsibility to make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised or to be consulted by a relevant NHS body or health service provider in accordance with the Regulations (2013/218) as amended. In this regard health service includes services designed to secure improvement:

    a. in the physical and mental health of the people of England, and

    b. in the prevention, diagnosis and treatment of physical and mental illness, and

    c. any services provided in pursuance of arrangements under section 75 in relation to the exercise of health-related functions of a local authority

Key considerations

2. From 6 to 8 June 2023 the CQC conducted a Well Led inspection of the Trust, drawing on one to one interviews with board members, subject matter experts, focus groups and stakeholders. As a result of the inspections, a number of changes were made, including moving the Trust's overall rating from good to requires improvement.

Overall trust quality rating	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires Improvement

3. The findings from the CQC inspection are attached as Appendix 1. In the report, the CQC told the trust that it must take action to bring services into line with six legal requirements. The Trust must ensure:

    a) Members of the executive leadership team work in a cohesive and collaborative way to address areas of risk or concern to ensure they are sighted on risks that could affect the delivery of strategy and provision of high-quality care. (Regulation 17)

    b) Senior leaders are visible in all services. (Regulation 17)

    c) Effective systems and processes are in place to manage risks in the Trust ensuring the risks are regularly reviewed and mitigated. (Regulation 17)

    d) Learning from incidents is shared across all services to mitigate against the risk of reoccurrence. (Regulation 17)

    e) Policies are up to date, have been ratified and have Equality Impact Assessments. (Regulation17)

    f) Action is taken to address a closed culture in the organisation and embed action to improve equality, diversity and inclusion. (Regulation 17)

g) Action is taken to respond effectively to concerns raised (Regulation 17)

h) Estates staff are managed consistently in line with other staff in the Trust. (Regulation 17)

i) Serious incidents are reported to external agencies in line with national guidance in a timely manner. (Regulation 17)

j) Staff receive supervision and appraisal. (Regulation 18)

k) Personnel files for senior leaders meet the requirements of fit and proper person guidance. (Regulation 19)

4. Following initial feedback from the CQC, the Trust and Herefordshire and Worcestershire Integrated Care Board took the decision to appoint an Improvement Director to lead the development and implementation of an Improvement Plan. Based upon the themes in the CQC report and extensive staff engagement exercise through September and October 2023 which almost 700 staff contributed to, the Trust has developed and commenced delivery of two key plans:

   a) Overall Trust Improvement plan covering:

      a. Culture and Equality Diversity and Inclusion

      b. Systems, Processes and Structures

      c. Regulatory and Accreditation

      d. Communication and Planning

      e. Risk Management

      f. Corporate & Administrative Services

   b) A focused plan covering:

      a. the CQC required actions at both organisational and service level and

      b. the CQC recommended actions at service level (organisational level captured within the overall improvement plan).

5. Over the coming months these programmes of work will aim to deliver:

   a) Training for all staff, starting with those in a leadership, managerial and supervisory role, covering skills which will help embed the behaviours and culture staff said they wanted. These skills will include restorative practice, the impact of incivility, seeking and acting on feedback, inclusivity and discrimination, bias, micro-aggressions & practical emotional intelligence.

   b) A broad Trust Board development programme covering the key themes identified by the CQC of visible leadership, inclusive decision making, effective challenge and risk management.

   c) Staff that are confident that if they speak up something will be done.

   d) Fairness and equity in management, development and how people are treated, giving equal opportunities regardless of race, disability or any other protected characteristic.

   e) Updated Governance structures ensuring integrated approach and operation of meetings at all levels. This scaffolding will enable visibility of decision making, escalations and resolutions, risk management, communication and give the channel where staff and patient/carer concerns are formally received and actions recorded.

f) Updated risk management systems and processes, aligning to the CQC findings and an independent review by the Good Governance Institute.

g) A clear view of areas at risk of a closed culture developing, giving the opportunity to put supportive actions in place at an early stage.

h) Effective incident reporting.

i) Systems and processes which ensure all staff receive a regular one to one supervision and appraisal as well as having a team meeting they can attend and contribute to.

j) All staff are managed by the same policies and approaches, based around a restorative culture.

k) Updated operational processes which reduce impact on clinical and operational time.

l) All policies have equality impact assessments in place.

6. The Trust has developed a monitoring system, whereby staff views are sought every 2 months. The questions asked align to the national staff survey and focus on how staff experience the working environment. This information will be used to understand progress of the improvement plan at both an organisational and Trust level.

7. Ultimately, improved staff wellbeing and experience will lead to improved care and patient outcomes. The Trust is working with both Healthwatch Worcestershire and Healthwatch Herefordshire to develop patient experience questions which will be asked by Healthwatch and used to assess progress.

Community impact

8. Scrutiny committees do not make decisions for Herefordshire Council. They make recommendations to Cabinet and to Council, which those bodies must decide whether to accept or reject. The community impact of implementing any recommendation should be assessed when Cabinet or Council decide to adopt the recommendation.

Environmental impact

9. Whilst there are no environmental impacts in considering this report and appendices, consideration has been made to minimise waste and resource use in line with the council's Environmental Policy.

Equality duty

10. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

Resource implications

11. There are no resource implications in considering this report and appendices.

Legal implications

12. Herefordshire Council has designated statutory health scrutiny powers including the review and scrutiny of any matter relating to the planning provision and operation of health services affecting the area and to make reports and recommendations on these matters to the Health, Care and Wellbeing Scrutiny Committee.

13. It has the responsibility to make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised or to be consulted by a relevant NHS body or health service provider in accordance with the Regulations (2013/218) as amended. In this regard health service includes services designed to secure improvement:

    a. in the physical and mental health of the people of England, and

    b. in the prevention, diagnosis and treatment of physical and mental illness, and

    c. any services provided in pursuance of arrangements under section 75 in relation to the exercise of health-related functions of a local authority

Risk management

14. There are no specific risks identified in considering this report.

Consultees

No consultation was carried out in the production of this report.

Appendices

Appendix 1: Herefordshire and Worcestershire Health and Care NHS Trust Inspection report

Background papers

None identified.

Herefordshire and Worcestershire Health and Care NHS Trust

Inspection report

Unit 2, Kings Court Business Park
Charles Hastings Way
Worcester
WR5 1JR
Tel: 01905733658
www.hacw.nhs.uk

Date of inspection visit: 14 February 2023 to 16 May 2023, 6 to 8 June 2023, 13 to 26 June 2023
Date of publication: 19/01/2024

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

We carried out this unannounced inspection of Herefordshire and Worcestershire Health and Care NHS Trust, of the mental health and community health services provided by this trust because since our previous inspection Worcestershire Health and Care NHS Trust, had taken on responsibility for providing mental health service to Herefordshire from Gloucestershire Health and Care Foundation Trust in April 2020.

We carried out this inspection because 2 services that had previously been inspected had been rated inadequate overall. This included acute wards for adults of working age which had been rated as inadequate in July 2022, and community-based mental health services for adults of working age had been rated inadequate in January 2020. We also inspected 2 services which had not been inspected since 2018, both which were previously rated as good. We also carried out this inspection because of concerns we had received about sexual safety of patients at Hillcrest ward.

We also inspected the well-led key question for the trust overall.

At this inspection, we visited 3 mental health services and 1 community health service. We also inspected the well-led question at provider level for the trust overall.

The trust provides the following services:

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

Our findings

- Community-based mental health services for older people
- Community mental health services for people with a learning disability or autism
- Community health services for adults
- Community health services for children, young people and families
- Community Health inpatient services
- Community end of life care
- Community dental services.

We inspected all key lines of enquiry in all domains (safe, effective, caring, responsive and well-led) in the 4 services inspected. These services were:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community health services for adults

We also assessed if the organisation is well-led and looked at areas of governance, culture, leadership capability and improvement. Our inspection approach allows us to make a judgement on how the trust's senior leadership leads the organisation, and the provider level well-led rating is separate from the ratings of the services we inspected.

In rating the trust overall, we took into account the current ratings of the 10 services which were not inspected this time and therefore bought forward the most recent ratings.

At this inspection, the key questions were rated overall, as requires improvement for safe, and effective, good for caring and responsive and requires improvement for well-led.

The trust-wide well led rating is not aggregated with all the service ratings. The trust-wide well led rating went down. We rated the overall trust-wide well-led as requires improvement.

At this inspection, we rated all 3 of the mental health services we inspected as requires improvement overall. This was an improvement in rating for 2 services since the last inspection. The rating for 1 of the mental health services inspected went down to requires improvement. The rating for the community health service we inspected went down and was rated requires improvement.

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

- We found environmental risks at 2 of the services inspected. In acute wards for adults of working age, where accommodation was mixed sex, staff did not sufficiently monitor and observe single sex spaces. This resulted in sexual safety incidents. Two services did not ensure ligature risk assessments were up to date and identified risks were not effectively mitigated.

Our findings

- Two services we inspected had not ensured that patient risk assessments were completed, reviewed, or updated. Not all services had mitigated risks to patients in relation to sexual safety in acute wards for adults of working age. In mental health crisis services, the safety of young people when admitted to a health-based place of safety was not always well managed.
- Safety was not a sufficient priority in all services. Staff did not manage sexual safety incidents well. Not all services escalated or reported sexual safety incidents. In acute wards for adults of working age, staff did not take action that was reasonably practicable to report, respond to or mitigate sexual safety risks.
- The systems and processes used to manage risks in the trust were not effectively managed. There was a lack of collaborative oversight, escalation or challenge. The trust board was not always sighted on all risks that could affect the delivery of strategy and provision of high-quality care.
- Across the trust, not all environments in services we inspected had been well maintained, clean or were fit for purpose. In mental health crisis services, the health-based place of safety in Worcestershire did not meet the standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales July 2011 Royal College of Psychiatry CR159) and the guiding principles of the Code of Practice.
- Staff compliance with mandatory training fell below expected standards in 3 of the 4 services we inspected. This included training in basic life support, fire safety training and Mental Health Act training. Systems and processes to monitor training compliance were not effective in these services.
- Some services did not receive regular supervision or appraisals. In 2 services the service did not provide data on supervision compliance, and in a third service, compliance was as low as 20%. One service inspected had appraisal compliance at 66%. Systems and processes to monitor supervision and appraisal compliance were not effective in these services.
- Psychology waiting times prevented patients receiving interventions in a timely manner in community-based mental health services for adults of working age in Worcestershire. The number of patients on the waiting list had steadily increased each month, from 57 in March 2022 to 161 in February 2023.
- We had concerns about staffing in 2 services. In Neighbourhood mental health teams, the service did not have enough staff and some teams had patients who were waiting to be allocated to a caseworker. Vacancy rates were between 17% and 61% across both Herefordshire and Worcestershire. In the Worcestershire health-based place of safety, there were not always appropriate staff available to assess a young person outside working hours. This meant young people had to then stay overnight.
- In services we inspected, some systems and processes did not effectively provide managers with oversight or assurance of how services were delivered. Managers did not always have systems to be able to assess, monitor and review the quality of the service. For example, locking of doors, reporting of incidents, adherence to trust policies and procedures training and supervision and appraisal compliance.
- Whilst members of the board had the skills, knowledge and experience required, we were not assured that they worked in a cohesive and collaborative way to address areas of risk or concern. Leaders at all levels were not always visible.
- Systems of accountability for some areas of governance were not always clear, and not all senior leaders discharged their responsibility of active challenge to decisions and actions robustly. Learning from incidents, and previous inspections had not been shared across the trust or acted on swiftly enough to bring about improved, safe care.
- There was evidence of a closed culture within the trust with minimal actions at board level and in services to address equality, diversity and inclusion issues felt by staff. There was a lack of urgency to implement culture change initiatives across the organisation.

Our findings

- We found a lack of evidence to support patient involvement in service development, redesign, and improvement. Whilst the trust published this was in place, there were few examples to show where this occurred.

However:

- The trust had a clear vision with values which were understood by all staff. All staff spoken with during our inspection knew the trust values and were able to relate them to their work within the team. Staff knew and understood the provider's vision and how it applied to the work of their team.
- Three services had decreasing rates of bank and agency nurses and support workers. Managers limited their use of bank and agency staff and requested staff familiar with the service. They made sure all bank and agency staff had a full induction and understood the service before starting their shift.
- In 2 services we inspected, staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- We were assured that trust safeguarding systems and processes were well managed and risks were mitigated. Staff in the trust were up to date with safeguarding training and knew how to recognise abuse and when to report it.
- Across services, medicines management was managed well. Physical healthcare was managed effectively, and staff encouraged patients to live healthier lives.
- We saw how staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- The trust had been impacted by a national cyber security issue which had affected access to the patient recording system. Action taken around the failure of the electronic care record system appeared both positive and proactive. Whilst difficult and time consuming, this was well managed. Staff had been unable to update patient records on this system for several months. Staff told us they could still access the system to view historical records but could not add updates. The trust had developed an interim patient recording system. Staff told us that they had access to both systems and that managers had kept them updated about the system issues.
- Staff knew their responsibilities under the Mental Health Act and Mental Capacity Act. The trust had effective and embedded systems and processes for management of duties under the Mental Health Act.
- The trust was well positioned within the ICB to influence the health and social care system. We have heard how key Board members advocate and action the agenda with stakeholders. Service managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.
- The trust had a clear focus and agenda within the research team with a positive plan to become self-sufficient. Quality improvement was actively encouraged from small local ideas to larger, more complex service improvements. The trust had an agenda to continue to develop their quality improvement approach.
- The trust had led on new integrated models of care to improve how people accessed and came into contact with services across Herefordshire and Worcestershire.

How we carried out the inspection

Our findings

During the inspection, our inspection teams carried out the following activities across 5 wards and 7 community-based mental health service and community health services and 2 health-based places of safety:

- spoke with 65 patients and 18 family members or carers of patients
- accompanied staff on 2 visits to patients in the community
- viewed clinic rooms and reviewed 70 medication charts
- spoke with 134 members of staff including senior leaders and managers, consultants, doctors, registered nurses, healthcare assistants, ward clerks, independent mental health advocates, occupational therapists, and physiotherapists
- reviewed staff rosters
- reviewed 63 sets of patient care records
- undertook 14 incident reviews where we looked at information relating to incidents across all 5 wards we visited
- observed shift handover meetings, a ward round, a reflective practice group and an occupational therapy patient session
- reviewed CCTV footage and the digital images log
- observed a Mental Capacity Act training session
- attended 14 community visits to observe care and treatment
- reviewed a range of policies, procedures and other documents related to the running of the service.

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

What people who use the service say

Community-based mental health services for adults of working age

We spoke with 15 patients who were pleased overall with the service they had received. Most patients told us that staff were kind, respectful and polite and had involved them in decisions about their care and treatment. Patients told us that staff gave them information and advice about medicines and healthy lifestyles. However, 5 patients told us that they had not been given a copy of their care plan.

We spoke with 3 carers, who told us that staff were responsive and caring. However, 2 carers told us they had not been as involved as they would have liked and that they had not been given information on how to access a carers assessment.

Mental health crisis services and health-based places of safety

We spoke with 11 patients and 3 carers. Feedback from patients, family and carers was positive. They described staff as kind and supportive. They told us staff communicated well with them and they received effective and high-quality care and treatment.

Our findings

Staff made sure patients understood their care and treatment. Patients said staff supported them with their immediate mental health crisis and their recovery by referring them to longer term interventions such as psychological therapies.

Staff involved patients in decisions about the service. Patients could give feedback on the service and their treatment and staff supported them to do this.

Patients told us they felt listened to and staff responded quickly to their views and wishes. Patients were particularly positive about being able to talk directly to consultants and with staff day and night. Patients described the service as life changing.

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

We spoke with 15 patients and 4 carers. Overall, the 15 patients that we spoke with were positive about the service and complimentary of the staff. We received some comments relating to agency staff. Some patients felt that they did not engage with them as well as substantive staff and felt that they were more difficult to work with.

We spoke with 4 patients on Mortimer ward. They told us temporary staff were kind and caring and responsive to their needs. Patients were complementary about the meals provided and said there was lots of choice. Patients told us they heard the loud building work noises during the week due to ongoing building work but had become used to the level of noise and frequency.

One patient said regular staff were very good and they felt comfortable to speak with them. They enjoyed planned walks to Churchill gardens with the occupational therapist and said walking helped them to feel better. They liked regular sessions with the Art therapist on Fridays. Another patient said they enjoyed chatting with staff and felt safe to a certain degree. There were regular staff at night who met their needs.

However, patients did not always feel safe in relation to sexual safety. One patient told us male and female patients usually walked around single sex spaces. Another patient told us about a sexual safety incident they reported to the police as they did not feel staff had taken their concerns seriously.

Community health services for adults

We spoke with 27 patients and 8 carers in this service. Feedback from patients, family and carers was overwhelmingly positive. They described staff as caring, friendly, and supportive. They told us they felt involved in their care and reported good communication from staff. Patients all felt they received effective and high-quality care and treatment.

Patients told us they felt staff listened to them and were responsive to their views and wishes. They said staff gave them advice on their care and treatment in an accessible and clear manner. This included explaining the nature, purpose, and side effects of medicines.

Patients spoke positively about occupational therapy. They said they were provided with appropriate specialist equipment and that staff made sure they were explained how to use it.

Patients, carers and family said they observed good communication with teams within the wider trust and also external teams. For example, they felt that staff regularly liaised with GP practices and were jointly aware of care and treatment decisions.

Our findings

Despite some staffing issues, particularly within the therapy teams, patients, carers and family mostly fed back that appointments were rarely cancelled or delayed.

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

Areas for improvement

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 6 legal requirements. This action related to 4 services we inspected.

Trust wide

- The trust must ensure members of the executive leadership teamwork in a cohesive and collaborative way to address areas of risk or concern to ensure they are sighted on risks that could affect the delivery of strategy and provision of high-quality care. (Regulation 17)
- The trust must ensure senior leaders are visible in all services. (Regulation 17)
- The trust must ensure that effective systems and processes are in place to manage risks in the trust ensuring the risks are regularly reviewed and mitigated. (Regulation 17)
- The trust must ensure learning from incidents is shared across all services to mitigate against the risk of reoccurrence. (Regulation 17)
- The trust must ensure policies are up to date, have been ratified and have Equality Impact Assessments. (Regulation 17)
- The trust must ensure that action is taken to address a closed culture in the organisation and embed action to improve equality, diversity and inclusion. (Regulation 17)
- The trust must ensure action is taken to respond effectively to speak up concerns. (Regulation 17)
- The trust must ensure estates staff are managed consistently in line with other staff in the trust. (Regulation 17)
- The trust must ensure serious incidents are reported to external agencies in line with national guidance in a timely manner. (Regulation 17)
- The trust must ensure that staff receive supervision and appraisal. (Regulation 18)
- The trust must ensure that personnel files for senior leaders meet the requirements of fit and proper person guidance. (Regulation 5)

Community-based mental health services for adults of working age

Our findings

- The trust must ensure it has effective plans in place to manage psychology waiting lists in community mental health teams to ensure that patients receive interventions in a timely manner (Regulation 9)
- The trust must ensure they have effective governance processes in place to monitor staff compliance with training and access to supervision. (Regulation 17)
- The trust must continue to monitor and review staffing levels in the neighbourhood mental health teams, particularly for teams in phase two of the transformation programme (Regulation 18)

Mental health crisis services and health-based places of safety

- The trust must ensure that risk assessments are completed for all young people when admitted to an area where adult patients are present. (Regulation 12)
- The trust must ensure that people with accessibility needs have full access to amenities. (Regulation 15)
- The trust must ensure the Health-Based Places of Safety meet the standards on the use of Section 136 of the Mental Health Act 1983 and guiding principles of the Code of Practice. (England and Wales July 2011 Royal College of Psychiatry CR159) (Regulation 17)
- The trust must ensure that premises are clean, and tidy and in a good state of repair. (Regulation 15)
- The trust must ensure all staff are aware of the correct procedure of locking doors to manage patient safety. (Regulation 17)
- The trust must ensure they have robust governance systems in place to monitor, assess and review quality of the service. (Regulation 17)

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

- The trust must ensure staff complete risk assessments for patients and ensure that these are regularly reviewed and updated. (Regulation 12)
- The trust must assess risks to the health and safety of patients receiving care and treatment, including patients' sexual safety; doing all that is reasonably practicable to mitigate such risks. (Regulation 12)
- The trust must ensure the ward team do all that is reasonably practicable to monitor and remove or mitigate environmental risks on Mortimer ward. (Regulation 12)
- The trust must ensure the mixed sex environment is designed, utilised, and monitored to mitigate associated risks and prevent sexual safety incidents. (Regulation 12)
- The trust must ensure that Mortimer ward maintenance work is completed. (Regulation 12)
- The trust must ensure systems and processes are in place to assess, monitor and ensure staff follow the trust's 'policies and procedures for the recording and reporting of incidents. (Regulation 12)
- The trust must ensure any episode of abuse is reported, and appropriate actions taken, including incidents of sexual safety; doing all that is reasonably practicable to mitigate such risks. (Regulation 13)
- The trust must ensure systems and processes are established and operate effectively to ensure oversight and consider the impact on patients of major building works alongside an operational ward. (Regulation 17)
- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on Mortimer ward. (Regulation 18)

Our findings

- The trust must ensure staff receive regular mandatory training. (Regulation 18)
- The trust must ensure staff receive regular supervision. (Regulation 18)

Community health services for adults

- The service must ensure staff receive annual appraisals of their work. (Regulation 18)
- The service must ensure staff receive regular clinical supervision of their work. (Regulation 18)
- The service must ensure staff across the service keep up to date with all statutory and mandatory training, particularly safeguarding training. (Regulation 18)
- The service must ensure that they have effective governance processes in place to monitor staff compliance with training and access to clinical supervision and appraisals. (Regulation 17)

Action the trust SHOULD take to improve:

Mental health crisis services and health-based places of safety

- The trust should ensure that young people are assessed quickly when presenting out of hours.

Community-based mental health services for adults of working age

- The trust should ensure all clinic rooms used by the community mental health services are fully equipped.
- The trust should ensure all staff receive regular clinical supervision.
- The trust should ensure records are completed to show that staff safety alarms are sufficiently charged and maintained at New Brook.
- The trust should continue to review the premises used by community mental health services in Herefordshire and Worcestershire to ensure they are fit for purpose and can effectively meet the needs of patients with accessibility needs.
- The trust should ensure all patients are offered a copy of their care plan.
- The trust should ensure all patients are informed if their appointment needs to be cancelled or rearranged.
- The trust should ensure it reviews processes to reduce incidents relating to administration errors.
- The trust should ensure that all staff are up to date with their mandatory training.

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

- The trust should review the quality of the closed-circuit television camera footage, particularly in the garden courtyard area on Mortimer ward.
- The trust should review availability of regular team meetings.
- The trust should review support for the Mortimer ward management team to ensure leaders have the right skills and knowledge for their role.
- The trust should update the staff induction to include environmental risks on the ward.

Community health services for adults

Our findings

- The trust should take action to ensure that occupational therapy and physiotherapy referrals meet the trust target.
- The trust should ensure that patients' families and carers can give feedback in an accessible format.

Is this organisation well-led?

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

Leadership

Senior leaders had the experience, knowledge and capability they needed to carry out their roles. However, we were not assured that the board worked in a cohesive and collaborative way, unitarily, to sufficiently and robustly review the safety, quality and governance responsibilities they held. Not all non-executive directors carried out their roles and responsibilities with sufficient, robust challenge.

All board members and senior leaders could speak to the overarching trust strategy, values and strategic priorities. However, not all senior leaders knew the details of significant elements of the trust strategies. Not all senior leaders could talk to key risks, and how they challenged colleagues sufficiently to bring about change in the delivery of key strategies of the trust. Some senior leaders we spoke with could not describe or recognise the early warning elements of a closed culture. Not all board members understood the importance for freedom to speak up and equality, diversity and inclusion. Answers given in some interviews we undertook were superficial, vague and lacked detail, and opinions of what constituted a healthy challenge, was not connected or aligned with each other. We heard that inclusivity and leadership events took place, but some members of the executive team were not present.

We heard how newer members of the executive team were more proactive in their approach than those who had been in post for many years. For example, we heard from one non-executive director (NED) who described their relationship with the trust as a "long association" with the trust which differed from other board members who had a dynamic approach to their portfolio and spoke with determination and commitment to bring about change with their key challenges and risks.

During our interviews with staff, and review of board papers and committee meeting minutes, we saw a mechanistic and transactional approach rather than a dynamic, challenging one and one which would drive forward the trust strategy between NEDs. We saw a questioning board rather than a board of action. At times, some NEDs were unable to explain how challenge to board directors was effective, proactive and brought about change on key issues in the trust. In our interviews with NEDs, and in committee meeting minutes, we found that challenge from NEDs within sub committees of the board was described with the use of questions such as "what we could do?", "what should we do?" or "how do we know?" which resulted in slow pace of chance to issues. One view from a NED was "we are the board", and did not see their role as one of challenge to board.

Encouragingly, since the previous inspection, the trust had recruited a director of people and this role had started to address some of the cultural concerns within the organisation. There was positive leadership in key areas of the trust, which included safeguarding, infection prevention and control and in information governance. Financially, the trust had delivered on its targets and operated effectively within the Integrated Care System (ICS).

Fit and proper person checks were not evidenced in the files of directors and NEDs. We reviewed 7 personnel files of executive directors and NEDs. Of these files, only 2 had evidence of robust references for the post holder, none of the

files held evidence of values-based interviews and up to date disclosure and barring service (DBS) checks were not held on file. One DBS certificate was in date and considered valid. Three files did not have any DBS certificates and 3 of the remaining 4 were over 3 years old (6 years, 5 years and 4 years). This was not in line with national guidance (Lampard, 2015). Despite the trust's commitment to a values-based recruitment programme and commitment to the Nolan principles (selflessness, integrity, objectivity, accountability, openness, honesty, and leadership) when recruiting directors, these were not evidenced in the personnel files. However, following inspection the provider told us all board members were signed up to the DBS subscription service, which is why up to date DBS certificates are not always in the personnel files and the Trust had processes in place to confirm that all subscriptions were in date.

We were not assured that learning was cohesive and co-ordinated and applied to all areas of the trust as a result of quality summits and various other methods of review, after things went wrong.

The trust board had clearly defined its challenges to quality, service delivery and its position in the Integrated Care System (ICS). There were clear strategies in place which planned to deliver on the overarching trust strategy. However, the ability to work in a co-ordinated and cohesive way to manage risk and strategy was stretched, which meant the pace of change on trust priorities was slow.

Some executives told us they were disappointed with the slow pace of change when issues had been highlighted. They told us the trust could not evidence measured improvement with outcomes based on clear facts. For example, one member told us "We didn't react quickly enough to issues at Hillcrest, [we are] frustrated we didn't act more quickly". We saw another example where there was a lack of pace to apply learning to other potential areas of concern, such as services in paediatric services and estates issues. Two NEDs told us they were "keeping a close eye" on two specific clinical areas as "there was potential for it to be a problem". There was no documented evidence of the oversight the trust board had on this issue.

Other examples include investment into FTSU, EDI and responding to results from the staff survey, which have been reported on further in the report.

Board members knew themes about challenges and high-level success but could not give the detail of these. We heard how executive members used their experience over evidence to tell if change had taken place, or a "conversation with a colleague" meant they knew change had been successful or not. We found executive members had an unrealistic expectation of how to identify quality and safety concerns, particularly closed cultures. Examples of change lacked detail and were often vague. For example, where failures had been identified at Hillcrest, "actions to bring about change were disappointing", and "spotting what is making the difference to retention was tricky", and "investment in some areas linked to the financial plan is on a variety of levels, some through patient stories at board." For example, one executive member told us "We have a number of concerns around the quality of our services, shifting culture in mental health services is not an easy thing" and "general community paediatrics has bubbled up".

Risks associated with estates did not receive significant focus at board in terms of the risks and experiences of patients and staff. The estates lead reported into the director of finance. We heard that the estates lead did not have regular contact with non-executive directors and was not sighted on high-level risks as would happen in other areas of clinical risk. Out of all the risks associated with estates on the risk register, none had been escalated to risk above a score of 16, which meant these were escalated via board committees and back to the estates lead to action and not escalated to board.

The pharmacy team worked well together however it was recognised that there were some challenges to the quality and sustainability of the service. This was primarily due to a lack of staffing resources within pharmacy and therefore the

service could not always provide pharmacist support to some services. However, in the 18 months prior to the inspection there had been a successful transition of dispensary staff from another pharmacy provider who had transferred into the trust as part of the new pharmacy hub dispensing service. A development programme led by the Pharmacy Education and Operational Lead pharmacist ensured there was succession planning. Each member of staff had been included in the development and training plan. For example, 2 band 7 pharmacists were currently acting up to the Medicine Safety Officer (MSO) role whilst the current postholder was on secondment. This was acknowledged as a good development opportunity and experience for both pharmacists.

There was a variety of methods used by senior leaders to connect with staff, but not all senior leaders were visible in all services.

Some senior leaders were not fully aware of the issues facing staff on the frontline and had not understood the risks and issues described by staff. Despite such issues brought to the attention of the NEDs and subsequently to board from their programme of visits, there was a lack of reported outcomes from various action plans in place to address the issues.

The trust had a programme of visits for directors and NEDs to visit clinical areas. Reports from these visits were escalated to board and relevant committees where conversations were created around the questions asked by staff. Four associate NEDs had recently been recruited and were part of this programme.

Staff had mixed views about visibility of senior leadership. Some staff focus groups told us that there was a lack of visibility from their senior leaders and some members of the executive team, in mental health services and some neighbourhood teams. Staff described a disconnect between the executive team and staff. Staff told us the understanding by some executive team members of some staff grade roles in the trust such as allied health professions was limited. Some staff told us they felt there was room for improvement for senior managers to recognise and understand the impact and outcomes that services provided and described a ‘blockage’ at middle managers’ level when they escalated issues of concern. However, the Chief Executive Officer (CEO) was complimented on their visibility within most services.

We heard from two NEDs that getting feedback from people was the trusts’ biggest challenge despite many different methods in place to do so. One director told us that the board members had probably not been seen by everyone since the COVID-19 pandemic and during that time, visibility from board was achieved virtually. The trust told us the visible leadership and active listening described in the People Strategy continued to be developed.

The CEO shared a weekly email to all staff with updates from around the trust and included achievements of individual staff that they had met whilst out in services. A monthly ‘Team Brief’ meeting attended by members of the senior leadership team and their teams was in place, so they were able to cascade messages. Documents from this meeting were made available on the staff intranet post meeting.

Peer reviews were undertaken by the patient safety team which included senior staff at matron level, head of department and on one occasion an external reviewer from the Integrated Care Board (ICB). We reviewed the minutes of 4 of these visits. There was a clear process in which to report, and areas looked at during the visits included the environment, staff experience patient experience. However, when reviewing the reports from these visits, we found issues which had been identified had not been addressed prior to our core service inspection visits despite adequate time in between in order to do so. We also found only 2 of the 4 visits between December 2022 and February 2023 had ensured the reviewers spoke with patients for their views on the quality and safety of the service they received.

Our findings

The trust had a workforce engagement forum in place to listen and understand from staff the key issues affecting them, supported by the communications team to ensure a wide audience. A dedicated communications officer for 'starting well partnerships' and for social media were in place, as well as a weekly brief, stakeholder update and the 'big shout out' to assist with visibility of senior leaders. At the time of our inspection, these work streams had yet to be audited to evaluate their outcomes.

There were clear priorities to ensure sustainable leadership with a development programme including succession planning.

The trust led focus groups between March and April 2023 on succession planning and talent management. Staff gave feedback on a variety of issues, one of which was their views on the replacement of key roles for the next 3 to 4 years. Staff said that a budget was required to build resilience in the workforce, workforce planning was too slow and succession planning did not include roles that were already vacant, and staff were unaware of the plans and lacked clarity. Another issue highlighted by staff included how the trust should ensure succession planning is an inclusive process. Staff gave feedback which included the need for clear career pathways, transparency on how jobs were advertised, and opportunities shared across the trust when posts become vacant. Some staff gave feedback during the focus groups they had not heard of the ICS leadership academy or did not know what it offered or how to access it.

The trust had a People Strategy (2022 – 2024) that set out 6 people commitments to drive it forward. It had been developed in consultation with volunteers, experts by experience, internal stakeholders and staff through Listening for Action events. These events covered topics of, 'connecting and reconnecting', 'rewards and recognition', 'our people commitment', 'delivering best in class people processes', a 'responsive and learning organisation' and 'increasing our digital capability'.

The trust had worked with the ICB to commission and design a set of inclusive talent management products to include best practice guidance, toolkits and masterclasses to enable development and nurturing talent over a 3-year programme. The trust offered ICS partners to join some of the senior leadership sessions and was called 'Senior Leadership Connect'. The trust also had 'education and clinical development', 'apprenticeships' and 'retire and return' initiatives as part of the People Strategy, alongside leadership development modules aligned to the leadership framework.

Whilst the trust had the People Strategy in place with clear priorities, this had not translated into a reality for many staff who worked in the trust. We heard in our interviews how people services were not seen as seriously as they should be and following our interviews with senior leaders, we found that the People Strategy was not understood in a collaborative and cohesive way by all members of the trust executive group. Board minutes from January, March, and May 2023 which included a Workforce Committee report described how 5 workstreams remained under review and levels of assurance for each workstream remained the same. For example, the people experience dashboard which provided a view of key information of areas important to trust staff, had no assurance level determined by the committee report author. We also heard that at leadership events, where there had been verbal agreement to sign off projects called, 'leading for inclusion' and work on 'cultural and compassionate leadership', the way forward had not translated into action. Staff from allied health professional (AHP) groups felt there was a lack of senior representation of their professions and opportunities for career progression. Following the inspection, the trust told us they had presented a national strategy for AHPs to a group of speech and language therapists in the trust and told us there were a number of staff from an allied health profession in senior leadership positions.

Vision and Strategy

Our findings

The trust had a clear vision of "working together for outstanding care". This vision was represented in trust documents, communicated through simple, colourful, and easy to understand posters and communications. The trust described in their strategy, what the vision meant for patients, staff and communities. The vision was underpinned by the trust values, supported by core beliefs with the aim to achieve the trusts' strategic priorities.

The trust described 5 values using the acronym CARES; courageous, ambitious, responsive, empowering and supportive. There were 3 core beliefs that supported the values and described how staff were 'valued through diversity', 'good physical and mental health essential to happy, health lives', and 'amazing teams who will be supported to achieve their potential'.

Senior leaders at associate director level and middle managers told us the vison was well known, and the values were embedded. Face to face meetings had been set up by the CEO to communicate the vision and values. During our inspection of the 4 core services, staff in all services told us they understood the vision and values and could describe how they applied them into their everyday work.

In 2021 the trust launched a 3-year strategy which aimed to set out the direction of travel, ambitions and priorities of the trust. The trusts' 5 strategic priorities were:

- Significantly improve health outcomes and reduce inequalities.
- Be ambitious and constantly innovate to deliver outstanding care.
- Be efficient and effective.
- Work with our partners to add value and collectively develop healthier more inclusive communities.
- Be a fantastic place to work.

The trust outlined how they planned to deliver the strategic priorities through 10 strategic service developments, through people, leadership and culture, and through the trust's enabling programmes within the ICS:

- pioneering and driving the development of new integrated models of care 2022 to 2023.
- improving access to psychological treatments 2022.
- providing 24/7 365 days crisis response, avoiding hospital admission 2022 to 2023.
- providing better access for children's and young people 2022 to 2023.
- striving to be excellent in frailty management across Worcestershire 2022 to 2024.
- developing learning disability services to be amongst the best in the country 2021 to 2024.
- shaping the Herefordshire and Worcestershire ICS 2023.
- shaping the developing the Mental Health Collaboration 2022.
- developing modern therapeutic inpatient facilities by 2023, and
- committed to the NHS net zero health services plan 2022.

The trust had also developed a suite of 6 strategies to support the main strategy. These included a clinical strategy which the trust said translated the trust strategy into a clinically led team level plan. A people strategy, with a focus on the employee experience to deliver outstanding patient care, a finance strategy, an estates strategy, and a green strategy.

Our findings

However, the digital strategy had been developed prior to the trust strategy and had not yet been updated to reflect changes since then. The older digital strategy focused on ensuring the right digital infrastructure was in place for the trust. We heard how elements of other strategies, (clinical, finance and estates) had evolved with digital threads running through them rather than a single interwoven strategy.

The medicine optimisation strategy was out of date. A new strategy was in the process of being re-written which would use the Royal Pharmaceutical Society's Professional Standards for Hospital Pharmacy Services as a baseline whilst also incorporating the views of staff and linking it to the trust's strategic objectives. However, it was not available at the time of the inspection. Following inspection, the trust told us they had presented the pharmacy department strategy to the quality and safety committee in September 2023.

The trust told us, and the strategy stated, they had collaborated with patients, staff, carers and communities to develop and design the strategy. However, it was not clear how the strategy was developed in co-production with those who used services.

There was limited reference to co-production in the strategy document itself. During interviews with key staff at the inspection we had limited evidence to support how co-production took place in the strategy development. The staff survey showed that 54% of staff felt involved in deciding on changes introduced that affected their work area or team.

The trust had a community engagement framework 2019 to 2023 which outlined how the trust planned to work in partnership with patients, carers, staff, partners and the wider community in the design, development, and delivery of services. For example, the Youth Board (to help shape services for children and young people), Community Engagement Panel (a focus group of service users, carers and the public to give views and feedback on a range of topics), experts by experience and patient facing volunteering. The trust website advertised these groups as ways to engage and be involved in planning design, delivery and development and review of services. During our inspection senior leaders did not articulate how patients and service users engaged with the trust to influence the strategy.

Following inspection, the trust told us that during the COVID-19 pandemic, there were limited opportunities for traditional forms of engagement, such as roadshows. They told us engagement on the strategy was extensive and included board level sessions, individual sessions with service delivery units, stakeholder updates and approximately 30 one to one sessions with leaders across the trust. The trust held 5 'listening into action' sessions with staff, and the strategy was discussed at key meetings, such as the clinical advisory group, community engagement group, medical and dental advisory committee, the patient panel and the youth board. Whilst the engagement took place with staff, there remained little evidence of co-production with those who used services.

During our interviews, one senior leader told us "it was not their job" to seek feedback from people using services.

The trust strategy clearly described its connection with the local health and social care system, and how the strategy had been developed with the ICB at the centre of its provision and priorities for the communities of Herefordshire and Worcestershire. System reform had taken place through the Herefordshire and Worcestershire Sustainable and Transformation Partnership into the current ICB structure. Key members of the trust board held positions on the ICB and were integral to support the trust's place in the system. The strategy captured how local partnerships would be harnessed to provide integrated health and social care in the wider system.

Progress against delivery of the strategy and plans was not effectively monitored with a lack of evidence to demonstrate progress. There was limited evidence available to show strategy outcomes or meaningful and measurable plans to do so.

Our findings

The trust stated within their strategy, progress against the priorities would be determined by 3 crucial factors;

- the continued commitment expertise and dedication of the people (staff, experts by experience and volunteers), and to continue to strive hard to be a listening organisation.
- secondly, to continue the legacy of strong collaborative working; and
- thirdly, to build on the strong commitment to co-production with staff, patients families, carers and the communities as equal partners.

The trust strategy document outlined the service developments that had taken place between 2022 to 2023 with 2 developments aimed for completion in 2024. These were clinically focused, generalised and not specific. Minutes of board meetings did not show how the board reviewed its outcomes from delivering the strategy. Instead, progress against the trust strategy was reviewed in the finance and performance committee in 2 formal reports.

Throughout our interviews and triangulation of evidence received at the inspection, we were unable to evidence the people commitment measure had been achieved based on feedback we received from staff during our interviews and focus groups. We have referred to this in the culture section of the report. Feedback from staff at some levels described issues with culture and lack of transparency, and as such, the trust was not always a fantastic place to work. Our report reflects our findings on the strategic priorities in other key questions of well led.

We were also not assured the 'learning organisation' commitment had been embedded in the trust, based on findings from incidents and issues identified at Hillcrest at previous inspections. We found areas of the trust where health outcomes were not always measured to evaluate how quality improvements for the strategic service developments had delivered improved care. Whilst ambitions of the leadership team were explained during the inspection, it was difficult to evidence this from the action plans in place for the various strategies. Efficiency and effectiveness were not embedded in all areas. There was a lack of evidence of co-production with patients and families and this was also a consistent theme absent from our interviews with senior leaders. However, we did see evidence of strong collaboration with system partners.

Culture

Senior leaders of the organisation had not recognised early warning signs of a closed culture work and so were not able to address the issues in a coordinated and cohesive way, no matter what plans were in place. The culture across the trust was not consistently positive or healthy and was not always one of respect, or one where all staff always felt empowered in their role.

Views on how staff felt about working for the organisation was inconsistent. The views of executives and senior managers differed from that of how staff felt about working for the organisation. Opinions on how the trust actioned the culture agenda with Equality, Diversity and Inclusion (EDI) issues also differed between senior leaders and staff. Senior leaders told us they knew what their issues were and what was a priority, however this was not represented in what staff told us was their experience.

Despite having a clear vision and a clear set of values, and despite staff knowing what these were, not all staff demonstrated and role modelled acceptable behaviours in the workplace. We were told of multiple examples, across all levels of the trust, where people felt they had been discriminated against because of their protected characteristics with a lack of action taken in response to these incidents.

Our findings

In staff interviews, we heard worrying examples where staff told us they had been openly discriminated against by colleagues, in respect of their race, appearance and preferences. We heard that when staff had courage to raise a concern about discrimination to their line manager, they had been treated with a dismissive attitude and a defensive response. We had serious concerns about how staff in the organisation from minority groups were represented and treated fairly and without being subjected to negative comments, micro aggressions and unacceptable comments about their name or appearance. We heard of an example where recruitment of 3 staff from a minority background, was considered "an influx" by a senior leader. We heard how staff from a white background felt they were "entitled" to staff networks to support their views and equality. Staff told us there was a fear of consequences should they report discrimination. When asked about the make-up of teams and how diversity was represented in teams, some senior leaders in interviews with us referred to people from minority backgrounds as "those people".

We were concerned that senior leaders told us they were unaware of incidents of discrimination and poor culture, only to later be informed that the same senior leaders were involved in working groups to address issues of discrimination and poor culture.

The staff survey results for 2022 had a 42% response rate. The results were split into various categories to an overview score for specific topic areas, and these results could be split further into service delivery units of the organisation. Further analysis of equality and diversity metrics of staff who completed the survey was available. Questions were scored on a scale of 0 to 10 with 10 being a positive score, and scores were compared to the best, average and worst benchmarked organisations as a comparison.

The survey showed deteriorating views about culture. In the 'people promise' section, in 9 areas, the trust scored an average score in 2 elements, and a below average score for the remaining 7, compared to the benchmarked organisations. The trust scored 7.5 as being compassionate and inclusive, (compared to an average score of 7.5). The trust scored 6.8 for staff having a voice that counts (compared to an average score of 7.0). The trust scored 6.9 for staff engagement (compared to an average of 7.0). The trust scored 5.9 for morale (compared to an average score of 6.0). Scores for all these elements had deteriorated from the scores in 2021.

The trust had developed a People Strategy with 6 pillars or strands of work derived and driven from the results of the staff survey. Other sources of intelligence used to drive the People Strategy included staff voice advocates group, 'listening 4 action' events and the integrated workforce action group. A 'valuing our people' action plan was taken to the Workforce Committee and to board and contributed to the development of the People Strategy.

The trust had developed objectives and an action plan for EDI and was integral to the People Strategy. The actions for 2022 to 2023 focused on questions from the staff survey based on ethnic minority experiences, and experiences of those with disability. The action plan was not inclusive of all staff experiences. The objectives were not measurable, time specific or had a lead person assigned to own the progress. For example, they included "to increase board diversity", "remove the differential between ethnicities, and "raised awareness of different types of discrimination and how they might present themselves". In the Workforce Disability Equality Standard (WDES) action plan, 2 out of 10 objectives had been scored as achieved, 5 as on track, 1 delayed and 2 without score. In the Workforce Race Equality Standard (WRES) action plan, 4 out of 9 had been achieved, 2 on track, 1 delayed and 2 without score.

The trust had created a new people experience dashboard through a Quality Improvement (QI) process. This had been in place since January 2023, consisted of 24 questions, split into 5 topics, which could be sliced by service delivery units and EDI characteristics. On a monthly basis, one question was asked of staff; For example, 'what is the trust like as a recommended place to work' and was sent to 200 staff. We heard how results from the dashboard were used by the board as an insight into how staff felt about the organisation. However, we saw minutes from the board meeting of

Our findings

March 2023, where the dashboard had been discussed in the Workforce Committee in February 2023. It stated no assurance was determined for the people experience dashboard and further work would need to be undertaken to explore how the data was used to monitor and measure performance. Those who had oversight of the dashboard told us the response rate was low and had low representation from staff with protected characteristics, yet believed the scores were an essential data source to create conversation at board to discuss formulation of action plans. We were not assured the tool was best placed to measure culture outcomes of the organisation.

The staff voice advocates group met for the first time in December 2022 and met quarterly with approximately 20 members from across the organisation. The chair of this group had an aim to reach 1% of the organisation with this group. A quality improvement model was used as a way to agree how to decide on the priorities on improving the culture agenda of the organisation. Themes identified from the group which required improvement included 'succession planning', 'career development', 'efficiency of the intranet' and to 'set up an organisational staff directory'. This work had not identified the emerging themes of a closed culture.

Staff networks were underdeveloped. They were attended by staff who were enthusiastic and passionate about dealing with EDI issues. Executives were invited to attend, and the Chair of the trust did so and was actively involved in giving feedback. Staff who worked in services had difficulty attending network meetings due to time constraints and 'required' permission to attend from their manager. Staff felt if they attended the network groups, they would be viewed negatively. Staff told us they found it hard to find information about the staff networks available particularly for staff who could access the trust intranet. Staff told us managers had little understanding of the staff networks and there was no clear way of how the staff networks fed into the executive team. Whilst some trust leaders supported the staff Involved, they told us they were not proactive in taking forward issues raised and it is left to the networks to bring change.

Senior leaders did not work cohesively or collaboratively with department leads to embed cultural changes at all levels of the organisation. Not all executives and NEDs had a commitment to address the poor culture in the organisation. Some executives had difficulty explaining how to recognise a closed culture and how to resolve issues that resulted from one. Some executives failed to acknowledge that staff who worked for the trust, felt EDI was important to them and a high priority in the trust.

Some executives thought the staff survey results were the most important data available to the trust to build an action plan on addressing the results to improve the EDI issues. We saw the priority and value given to hearing direct feedback from staff about example situations around culture and discrimination was lower than expected. Some department leads we spoke with described the trust had a tick box approach to the EDI agenda and the trust was slow to bring about change and take action to tackle closed cultures in some areas of the trust.

The culture within the executive team was a top-down directive on culture. We heard from some department leads that some executives had an expectation that it was the job of others to take the lead to solve the cultural issues in the organisation and report back on what they had achieved. Staff told us they feared criticism if they had not been successful in achieving change. Some teams worked in silos, for example the estates team. We heard how staff who reported into the estates team had their own operating models for rotas, pay schedules and staff from diverse backgrounds who were not aware that staff networks existed for support.

Our findings

Some senior staff told us they felt unable to raise concerns for fear of retribution or blame or were not treated with respect when they did. Some senior staff told us when they had highlighted gaps in feeling equal, respected for their diversity and included in the organisation, board members had asked them why they had not actioned it themselves, or had been told there were no finances available to progress the action and senior staff would have to manage with what they had.

Prior to inspection, the trust submitted written information as a self-assessment on 'how well led' the trust were. The trust told us a reverse mentoring initiative was in place, but during our inspection, of all the staff we spoke with, staff did not speak to the programme, or describe the benefits the programme had given them. One executive told us there were other priorities and programmes to "get off the ground". We reviewed trust board papers between January 2022 and May 2023 and reverse mentoring had not been discussed. We were not assured this had been delivered or was embedded.

However, we found there was a culture of reflection and no-blame within the pharmacy team. When staff felt pressured, they were able to raise concerns and discuss how to support each other and what action could be taken. For example, staff within the pharmacy hub had a meeting to discuss their concerns regarding staffing and workload pressures from working in a small environment which impacted on staff morale and wellbeing. The team had reflected and were working collaboratively to develop an action plan.

Staff who worked for the organisation were clear on the importance of how services needed to meet the needs of people who used services. We were not assured of a full commitment across the trust senior leadership teams to accept there were elements of a closed culture in some areas of the trust. Whilst there were some attempts to tackle a poor staff culture in some areas of the trust, this was slow, inconsistent and ineffective and would continue to have a detrimental effect on those who used services.

Executive leaders of the trust told us they had a strong commitment to co-production, to improve culture, but we were provided with little evidence to demonstrate this at the time of our inspection. For example, the estates team did not engage with people who used services to develop their estates strategy or to involve people from services when refurbishment and changes to environments were planned. We reviewed board papers from the 12 months prior to the inspection and there was no evidence of discussion or highlights where co-production had taken place in the trust. There were a number of groups made up from people who used services, carers and volunteers to give feedback on services, which included the Youth Board, a community engagement panel, and expert by experience group, and equality advisory group and a recruitment and selection panel who are involved in interviewing staff. The trust told us Patient-led Assessments of Care Environment (PLACE) environmental assessments involved people who used services and their carers.

Not all staff at ward level felt proud to work for the trust. Staff focus groups told us about a disconnect between ward and board, and some staff described the culture as not inclusive and said there was a risk of blame and being targeted for speaking up.

The trust had a people strategy that contained a people commitment statement. This told staff what they should expect from the organisation as an employer to be able to give their best at work. This included being treated with civility and respect, feeling valued, enabled to be healthy, happy and safe at work and to work flexibly. We heard evidence this was not delivered in practice.

Staff survey results showed staff scored below average for 'we are a team' element, below average for 'health and safety' element and average for 'we are compassionate and inclusive'. 60% of respondents would recommend the organisation

as a place to work, a reduction from 63% in 2021 and 68% in 2020. However, executives and non-executive directors felt proud of the organisation and the work the trust achieved. Senior managers who worked at a level where responsibility for oversight at service delivery level and head of department level was held, felt positive about the services they delivered.

The trust had a weekly 'Big Shout Out' email which recognised staff for positive work and said thank you for their contribution. We saw examples where colleagues had recognised staff for their efforts and work. An annual awards ceremony took place where teams came together to celebrate the work they did in the organisation.

The trust had policies and processes in place to deal with behaviours and performance that was inconsistent with the vision and values. However, staff survey results showed deteriorating scores on how the trust dealt with discrimination. Speaking up about concerns was not embedded in the trust. There was not adequate support and provision to enable staff to speak up and raise concerns. Staff were not confident in sharing concerns and trust leaders were not proactive in listening to and responding to the speak up agenda.

The staff survey showed 4.7% of staff who completed the survey had experienced discrimination at work from their manager or colleagues, which was lower than previous years and lower than the average benchmarked score. 15.3% had experienced the same from other colleagues, a score higher than the average and higher than the score for 2021.

The trust's WRES data 2022, showed staff from an ethnic minority background were 4.95 times more likely to enter the formal disciplinary process which was significantly higher than the national figures (1.14 times more likely). The trust provided data to show 25 cases had been referred to human resources following concerns over staff conduct in the 12 months prior to the inspection and was representative of all levels of staff. 14 cases had been closed and had been subject to disciplinary action, with one dismissal and other outcomes such as final written warning (4), performance management (22), informal action (1), other action (1), and not upheld (2). There were 4 no case to answer outcomes. Eight cases related to white British staff (57%) and 2 (14%) related to staff from an ethnic minority group and the remaining 4 cases (29%) were not specified. Of the 11 cases that remained open, 5 resulted in informal action, 1 referred to a disciplinary hearing and 1 was no case to answer. 4 cases remained ongoing at the time of our inspection. Of all 25 cases, 16% (4) related to staff from ethnic minority groups, 64% from white British group and 20% of cases did not state their ethnicity.

The trust had recently increased the resource for the Freedom to Speak Up Guardian (FTSUG) from one day per week to 3 days per week, which was slightly above the benchmark nationally. The FTSUG reported into the Director for People and Organisational Development, and there was a NED sponsor. Staff told us the directors made representation on behalf of the FTSUG at trust board, although the FTSUG had delivered some presentations to board to raise awareness of their role. We heard that the FTSUG guardian did not have a direct report into the Chief Executive but knew this was available if required. Given how complex the issues were within the trust around EDI, discrimination and culture, and the slow pace of change and deterioration of staff survey results, we were not assured the trust had committed to ensure the resource for FTSUG met the demand of issues faced by the trust. We were not confident that executive and senior leaders in the organisation saw 'speaking up' as their role to take responsibility for initiatives to drive improvement in raising concerns and preferred to delegate to others to do so.

The trust board received one formal paper from the FTSUG, with 2 reports a year submitted to the Workforce Committee. FTSU data contributed to the wider Workforce Committee report along with workforce reporting submitted by the human resources team on a quarterly basis as needed. The FTSUG submitted quarterly results of concern to the National Guardians Office data portal, from a log which held themes of speak up concerns in the absence of specific database for such information.

Our findings

The FTSU annual report for 2023, presented to the Workforce Committee highlighted "the need for the role to be better resourced and to be more strategically embedded in organisational culture within our trust." We saw an example where the trust had intentions but had not acted to drive forward the importance of speaking up. We saw in the report to board, the trust had "an intention to determine the most suitable reporting and structure and triangulation processes for speaking up for example between the Workforce Committee and the Quality and Safety Committee". No other plans for action were proposed.

Previously, there was no formal training for staff on 'speaking up' in the trust. This was rolled out as e-learning in October 2022, and was to raise awareness of speaking up. Compliance as of February 2023 was low, with 'speak up' for all staff was 70%, for 'listen up' for managers was 68% and for 'follow up' for senior leaders was 61%. Training for 'speak up' for staff was aimed only at qualified staff and roll out to all staff across the trust was planned 'early 2023' but had not been completed at the time of our inspection.

The trust reported 54 speak up concerns between February 2022 and February 2023. The staff survey 2022 reported 65% of staff felt confident to speak up, a declining trend since 2021 and 2020.

At the time of our inspection, the trust had a revised speaking up policy in development and it had been submitted to the Workforce Committee as a draft. There was a policy for receiving, investigating responding to and learning from complaints, but this was in relation to complaints made about clinical service delivery. Following inspection, the trust submitted a paper which had been presented to board in September 2023 with an action plan on how they would improve speaking up in the trust and intended to adopt the national freedom to speak up policy in January 2024.

Following completion of the 2022 FTSUG report, the trust completed a deep dive into FTSU. It identified 2 areas of further development: firstly, the resource for speaking up, and secondly the culture around the role. The trust reported the deep dive was undertaken "during a period of challenge when the trust was under scrutiny given the CQCs visible presence relating to Hill Crest."

In addition to the training, FTSU information was promoted through trust wide communications, bespoke awareness sessions and drop-in sessions during October and November 2022. Staff were encouraged to complete an online survey to gauge understanding of speaking up. The intranet held key information about FTSU where staff could use an inbox service to raise concerns. The trust told us work was in progress to update posters, banners, lanyards to increase visibility of FTSU and the 8 champions across the trust. In July 2022, FTSU became part of the trust induction with a 15-minute session. The FTSUG was named in the staff induction booklet and 'raising concerns' contact and had a half page description of how to raise a concern and a link to the FTSUG. Staff told us this had had a positive impact.

Staff told us the trust's commitment to speaking up was "superficial" and felt like a "tick box" exercise and "speaking up often felt like a lonely place". Staff did not always feel they had the confidence and know how to challenge discrimination and negative attitudes towards speaking up. We saw trust strategies and reports that made references to EDI and culture work and described aims to "address issues" and "embed an open honest culture", but little detail on how this would be achieved.

The trust responded to complaints within their policy 'receiving, investigating, responding to and learning from complaints'. This policy had no date for when it was ratified and had no Equality Impact Assessment in place and had been submitted to the inspection team with the wrong trust header (from before the merger of 2 trusts) and was corrected during the inspection. The policy had been extended to December 2023 until it could be reviewed.

Our findings

We were not assured there was full and cohesive commitment and action to address the EDI issues highlighted by the staff survey EDI data, and soft intelligence from staff. The trust was in its infancy to develop and implement the EDI agenda. There was a lack of a clear process to ensure EDI was a golden thread in all interdependent trust strategies and there were no equality objectives set as part of the public sector equality duty. Significant improvement and progress had not been made for staff from minority groups.

We saw that the trust had governance processes in place for EDI to report into the Workforce Committee which reported directly into board. There was an EDI lead who reported to the Director for People and Organisational Development and the resource allocation for EDI was equivalent to one full time position.

The trust employed 4,632 staff and of those, 303 staff members identified themselves as being from a black and minority (BME) background (6.54%, compared to 6.44% in 2022 and 6.2% in 2022). The WRES annual report provided at this inspection, 1 April 2022 to 31 March 2023 stated, not all staff had completed their ethnicity data (416 staff) in their staff electronic record because "there is still a misconception that managers can see staff details", there is a "lack of understanding of how the information is used and collated" and due to worries by staff "it would hold them back from progressing and concerned about being used as a token if they belonged to a minority group." This was an increase of 21% from 2022. The trust delivered sessions for staff on how to report ethnicity and to address concerns staff had. The trust reported this approach would be reviewed to understand if there needed to be an ongoing discussion with teams annually to ensure data was kept up to date. The trust induction programme also communicated the importance of completing personal data when starting work with the trust.

The trust had not taken adequate action to reduce bullying, harassment or discrimination. We were not assured that there were embedded processes to act upon and address concerns from staff who were from an ethnic minority background. All NHS organisations must produce and publish data that reflects the race, disability, equality, and equity within healthcare organisations to ensure staff from black and ethnic minority groups are treated fairly, valued and developed to identify and promote talented employees as well as help to eliminate potential discrimination. The trust stated that by collating data based on the WRES 9 indicators, the organisation "will assess its workforce and develop an action plan to improve workplace experiences of staff from ethnic minority backgrounds."

Levels of bullying, harassment and discrimination had increased since last year. Staff at the trust reported they had experienced levels of bullying, harassment or discrimination. In the staff survey 2022, 70% of staff felt the organisation respected individual differences, which was below average and a reduction from 2021. 19% of staff survey respondents from a white background had experienced harassment, bullying or abuse from staff in the previous 12 months, (higher than average and higher than 2021) compared to 25% of respondents from all other ethnic groups (higher than the average and higher than 2021). 4% of staff survey respondents reported discrimination at work from their manager or other colleagues in the last 12 months who were from a white background (below average and lower score than 2021), compared to 18% from all other ethnic groups (higher than average and higher than 2021). 12% of staff had experienced bullying, harassment or abuse from managers in the previous 12 months due to a long-term condition or illness compared to 6.5% of staff without a long-term condition or illness. This was below average for both staff groups, and lower than 2021. 24% of staff had experienced bullying, harassment or abuse from other colleagues in the previous 12 months due to a long-term condition or illness compared to 12.5% of staff without a long-term condition or illness. This was above average for both staff groups, and higher for staff with a long-term condition or illness from 2021 results.

Data from the trusts' WRES was uploaded to NHS England in May 2023. The trust produced a WRES annual report but no data relating to WRES was published in the trusts annual report 2021 to 2022. In addition to the nationally mandated data collected, the trust focused on data collected from the people experience dashboard to guide their action on the EDI agenda. The EDI annual report to board 1 April 2022 to 31 March 2023, provided to us on inspection was in draft.

Our findings

Some sections were incomplete including those which required comment on staff survey results in relation to staff who had reported they had experienced discrimination at work from managers or other colleagues. Comments for edit remained on the document and the name and title of the board lead for EDI was questioned in the comments. It appeared the trust had not formally decided who the trust lead for EDI would be, despite this post being in place for 2 and a half years. The Director for People and Organisational Development told us they had EDI under their portfolio.

Staff told us how addressing the EDI agenda in the trust felt "like a lonely place" and the boards' focus tended to be on a financial and clinical perspective, without being aligned to EDI. Staff told us there was a "blockage" from senior leaders who failed to recognise, accept and act on the work the trust needed to do to improve culture and develop the people agenda. However, we heard that new board members appointed in the last 2 to 3 years had embraced the need for improvement in the EDI work.

We were not assured there were embedded processes to act upon and address concerns staff with a disability had on how their needs were addressed. The trust reported on its WDES data, mandated to all NHS trusts in England. This is designed to improve workplace experience and career opportunities for people with long-term conditions or illness. There are 10 metrics and indicators scored. As with the WRES, the trust reported they would "commit to take a proactive approach to improve experiences of staff with a disability or long term condition or illness". Not all staff reported their disability or long-term condition in the electronic staff record. In 2022, 204 staff reported, with 948 of the workforce who did not declare their disability status and therefore concluded that the ratio of staff with disability at different pay bands across the trust was underrepresented. Staff with long term conditions or illnesses were 1.21 less likely to be appointed from shortlisting (improved from 2021 when it was 1.04). The perception of equal opportunity for career progression or promotion slower amongst staff with a disability (51.5%). Those with long term conditions or illnesses feel less valued and were more likely to experience harassment, bullying or abuse from patients, relatives or public.

The trust did not have a set of actions to address the data, but reported the Staff Disability Network would have opportunity to identify opportunities to improve the working environment for all staff with a disability and to ensure equality was embedded into everyday practices as an employer.

Trust strategies made little reference to EDI. The people strategy made one reference to EDI. They stated they would "refresh our approach to educate all staff in EDI, supported by regular communications (internally and externally) about EDI issues. All recruitment and learning and development offers will integrate equality, diversity, and inclusion considerations as we understand that this is a dynamic and fast changing area, relying on feedback from our annual staff survey, internal voice groups, best practice, and regional and national people plan priorities".

The overarching trust strategy gave mention to diversity on two occasions. One statement in the trust strategy read "we will be embedding EDI in all that we do. The way we do things around here is embedded in our strategy and brought to life." The trust had no strategy for EDI, although an EDI committee had recently been established.

Trust policies did not always have equality impact assessments (EIA), in line with The Equality Act 2010. EIA's help the trust to determine what impact a policy or process would have on people in the organisation who face disadvantage and underrepresentation. Whilst the trust had over 200 policies, we reviewed 11 and found 8 with either no EIA or and EIA completed before the ratification date of the policy, which meant it was outdated. We were told there was work to be done on trust policies and work had been rushed through ahead of the inspection to completed and update as many as possible. The trust provided training on how to complete EIAs but this did not include board members. Guidance had recently been produced for completing an EIA, but at the time of our inspection this had not been ratified by the board.

Our findings

In services, we saw cooperative teams with supportive relationships of each other. Teams worked collaboratively, within their service delivery units, and we saw some evidence of learning between service delivery units.

Leaders of service delivery units met regularly to share information. A weekly Friday 'Shout Out' was in place for staff to appreciate their colleagues and share values with offers of thanks.

During the COVID-19 pandemic, the trust initiated a 'Working Well with Teams' conversation where staff could complete a diagnostic tool which provided an indication of areas of strength and need against eight domains which enabled team discussions in order to focus on areas they agreed needed attention.

Since September 2022 the trust had trialled the NHS England TED (Team Engagement and Development) tool. 14 teams were testing the approach and resources. Additionally, the trust offered a range of other team support options, including, Schwarz Rounds, Lunch and Learn sessions, Compassion Circles, Values Circles, and Peer Support sessions.

The culture of learning in response to incidents was not always embedded in all services where outcomes of incidents were consistently shared.

We were not assured that learning was always effectively and routinely shared with teams following investigation of incidents that occurred. We reviewed incidents and did not see evidence of how learning was identified, or notable practice was shared in the absence of a live action log or a feedback loop to the Quality and Safety Committee. Safety huddles, quality reports at service level, serious incident forums and the Clinical Professional Advisory group took place that were attended by senior managers and the Director of Nursing and the Medical Director. However, it was not clear how staff in services received feedback on learning and good practice following incidents. Staff told us there used to be a newsletter to share learning, and the trust were looking at how to share learning widely across service delivery units.

We found executives and NEDs to be defensive of incidents which had occurred in the trust during our interviews, rather than open to discussing the issues which led to the incidents, the actions taken and learning from the incidents.

Health and safety team members were available to staff who advised on all matters of Health and Safety. They published regular newsletters that contained learning points from any local or national incidents or events. Health and safety representatives were available in clinical teams, who attended the Health and Safety Committee to be the staff voice and to escalate any particular matters of concern.

The trust was prepared to move towards the introduction of the Patient Safety Incident Response Framework (PSIRF) in the summer of 2023, a new national framework for reporting and learning from patient safety incidents. Patient safety investigating officers were now in post to specifically undertake this work.

The trust had processes in place for succession planning and career development. However, in services we inspected, not all staff received supervision and appraisal and managers did not have effective systems and processes to monitor compliance for this.

The trust led focus groups in March and April 2023 to discuss how to effectively plan for recruiting to roles which were due to become vacant. The trust strategy 2021 to 2024 described how the trust was 'developing a talent management programme to meet the needs of staff at all levels'. One of the 6 areas of focus for the people strategy was 'to embed an inclusive approach to talent management in a way that supports everyone to achieve their best'. The trust had a Workforce Committee and a workforce steering group.

Our findings

Within the people strategy, appraisals and career planning development was an area of focus. Appraisals and supervision did not always take place for staff in services we inspected despite the average overall compliance rate for staff in the trust of 86% over the 12 months prior to the inspection. Yet, the trust stated it would rely on an increase in appraisal compliance rates as a method to measure improving culture and hoped to reflect a successful outcomes when the staff survey data reflected the trust as a great place to work and appraisal rates had achieved between 95% to 100%. The last survey results showed that 60% of staff would recommend the organisation as a place to work, a decreasing trend since 2020.

The trust had developed a Leadership Qualities Tool, a simple self-assessment tool to allow staff to have a conversation with their line manager about leadership strengths and areas for professional development.

The trust had set a level of 80% compliance with clinical supervision. However, in total, the trust's compliance was 62% with service delivery units ranging from 51% to 87% with primary care and community mental health services the highest.

We heard from our interviews that the work on recruitment and retention was "hard work" and "felt like a thankless task", and there was an appetite for repeated risk summits which focused on areas where there are issues rather than focusing on ideas into action to address recruitment and retention issues.

The relative likelihood of white staff to be appointed from shortlisting compared to staff from ethnic minority backgrounds had decreased from 2.4 times more likely in 2021 to 1.03 times more likely in 2022 and this was lower than the national likelihood (1.54).

The trust staff survey and annual WRES report, showed that staff from ethnic minority backgrounds reported a decrease of 5.6% in the belief the organisation provided equal opportunity or career progression compared to white staff who reported a 1.9% increase in their confidence to access career progression and promotion.

Every quarter, the trust was required to submit a self-assessment of 8 EDI elements to NHS England. The trust was rated 'maturing' for 1 element (access to inclusive and compassionate health and wellbeing support), 'developing' in 1 element (removing barriers to help people speak up) and 'emerging' in 4 elements (collaborative system approach, building accountability, eliminating racism and bias in disciplinary and recruitment). Two elements were rated 'undeveloped'. These were leading with compassion and inclusion and tackling racism and other types of discrimination. Overall, the self-assessment was rated as emerging.

The trust promoted a health and wellbeing offer for staff. A staff wellbeing post had been created and was line managed by the Associate Director or HR and reported into the Director for People and Operational Development.

The staff survey data showed 74.5% of staff felt their managers took a positive interest in staff health and wellbeing (below the average benchmark score of 78%) and the organisation took positive action of staff health and wellbeing was 64%, comparable to the average benchmarked score.

A wellbeing hub within the ICS was in place, with the trust acting as the host and leading on its provision. Funding was due to end for this resource in July 2023 and we heard this would be a huge loss to the resources available to staff and the ICB. A national campaign was in place to raise awareness about the positive impact the hub had had on staff wellbeing and how important it was to keep this resource in place. The trust was unable to maintain this resource financially, despite proposals being made of ways to achieve this.

Our findings

Benefits to the wellbeing hub included rapid access to mental health triage for all staff who work in the ICB. It provided signposting to services needed for staff health and well-being, such as counselling, yoga, advice, menopause support and training. The hub received on average 40 referrals per month from across the county. The hub had significantly improved the wellbeing offer the trust provided, but communication about its availability and purpose required improvement. Staff did not always get time to read the '2-minute catch up' emails where the hub was advertised, and managers did not have the awareness it existed.

In addition to the hub, the trust offered, for the third year running, a 5-day festival called 'WellFest' which promoted staff to focus on physical and mental wellbeing. In addition, the trust offered access to counselling, Moodmaster courses, Health Minds (a specific pathway for staff who experience stress, anxiety, low mood, or depression) a confidential offer of support for staff. Supportive conversations were available from the Health and Wellbeing lead, Chaplaincy, HR, learning and development and coaching support from the organisational development team. An 'End of Shift Checklist' was in place to assist with a debrief and set of steps to 'switch off' after a day at work. The trust also accessed 'NHS People', a package of emotional, psychological and practical support for staff. Staff physiotherapy, weight management programme and workstation assessments were available. Schwartz rounds (a confidential monthly forum to discuss and reflect on work demands) were available. Carer Aware was available to staff who were responsible for caring for someone close to them. Staff were offered the opportunity to create a 'carer passport' to help recognise caring responsibilities alongside their work role.

Governance

The trust had a governance structure, processes to support the delivery of the strategy. However, we found this did not always operate and function effectively.

Meetings took place at all levels of the organisation and reported into more senior level meetings or committees. There were 8 board committees, 2 of which related to mental health, one specifically for legislation and one for the mental health collaboration which was a driver for mental health provision in the ICB. Sub committees were in place for 4 committees as expected. Senior leads for services, knew how to escalate into relevant committees and quality meetings.

The quality and safety committee was a key component of the integrated governance arrangements. It monitored key performance indicators combined with narrative, with the aim to ensure quality of care in services were monitored. We were assured that information governance, safeguarding, infection prevention and control, research and development and systems in place for complaints were robust and worked effectively. Each department had robust ways to monitor and review their portfolios and had clear actions to address issues with timelines and identified individuals to take responsibility for these.

However, we saw that not all policies were ratified, had equality impact assessment or were in date or aligned to the trust name. Some policies remained in the name of Worcestershire Health and Care Trust only and had not been updated. The way in which serious incidents were reviewed and classified was not robust and we have reported on this in risk management.

The trusts' quality governance policy was in place to underpin how systems supported the delivery of care. Service delivery units had quality plans in place to identify themes and actions to take to address risk. There was a process in place to undertake quality impact assessments with any new service projects or changes to a service, signed off by the Director of Nursing and Medical Director.

Our findings

A clinical audit programme was in place and was overseen by the Clinical Audit and Effectiveness Group which reported into the Quality and Safety Committee.

Medicine optimisation was not included in the overall trust strategy which was a cause of concern.

There was a governance structure in place for the safe use of medicines, however there were many varied committees which was a challenge to ensure they all linked into the Medicine Management Safety Committee. This committee reported to the Quality and Safety Committee and the Chief Pharmacist attended twice a year to present reviews of medicine incidents and highlight any trends. This did ensure that medicine optimisation and medicine management had links to the trust board.

The Chief Pharmacist had direct links to the executive board as they were accountable to the Medical Director who was an executive board member.

Trust committees reviewed key risks at each meeting and considered changes that required escalation to board. However, systems of accountability for some areas of governance were not always clear, and not all senior leaders discharged their responsibility of active challenge to decisions and actions robustly.

We were not assured that all reporting lines up to board were effectively embedded or how some individuals were held to account for their portfolios. For example, we heard how some NEDs posed questions to issues highlighted as risk to the trust, which resulted in a questioning approach, with a slow pace of change rather than a dynamic decision-making process to bring about change at pace. We heard and saw through our review of documentation how estates issues did not receive significant focus at board in terms of the risks and experiences of patients and staff. We saw minutes of meetings, action plans and mitigations that had questions and intentions 'to do' or 'we will' rather than concrete, decisive actions with deadlines and ownership.

On most occasions, committees had been attended by their respective chairs and lead executives. We saw evidence of how many board meetings and committees had taken place between April 2021 and March 2022. Trust board meetings and board development sessions had been well attended but the Charitable Funds Committee had one meeting without its' chair and the Workforce Committee had been attend by the chair on 4 out of 6 occasions. Some key executive members did not have full attendance at the committees throughout the year.

We saw the trust was well placed and embedded in the health and social care system in the Integrated Care System (ICS). They had senior leaders in key roles in the ICS and the trust's strategic service developments were planned to shape the health and social care system over the next 3 years. These focused on prevention in early years care, with multiple partnerships across several organisations; integration to join up service around people who need services; commitment to promoting access to services for minority groups in the counties, and partnership working to achieve improved health outcomes for the communities of Herefordshire and Worcestershire.

New models of care had been implemented underpinned by the Five Year Forward View, with clear governance systems in place to oversee their roll out, ongoing monitoring and outcomes through board committees and reporting lines. Case studies and strategy papers were in place as evidence to demonstrate clear oversight.

Partnership working arrangements were well defined and delivered for the Mental Health Act. While there had previously been a section 75 (arrangements between NHS bodies and local authorities, (National Health Service Act

2006)) agreement in place, this agreement ceased in April 2021. Two local authorities ran the approved mental health professional (AMHP) service. When we spoke with a lead approved mental health professional, for 1 local authority, they told us there was 3 approved mental health professionals on duty during the day and 1 at night for the county they covered.

The lead approved mental health professional we spoke with was contracted by a local authority and had lead responsibility for the approved mental health professional (AMHP) service within a county. The MHA administration manager told us the trust had a specific section 12 (general provisions as to medical recommendations) rota in place, which was managed by the trust's medical staffing team. The MHA administration manager said they periodically checked this rota for accuracy.

The lead approved mental health professional we spoke with said that the availability of beds within the trust was problematic. They told us there had been an increased use of section 140 (notification of hospitals having arrangements for special cases). The lead approved mental health professional said they attended the trust's MHA steering group and a monthly interagency meeting.

Robust arrangements were in place to ensure that trust hospital managers discharged their specific powers and duties according to the provision of the Mental Health Act 1983. The trust had robust arrangements in place for the receipt and scrutiny of detention paperwork. The scrutiny process was multi-tiered, which included nurse, MHA administrator and medical scrutiny. The trust had developed checklists to assist staff with the receipt and scrutiny process.

There were a number of systems in place relating to the operation of the MHA. These included, for example, reminders for section expiry dates and consent to treatment dates. The trust had service-level agreements in place with neighbouring acute trusts to provide MHA administration. The trust's company secretary was the executive lead for the MHA. The MHA administration manager had day-to-day responsibility and oversight of the MHA within the trust.

The trust had a MHA steering group which was chaired by the trust's company secretary and met every 3 months. The topics discussed in these meetings included, for example, MHA activity, any MHA incidents and complaints, updates from the local authorities and CQC national MHA reports. Information from the steering group was disseminated to the ward staff by the operational leads, and to the medical staff by the medical representative, who attended the meeting.

The trust had a mental health legislation committee which was chaired by a non-executive director and met every 3 months. The committee had oversight of, and monitored, all aspects of the MHA performance across the trust. The mental health legislation committee reported to the trust board.

The trust produced quarterly reports on MHA activity. This included, for example, reporting on the level of MHA activity, the gender and ethnicity of people detained under the MHA, and the outcomes of First-tier Tribunals (Mental Health) and hospital managers' panels.

The MHA administration manager was responsible for developing and updating policies about the MHA. The MHA administrators also participated in this work. The trust had a number of MHA policies, including the 'Mental Health Act 1983 – Guidance for receipt and scrutiny of statutory paperwork' policy, which provided advice and guidance for staff and MHA administrators about MHA documentation.

Our findings

The trust had a system in place to address issues raised by the CQC's MHA Reviewers in their MHA monitoring visits. Responses to the actions raised by the MHA Reviewers were collated by the MHA administration manager. The MHA legislation committee had oversight of the process and considered trust-wide learning from the actions raised.

The MHA training was mandatory for staff who had contact with patients detained under the MHA. The training was usually delivered by the MHA administration manager with either a ward manager or approved mental health professional. Due to the pandemic, we were told MHA training had been delivered remotely. However, face-to-face training was resuming. Training for junior doctors in relation to section 5(2) (application in respect of patient already in hospital) had been introduced, following issues in the completion of the relevant documentation.

The trust had 15 associate hospital managers (members of a committee authorised to consider the discharge of patients detained under certain sections of the MHA). The MHA administration manager said they were hoping to recruit a further 3 associate hospital managers.

The associate hospital managers were appointed following an open recruitment process. The trust's human resources department managed the recruitment process. Upon appointment, associate hospital managers received a period of induction and training, including shadowing panel hearings. When confident, a newly appointed associate hospital manager would start sitting on panel hearings.

The associate hospital managers had annual appraisals with the MHA administration manager and participated in training with other hospital managers across the West Midlands. There was a system in place for the associate hospital managers to provide feedback of any concerns they had. Additionally, the associate hospital managers had direct access to the MHA administration manager and trust's company secretary should they need to raise any immediate issues.

There were a sufficient number of staff working within the MHA administration team. The team comprised of a MHA administration manager, 3 MHA administrators and 2 MHA administrative assistants. There was a good working relationship between the MHA administration team, the wards and community teams. The MHA administration team were able to escalate issues to their line manager, including in their regular one to one sessions. The MHA administration manager was managed by the trust's company secretary.

Management of risk, issues and performance

The system and process used to manage risks in the trust was not effectively managed with a lack collaborative oversight, escalation or challenge. The scoring system used to manage risk was not co-ordinated. The trust board was not always sighted on all risks that could affect the delivery of the strategy and provision of high-quality care.

The trust had a board assurance framework (BAF) to manage the principal risks which were aligned to the strategies in place. Operational risk registers were in place and fed into the overarching trust risk register. The BAF was considered at 7 of the 9 board sub-committees and trust board. Any risk which scored 15 and above was reported to trust board and consideration given as to whether it ought to be included in the BAF. The BAF provided by the trust during the inspection, contained 6 risks related to:

- ICS approach does not lead to benefits of integrated care being realised
- Ability to attract, develop and retain an appropriate workforce
- Working in a challenged health economy, concerns of reduced partnership working

- Failure to achieve improving health of the population.

The trust had 2 risks as appendices to the BAF:

- Failure to achieve good quality care
- Failure to achieve sustainable use of resources.

Each risk on the BAF had a starting risk score, a current risk score and a subsequent target rating. It contained existing controls, assurance, gaps in controls and assurances and correction action or action plan. Only one risk had a risk appetite score that was lower than the current risk.

However, in the minutes of the Audit Committee dated 27 April 2023, a report submitted by the Risk Moderation Group stated the trust reported the BAF contained 7 risks. These did not match the BAF submitted at inspection.

- A risk around quality of care and breach of regulatory standards.
- Long term financial sustainability.
- The potential tension of working within our Integrated Care System, balancing the support to the system with managing our internal services.
- The need to attract, retain and develop an appropriate workforce.
- Working in a challenged health economy sometimes lead to focus on areas of immediate concern rather than partners working collaboratively for medium term priorities.
- Impact of COVID on every aspect of our organisation.
- Delivering services taking account of population health data.

The risk management approach was applied inconsistently and was the responsibility of one director to filter risks and escalate only high-level risks to board. We were not assured that risks were fully articulated and escalated to board as the filtered process in place prevented a full picture of trust risks ever reaching senior executives.

The company secretary had delegated responsibility for managing the strategic development and implementation of corporate risk management and assurance. They were responsible for the development and maintenance of the BAF and high-level risk register. The company secretary also chaired the Risk Moderation Group which reported into the Audit Committee. Directors and NEDs who chaired committees and sub committees within the trust had delegated responsibility for their area of risk. For example, the Director of Nursing and Medical Director held responsibility for clinical risk at the Quality and Safety Committee, the Director of Finance had delegated responsibility for financial risk management. Service Delivery Unit leads, and senior managers had individual responsibility for the management of risks within their department.

The trust's Risk Management Strategy 2021 to 2026 stated a scoring system was in place to score risks. The range of scores were 1 to 3 (green risks), 4 to 7 (yellow risks), 8 to 11 (amber risks). Scores 12 to 14 were to be reported to either Quality and Safety Committee, Workforce Committee or Finance and Performance Committee. The Audit Committee received reports on the effectiveness of risk management processes. Risk score of 15 and above would be reported to trust board via the Quality and Safety Committee and consideration given to include in the BAF.

Our findings

All senior staff we spoke with told us about the scoring system for risk, and this differed slightly to that of the strategy. In practice, all staff we spoke with told us how scoring of all trust risks was overseen and controlled by the company secretary. The company secretary met monthly with everyone with delegated responsibility for risk as described in the governance structure above. Each area of responsibility was expected to discuss and escalate risks to their direct report subcommittee, which in turn escalated to a board committee if agreed this was required.

Any risk scored 6 or below was expected to be managed within the service through a risk assessment process held in the electronic system called Ulysees. Service Delivery Unit leads then worked with managers to identify controls and form an action plan to sufficiently manage risk. Risks were removed if addressed through this process or remained if ongoing. Any risk rated 12 and above reached a committee for discussion and review. Each committee chair met with the company secretary to regularly review the risks held. Staff told us there was support and challenge on the scores given to risks and often would be mitigated down to be managed by the committee or mitigated down further to be managed by department and leads. Risks scored 15 and above would reach sight of the board and be placed on the high-level risk register. Staff told us board would ask what action was being taken and would revert to each committee where ownership of the risk sat for a 'deep dive' into the issues and report back to board.

The trust's system for rating and recording serious incidents gave us cause for concern. The categorisation of incidents against the NHS framework was not consistently applied during safety huddles and left us concerned that all not incidents had been correctly categorised, escalated and did not always have full investigation, reporting and learning. This was significant as the trust did not always recognise the seriousness of some events and did not always notify CQC in line with statutory notifications process and the spirit of openness and transparency, even though they had been reported to the NHS national reporting system. Senior staff we spoke with told us the decision made to grade an incident was done on a "feeling" or "experience" as well as levels of harm.

There was a safety huddle at which quality leads, Director of Nursing, and Medical Director attended along with the business manager to the CEO. The safety huddle determined the level of the incident based on the level of harm caused. This included, no harm, low harm, moderate harm, severe harm or death. In line with trust policy, a nominated individual may re-grade the incident in terms of harm level as information emerges. The huddle was responsible for this. The trust held a serious incident forum, a subcommittee of the Clinical Governance Sub Committee with designated responsibility for reviewing, evaluating and critiquing all significant events and serious incidents, if escalated.

The trust's pace of responding to lessons learnt was a concern. There were similar issues that had repeated in several services across the trust, such as seclusion practice and patients whose behaviour challenged the environment. The trust's level of scrutiny and oversight to anticipate future risk and planning services was a concern.

We reviewed 10 serious incidents from across the trust at the well led inspection. Some incidents were delayed in being added to the electronic reporting system or to the national reporting system STEIS. 5 were within 1 to 5 days. One took 12 days, one took 18 days and one took 111 days to be reported. Of all the serious incidents we sampled none had been notified to CQC, (including a serious sexual assault and inpatient death) in the interest of an open communication. The incidents had been notified to the national reporting system as required. There was not a clear sign off process, sometimes with delays. On average it took 4 months for an investigation to be signed off as complete, 7 of which were signed off at the serious incident forum, 2 by the Head of Patient Safety and one with no sign off recorded. Recommendations were included in the investigations, but lacked detail of how assurance would be sought to ensure the recommendations had been completed or embedded to prevent future reoccurrence. Whilst we saw the trust had reported to national reporting systems, the internal systems and processes to identify, and act upon serious incident to prevent reoccurrence were not as timely or robust as they could be.

Our findings

We were not assured that action was taken in a timely way to control, mitigate and respond to risk based on the current delegated responsibility in the trust. We saw a disconnect between ward to board to escalate risks for the board to be fully sighted and act where necessary.

The board were not always fully sighted on risks from service delivery units, which in turn, meant action was not taken at pace to mitigate, review monitor or take steps to resolve risks. Following inspection, the trust submitted their full risk register, dated 8 June 2023. There were 148 risks in total and 23% of risks on the risk register had no assurances and or controls in place.

In July 2023, the trust submitted further information about their risk register, in response to feedback to the trust post inspection from CQC. This information contradicted the original submission, and was presented in a word table, and was not the risk register itself. When compared to the original risk register submitted in June 2023, the total number of risks differed, (162) with 15 new risks added post inspection and 9 risks from the original submission not included and 6 risks not on the original submission. This version had 18 risks with no assurances and or controls in place (11%). This meant we continued to have concern about the quality of data the trust held about risk.

We had serious concerns that some of our findings from the core services inspection were not adequately escalated in the trust risk register. Our concerns related to sexual safety on the acute wards for adults of working age (Hillcrest and Stonebow) had not been responded to until our inspection. The risk register stated “Concerns have been raised regarding sexual safety on working age inpatient wards. We currently have mixed gender wards with poor policy, procedures, and estates to support and maintain the sexual safety of patients and staff on the wards.” This risk was added on 1 June 2023, initially with a risk score of 16 but mitigated to 8 therefore to be managed by the service manager. This risk had no controls in place and no assurance of how the risk would be mitigated or reviewed.

Five risks related specifically to estate risks. In our inspection of core services, we were concerned about the environment at Stonebow. This was added to the risk register in June 2022, scored at 8 and therefore managed by the service lead and not escalated to board, or board committees. The control measure for this risk lacked detail and stated, “estates to explore options”. In our focus groups we heard that estates worked in silos. The estates workforce was on the risk register and scored as 9, added on November 2021 and so overseen by the estates lead and not a committee. Controls and assurances for this risk had not been updated.

There were 8 risks associated with clinical risks, 7 related to digital risks, 1 medicines risk that had no controls or assurances. There was a risk related to business continuity which stated the continuity and incident plan was incomplete since the patient care record system outage. This was added in March 2023, scored as 5 (therefore not escalated to committees) and managed within the digital team. There were no controls or assurances for this risk.

There were 2 risks related to safeguarding on the risk register. One related to the trust not providing information in a timely way to partner agencies, scored at 6, and the risk of abuse or neglect to children not properly assessed or mitigated, scored at 2, both added in September 2022, with no assurances documented. Both these risks were scored low enough to be overseen by department leads.

The trust had other ways of identifying risks in services. This included board members who completed service visits or ‘Patient Safety Walkabouts’, together with a programme of peer reviews whereby teams were visited and were asked for their concerns and worries so that these could be acted upon. Where any risks were identified, they would be assessed

and if appropriate, added to the risk register. The trust encouraged staff to raise worries or concerns if they felt risks were unknown, for example through the Freedom to Speak Up Guardian or Staff Side Representatives. However, we found actions identified from service visits or patient safety walkabouts were not always actioned or monitored, with several issues which continued to be an issue and identified during our core service inspections.

The trust had a Public Interest Disclosure (Whistleblowing) Policy that was available to all staff. Where staff preferred to raise concerns or ask questions anonymously, they could submit a query to the 'Rumour Mill', an online form where staff anonymously ask questions about anything relating to their workplace, the organisation, or future changes. The query would be reviewed and responded to by an appropriate person within the organisation, with the question and answer published to the staff intranet for openness and transparency.

The pharmacy department risk register had not been updated in 3 and a half years although it was currently being updated. The main identified risk for the medicine optimisation service was linked to the lack of capacity and vacancies within the pharmacy team to cover every specialist area of the trust. Due to the gaps in pharmacy service provision, there was an increased risk to safe medicine management in areas with no pharmacist input. The newly established pharmacy hub located at The Princess of Wales Community Hospital was a health and safety risk for staff working in this area. The specifications of the department did not meet the service provision for safe storage and dispensing of medicines. The storeroom was too small for the safe delivery and storage of boxes. Staff had tripped and fallen over boxes placed on the floor. However, staff had not always reported accidents in the workplace because they had not had training or the time to use the trust reporting system. Although the risk was recognised by the pharmacy team it was not clear if senior trust management understood the risk to the overall service for safe medicine management.

Processes to manage current and future performance were in place, but did not always work in a co-ordinated and cohesive way across all committees and subgroups. Risks to the organisation were not effectively escalated and mitigated. The risk management approach was not co-ordinated across all committees and transparent up to board level which meant risk issues were not always dealt with appropriately or quickly enough.

The sustainable delivery of quality care was put at risk by the financial challenges faced by the trust. Senior executives told us that achieving cost improvement targets was a worry and the financial challenges within the ICS was a concern and impacted how the trust used its financial resources.

The trusts approach to risk was reactive. We were not assured that the board were sighted on all significant risks in the services and therefore were unable to effectively manage current and future performance.

The risk register contained 148 risks, 28% scored 1 to 7 (green or yellow), and 33% scored 8 to 11 (amber) and therefore managed by service delivery unit leads. 28% of risks scored 12 to 14 and therefore overseen by committees. The high-level risk register, seen by board showed 11% (17 in total) of all trust risks were scored 15 and above. 8 of the 17 were categorised as corporate risks with the other 15 related to specific Service Delivery Units. Those designated as corporate risks were categorised as business risk (data analysis), environment risks (eliminating dormitories programme), finance risk and staffing (community hospitals and in-patient mental health wards). Only 4 risks of the 8 scored 16 and therefore had been escalated to the BAF. The risk associated with staffing, scored 20 on the trust risk register, but appeared on the BAF as 16. This had been agreed at the Audit Committee meeting in April 2023 but had not been amended on the corporate risk register.

Senior leaders told us the biggest challenges they faced as a trust was the attraction and retention of staff, the maintenance of high-quality care, increasing demand and activity and financial sustainability.

Our findings

There were a number of risks that had been added to the risk register between 5 and 8 years ago. Of the 148 risks on the risk register, 67% (44) of risks on the trust risk register had been added since January 2022, 56% (57) were added since January 2023. 30% (45) of risks were added to the trust risk register between 2016 and 2021, 11% (11) of which were 5 to 8 years old and 2 risks added 9 years ago in 2015.

In July 2023, the trust submitted further information about their risk register, in response to feedback to the trust post inspection from CQC. This information contradicted the original submission, and was presented in a word table, and was not the risk register itself. When compared to the original risk register submitted in June 2023, the document did not categorise the level of risk as green, yellow or red. This document showed of the 162 risks on the risk register, 28% (46) of risks on the trust risk register had been added since January 2022, 43% (70) were added since January 2023. 24% (39) of risks were added to the trust risk register between 2016 and 2021, 8% (13) of which were 5 to 8 years old. 1 risk was included in this document, added 9 years ago in 2015.

The trust conducted risk summits where concerns required action over and above the usual governance and escalation process. Risk summits resulted in identification of actions, with a lead for each action and agreed timescales for completion. Once actions were deemed to have been completed, a de-escalation of the risk summit occurred, and surveillance moved into business as usual. We saw that risk summits had occurred in 2020 for issues identified in adult mental health services and learning disability services and in 2021 for issues identified at Hillcrest and more recently at this inspection. Some senior staff told us that back in 2021, the risk summit process was not robust enough to resolve the issues identified, and the board had assumed the action plan had been embedded and the issues resolved.

The trust had an audit tracker which was reviewed by the Audit Committee. This was in place to provide oversight of audit outcomes and their actions to be considered by relevant committees.

An audit was carried out by an external auditor and summarised in an annual report in June 2022. The annual report covered the period 2021 to 2022 and looked at 3 areas; financial sustainability, governance and improving economy, efficiency, and effectiveness. For all 3 areas, the auditor had not identified any weaknesses in arrangements for 2021 to 2022.

An internal audit plan was in place for 2023 to 2024, reviewed by an external auditor who were an NHS hosted service. The company gave assurance to the trust, that their audit plan had been developed to meet its assurance requirements. It reported the level of audit activity within the trust had been appropriately prioritised based on the allocation of internal resources and recommended the Audit Committee should recognise this as a limitation. Audits within the trust had been given assurance or significant assurance, except for patient monies and re-opened complaints. A three-year audit plan had been put in place for 2023 to 2026 with a review annually. The Audit Committee approved the plans in place in February 2023 and accepted the reports of auditors in April 2023.

An audit was carried out by an external auditor, and issued to the trust on 18 April 2023, for the Audit Committee to approve on 27 April 2023. It focused on key controls around significant risks, financial sustainability and fraud related risks and tested fixed asset additions expenditure, reconciliation, and income. Not all areas were concluded but were planned to be concluded by December 2023.

The trusts clinical audit programme was overseen by the Clinical Audit and Effectiveness Group. This group, chaired by the Chief Pharmacist, reported through to the Quality and Safety Committee. The 2023/24 clinical audit plans were, at the time of our inspection, waiting for approval by the service delivery units, prioritising audit topics that related to, for

example, NICE guidance compliance, issues that have emerged through incidents and complaints or through assessed risk. The trust participated in relevant national clinical audits and subscribed to the Prescribing Observatory for Mental Health Audit programme. The trust board was provided with an annual report regarding compliance with the audit plan which included examples of improvement outcomes as a result of the audit programme.

An audit of finances for 2021 to 2022 stated that overall, the trust delivered financial performance in line with the agreed revenue and capital target set for 2021/22 which included delivery of £2.4million of savings on a non-recurrent basis. The 2022/23 plan projected a surplus of £2.5million. This required the trust to deliver savings of £6.6million which was planned to be achieved recurrently. The local ICS had significant financial risk and submitted a final plan with a deficit position of £52.6million which was rejected by NHS England.

An audit of finances for 2022/2023 reported at month 10, the trust reported a year-to-date surplus of £4.2million in line with the planned position of £4.2million. The trust was expecting to meet the £10.1million efficiency target for the year. At month 10 it was reporting £8.9million of efficiencies, ahead of year-to-date plan. The forecast delivery was expected to be £6.6million recurring and £3.5million on a non-recurrent basis. The cash position at month 10 was £34.4million with a year-end forecast of £30.1million.

The trust's Capital Resource Limit (CRL) was set at £20.6million for the year. At month 10 the year-to-date capital expenditure was £15.1million. It has agreed with NHS England to carry forward £5million into 2023/2024 for the nationally funded dormitories scheme. NHS England had re-introduced controls and monitoring of agency spend nationally. Each ICB had received expenditure limits, and for the Herefordshire and Worcestershire ICB it was £49.1million for 2022/2023, of which the trust's expenditure ceiling was £11.3million. As at month 10, the Trust had spent £16.3million on agency, which was £6.8million above the year-to-date ceiling. The trust's 31 December 2022 cash balance was £33.1million, £4.6million below the 31 March 2022 balance of £37.7million.

The trust had a Programme Management Framework (PMF) which held oversight for significant and business critical programmes of work related to delivery of strategic goals and ambitions.

The Programme Management Office (PMO) had a role in the oversight and support and delivery of projects. The PMF was used to develop plans, risks and reporting structures for major projects, and included a 'Getting It Right First Time' (GIRFT) adult mental health and inpatient rehabilitation pathway development, virtual wards development and delivery, and eliminating dormitories project.

The trust had an Emergency Preparedness Resilience and Response and Business Continuity policy which set out how the trust responded to any event or situation that impacted on the ability to deliver any or all of its services. The trust used this process with good effect in response to the COVID-19 pandemic. As part of the organisational response to COVID-19, the trust board operated within emergency planning principles, a COVID-19 control room, regular COVID-19 huddles which received and considered national guidance or instructions. Any changes to services were subject to quality impact assessments and collaboration with partners in the wider system. Following COVID-19, the trust continued to consider which changes were positive or less well received to consider if they would continue. For example, individual risk assessment protocols for managers and staff to discuss how personal risk factors impacted on their ability to work safely.

In August 2022, the trust experienced an outage of the electronic care notes system, which also occurred nationally. During the outage the trust implemented gold, silver and bronze command in line with its business continuity policy and PMF to manage the situation. The command centre was due to continue until June 2023. The trust implemented a combination of use of an alternative electronic notes systems and a paper record system. Staff told us that information

could be saved in several forms, but the trust had been able to scan over 300,000 documents into the restored notes system. The trust board received assurances from the digital team and the Caldicott Guardian on a regular basis that data protection was in place, and security of data was not compromised. A complete restoration team worked to restore the functions as soon as the wider healthcare system would allow, even though the trust was not a priority amongst other providers within the system. The digital clinical assurance group maintained oversight of the incident, the restoration and reported into the Quality and Safety Committee and up to board. The trust told us they had learned lessons from this incident and had planned to use the lessons learned when procuring their next electronic notes system, for example, ensuring the procurement process was robust, and ensure oversight of future recovery and restoration of any new system.

When considering developments to services or efficiency changes, the trust assessed impact on quality and sustainability with a quality impact assessment. Financial pressures were well understood by the committees and trust board. However, some department leads and staff told us they had been told by senior managers, development to services could not be funded due to financial pressures in the system.

Developments to services were presented by project leads to the Clinical Professional (and Ethics) Advisory Group (CPAG) for review. This allowed for check and challenge to ensure all quality and safety considerations had been fully assessed and where potentially adverse impacts on quality were identified, a judgement was made whether mitigation actions were at an acceptable level. If approved by CPAG, the quality impact assessment (QIA) had sign off by the Director of Nursing and Quality and the Medical Director. Summary reports were provided through to the Quality and Safety Committee and trust board. Where a QIA was not approved, this was escalated appropriately and if necessary, through to trust board.

The trust had planned for a turnover of approximately £259million in 2023/2024 and had submitted through the ICS, an agreed surplus plan of £2.7million. The trust had a history of strong financial delivery, with achievement of consistent surpluses since its inception in 2013. The trust rating under NHS England's Strategic Operating Framework (SoF) was downgraded to 2 from 1 based on the inspection findings at Hillcrest ward and subsequent inadequate rating by the of wards for adults of working age and PICU inpatient facilities. The trust was in an underlying breakeven position with its planned surplus deemed a system 'stretch target' which was planned to be delivered through a set of non-recurrent efficiency plans and one-off windfall gains. The trust sat with a set of system providers with significant financial deficits and its planned surplus, together with ICB surplus offsetting combined deficit of £78million. The 2023 to 2024 system plan had been agreed at £19.2million deficit with a requirement to produce a 3-year financial recovery plan by September 2023 to deliver financial balance. The system financial position had been rated at a SoF of 3. As a result, the trust had applied controls in anticipation of this.

The trust planned to spend £15.6million on capital projects including expenditure of approximately £6million on the elimination of dormitory accommodation in its mental health inpatient services, which was already underway at the time of this inspection.

The trust's external auditor issued an unqualified opinion on the trust's 2021/22 accounts. In respect of the findings for the trust's arrangements for ensuring value for money, external auditors found no significant weaknesses in respect financial sustainability, governance and improving economy, efficiency and effectiveness.

The trust had updated its Performance Management Framework in February 2023 for use in 2023/24, but it did not include any criteria for tolerances against budget. However, it included how financial performance reported into 3 committees, role and responsibilities of executives and committee members, recovery plans where delivery breaches targets, how nationally published indicators were monitored and how assurance ratings were monitored.

Our findings

The Audit Committee had terms of reference, and sub committees and was able to review the integrity of financial statements, and remained independent of any executive responsibilities and decisions when seeking assurances on controls.

The trust told us it was rare that financial pressures compromised care. However, we heard examples where financial targets appeared to be a priority over the development of essential services in the trust to address some risk areas. The trust told us they were in a difficult position financially within the ICS and the surplus within the trust finances, was not openly available for internal business cases. We heard from several senior staff who were department leads, that when they had approached the trust board for funding to develop their service or submit proposals for expanding staffing, or resources, the board were unable to support the proposal. For example, in wellbeing offer, the continuation of The Hub, in FTSU more resource to develop the role, funding to develop the EDI agenda, support to develop staff networks, or increased resource to develop the safeguarding team.

Information Management

The information used in reporting, performance management and delivering quality care was usually accurate, and timely. The trust board, committees and subgroups received information in relation to the meeting's particular focus. However, the data was not always used in a connected or cohesive way, or triangulated with all available resources and as a result, data was used mainly for assurance and not always for improvement.

The trust used 3 committees to take responsibility for performance management data oversight. Workforce Committee, Quality and Safety Committee and Finance and Performance Committee. Each Committee had responsibility for defined areas and indicators. The Integrated Governance Group meeting supported these committees and was chaired by the Chief Operating Officer. Membership included key executives and heads of department from across the trust. This meeting coordinated the operational analysis of performance reports which included performance report, quality and safety report, the workforce dashboard, the finance report, and any supporting recovery plans. Escalations from this group were considered by the relevant committee (Finance and Performance, Workforce, or Quality and Safety). Where areas of performance were below the required standard, and in accordance with the trust's Performance Management Framework, recovery plans were required.

The trust had an integrated performance dashboard which covered finance, performance, quality and workforce metrics. This, coupled with the different tiers of performance reports, as outlined, provided a view of the performance of the trust and was used by senior leaders to monitor services.

As part of the programme of agreed audit work, the trust completed an annual data quality audit. These audits were based on a process of control evaluation and testing, with the aim of assuring the timeliness, accuracy and completeness of clinical data. The findings and recommendations from the audits were reported to the Audit Committee. For example, the 2022/23 data quality audit was focused on a review of the outcome measures in Improving Access to Psychological Therapies (IAPT) services, to establish the extent to which patient records were updated in a timely manner with the outcome of the treatment received.

Governance systems in place at service delivery levels allowed team leads the opportunity to challenge information, before it was presented to the Integrated Governance Group, committees and trust board. We heard how clinical teams had access to a wide range of readily available information and were supported by corporate teams to aid understanding the data. Data could be reviewed at all levels of the organisation from organisation wide, down to individual staff and those who used services.

Our findings

The trust's Data Quality Improvement Group, with representatives from clinical teams and from the Information Team, enabled an exchange of views to ensure the data remained meaningful and useful to clinical teams. In addition, the IT Programme Board received reports and feedback from clinical teams to better understand any day-to-day challenges with accessing information.

The trust used Statistical Process Control (SPC) analysis to assess performance and sustainability. It demonstrated variation in services to help service delivery leads identify where action was needed.

We saw examples of how information was used well. Safeguarding teams, infection prevention and control teams and information governance teams had effective systems to monitor data, devise actions plans and maintain oversight of performance in their areas.

Whilst other areas had effective ways to collate and analyse data, this was not always reviewed in full. For example with freedom to speak up, equality diversity and inclusion data, and risk escalation as highlighted earlier in the report. We also saw examples where reports submitted to the inspection team were inaccurate or not the most recent version. For example, the 2023 annual mortality report had errors and statements that were not factually correct. The BAF presented at inspection was not representative of the version submitted in committee papers.

An Electronic Prescribing Medicine Administration (EPMA) system had recently been introduced onto two wards at the Princess of Wales Community Hospital. A few issues had been identified but these were being addressed prior to rolling out the system further. Although there was a project team and information technology support there was no dedicated pharmacist involved in supporting the new EPMA system from a medicines perspective.

The trust had arrangements in place to ensure the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant.

The trust's Data Quality Improvement Group completed assessments on the quality of data used within reports. This included quantitative data related to activity, as well as assessing the quality, completeness and timeliness of clinical note recording. The group produced an annual workplan, the progress of which was reviewed by the Audit Committee. To help support data quality improvement, a suite of self-service data quality reports was available for users of clinical systems. The trust's Data Quality Maturity Index (DQMI) score was also monitored and reported as part of the performance reporting to Integrated Governance Group.

However, the use of data was inconsistent. We saw examples of data that had not been triangulated and all sources of data from across the trust were not used effectively to drive change. For example, EDI data was not combined with the people experience dashboard and with outputs of 'working well with teams' conversations, or outputs from the director walkabout programme. The risk register did not align to the strategy, and strategies did not fit the need of the values and culture work that was required.

The trust had a range of technology systems to collect and hold data, but the data was not always used consistently or triangulated with all available sources and used in a cohesive way to respond to risks or improve issue which impacted on quality of care. For example, the trust used an electronic system for reporting incidents reporting system. As reported earlier, not all incident data was timely, or used to learn from events and to prevent recurrence. An Electronic Staff Record (ESR) system was available to staff, and the trust used this data to identify key demographics of staff diversity but as identified early in the report, not all staff had populated their record with this information, so the data was incomplete, and the trust was unable to use this to its full potential.

Our findings

We heard how some teams had effective information management systems to gather key information such as safeguarding, infection prevention control, information governance, freedom to speak up, guardian of safe working hours, complaints, and the staff survey. Mental Health Act compliance had robust information systems to monitor compliance with The Act and reported outcomes in this area. Structured performance charts enabled service delivery leads to monitor the performance of their areas.

All services in the trust used an Electronic Patient Record (EPR) system to record patient notes and activity. The use of EPRs ensured timely access and availability of patient information to clinical staff involved in providing care. Business intelligence used stored data to measure clinical performance and quality outcomes, for example, serious mental illness physical health checks and routine outcome measures completion in mental health services. As reported earlier, the trust managed an outage of the EPR effectively. The outage on a national scale meant that no data extracts were available for reporting purposes between 3 August 2022 and 5 January 2023. Whilst data flow recommenced on 6 January 2023, the ongoing and incomplete nature of restoration meant that many areas of reporting remained compromised.

This event presented a huge challenge for the trust. Although the cause of the outage was entirely outside of the trust's control, the response was swift, and strong management response was put in place to both fix the problem and mitigate the impact. The trust had a strong 'command centre' structured response which meant that they were able to keep a strong grip on the critical information flows to enable clinical teams to maintain the provision of safe high-quality care.

Positively, the trust used a national reporting system in line with the National Quality Board (NQB) guidance (2016) 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place and time' to understand the staffing position and inform decisions. The core of safe staffing reporting focused on workforce and quality metrics, finance information, professional judgment and feedback of staff experience to detail the staffing position. Data collected was triangulated against validated tools for measuring safe staffing levels.

Required data or notifications were not always submitted to external organisations.

The schedules published by NHS England for the submission of national datasets and statutory returns, were adhered to by the trust's information team. Processes were in place to ensure that submissions were not affected by any single points of failure, for example annual leave or sickness. Also, the Quality and Safety Team ensured notifications met nationally set deadlines, for example the reporting of Serious Incidents onto STEIS. However, we were not assured that all serious incidents had been notified to CQC in line with statutory notifications process and the spirit of openness and transparency, even though they had been reported to the NHS national reporting system. This included an inpatient death and an allegation of serious sexual assault on adult inpatient mental health wards which would have required a statutory notification to CQC. Whilst we saw the trust had reported to national reporting systems, the internal systems and processes to identify, and act upon serious incident to prevent reoccurrence were not as timely or robust as they could be.

There were robust arrangements to ensure the integrity and confidentiality of identifiable data, records and data management systems in line with data security standards. We were assured that the information governance of the trust was in a strong position.

Information asset risk assessments were undertaken and reviewed annually for all information systems on the information asset register. All EPRs containing patient identifiable data were subject to this process.

Our findings

The NHS Digital Data Security and Protection Toolkit (DSPT) is an annual online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use the DSPT to provide assurance that they are practising good data security and that personal information is handled correctly. Completion of the DSPT is therefore a contractual requirement specified in the NHS England standard conditions contract and it remains Department of Health and Social Care policy that all bodies that process NHS patient information for whatever purpose provide assurances via the DSPT.

The trust's DSPT final return for 2021 to 2022 was made on 29 June 2022. All mandatory evidence items were submitted. The trust was graded as 'Standards Exceeded'. The trust continued with Cyber Essentials Plus (CE+) compliance on 6 June 2022. The DSPT final return for 2022 to 23 will be submitted by the trust prior to the final deadline for submission of 30 June 2023.

Engagement

The trust worked collaboratively with external stakeholders within the wider healthcare system, and ICB to build a shard understanding of challenges to the system and the needs of the population to design improvements to meet them.

The trust had a Community Engagement Framework and Strategic Approach to Co-production which described the trust's approach to engagement. These documents had recently been refreshed and combined into one single document – A Framework for Working with People and Communities. The new framework aligned with the ICS Engagement Strategy and outlined the key NHS England 10 principles and further work in the future.

The trust actively sought views of interested, impacted, and invested stakeholders for the purpose of service improvement and development. A range of forums and groups facilitated conversation and feedback on services. For example, the Community Engagement Panel, a Youth Board for young people aged 14 to 25 years, a Mental Health Advisory Group for stakeholders particularly interested in Mental Health services, an Equality Advisory Group, comprising members who identify with/represent one or more protected characteristics or other vulnerable groups, and a virtual network.

The trust received feedback on services through the patient experience agenda, friends and family tests, quality surveys, and through staff surveys.

The trust told us about one key area of work under development was continuous engagement to ensure that views were routinely sought by people who use services, and always early on in a service change programme and throughout to post implementation.

The trust engaged with a range of equality groups through the Equality Advisory Group but carried out further work to build relationships with these groups through the development of place-based engagement networks – one for each county – that brought together colleagues working in engagement from across health, care, public health, and the voluntary sector. The trust told us that by sharing resource and contacts, this improved support for existing stakeholders in the community, and to build new relationships.

Over the previous 12 months the trust developed an existing programme into a 'Now We're Talking' partnership, where a range of local organisations including charities and community groups come together to plan and co-ordinate mental health communications and engagement activities.

Our findings

The partnership delivered a number of initiatives including a series of mental health maps, which summarised local mental health support on a page. These resources were on display in healthcare, business and community settings across Herefordshire and Worcestershire. Over the summer of 2022 a local band in collaboration with the trust produced a song and video encouraging young people to 'Reach Out' for help and support. In September 2022, a team of 100 runners represented the 'Now We're Talking' partnership in the Worcester City Half Marathon / 10km run. At the end of 2022 together with Herefordshire and Worcestershire Football Association, the 'Kickoffaconvo' podcast was launched, talking about all thing's mental health. During 2022 to 2023 the 'Now We're Talking' website had 78,000 page views.

The trust had a Patient Advice and Liaison Service (PALS) service and complaints procedure, available for patients carers, and members of the public who wish to raise a concern or ask a question about care or treatment. The trust policy stated complaints were to be logged within 2 working days and the complainant to receive an acknowledgement. The timeframe in which the trust had set to respond to a complaint was 25 working days, and to respond to a PALS concern within 5 working days. We found the complaints policy had no equality impact assessment and was provided to us on the older trust header page with the former Worcestershire Healthcare Trust title. The policy did not have a ratification date, and the policy expiry date had been extended to December 2023 to allow revision of the policy under the new national guidance due out on how to respond to complaints.

The trust told us all complaints and PALS contacts were reviewed by the relevant service for individual learning and for learning themes. A broad but key area of learning from complaints related to issues with communication and establishing a shared understand with patients about the plan of care. A key Quality Account priority for 2023 to 2024 sought to address this through ensuring the trust had a shared care approach. We reviewed 10 complaints; 8 of which had not been responded to within 25 days. On all but one occasion the complainant had been notified of the reason for delay. In most cases, an apology was offered, and learning had been identified.

The trust received 1782 compliments between January 2022 and March 2023.

There was limited opportunity provided to people who used services to be engaged and involved in decisions to shape services and culture. Whilst the trust told us they were committed to co-production with patients, carers and stakeholders, they extensively described co-production as engagement with stakeholders, but did not include those who used services.

We heard limited examples of patient involvement in how care was shaped, such as the director walkabout programme, but this did not always capture the voice of people who used services. We heard how patient stories were told at board, and executives saw this as a positive way to gather feedback about experiences of using services and we heard how recruitment of staff included those who used services. The trust conducted PLACE environmental assessments which were supported by users of services.

The trust had an Expert by Experience Herefordshire Programme, and a Community Engagement Panel to encourage those who have used services to be involved in the trust. This included, staff recruitment, project work, staff training, peer training in the Recovery College, engagement at public events, attending meetings to give feedback and taking part in research. We saw limited evidence how this had impacted service delivery.

Staff had opportunity to be engaged so their views were reflected in the planning and delivery of services. The trust strategy had involved staff at senior leadership level, which included engagement through board strategy group,

clinical and operation strategy groups, 'triangulation challenge' sessions between March and May 2021. All staff sessions were used to engage staff in the development of the strategy in 5 'Listening into Action' sessions. Key groups such as the Community Engagement group, the Medical and Dental Advisory Committee, Clinical and Professional Advisory group, patient panel and Youth Board had opportunity to be involved.

Views of the pharmacy team were captured at a variety of meetings, such as a pharmacy huddle on a Friday and monthly team meetings. Staff told us that there have been some challenging and difficult times however this had been acknowledged and staff had felt listened to. There was good support between colleagues and line managers.

We were assured by the engagement and collaboration with the ICB had placed the trust in a strong position to influence the delivery of health and social care to the community. We saw minutes of engagement meetings that took place with stakeholders and the role the trust played in the wider healthcare system.

The trust worked closely with statutory and voluntary sector partners. Key senior leaders were actively involved in a wide range of system forums, which included the ICB board, health and wellbeing boards, the finance forum, communications and engagement forum, people board and people forum. The trust had a good track record of developed collaborative partnerships with most stakeholders. The trust had roles in partnerships, such as the West Midlands MH Partner Collaborative and the Forensic MH Collaborative were in place. The trust had a focus on delivery of place-based models of care in communities. However, we heard that not all stakeholders felt the relationship was always open and transparent, in sharing of patient outcomes compared to concerns raised by those who used services.

The trust was now a lead provider for the Herefordshire and Worcestershire Mental Health Collaborative. This was a pathway redesign within a new model of service provision, where mental health services would be driven by collective local leadership and expertise. The trust had embedded this partnership into their strategy. The trust had in place a Mental Health Collaborative Committee, which was a multi-agency sub-committee chaired by a NED from the trust. This fed into the Mental Health Collaborative Executive Group chaired by the trusts' CEO. There was representation at the ICB Quality and Performance Committee and clinical leadership groups. This strand of work ensured the trust was well placed within the wider system to support its strategic service developments for 2022 to 2024, one of which was to achieve better health and reducing health inequalities in the community. Other new, integrated service models were established through partnership working, such as Neighbourhood Teams and the Community Transformation Programme.

There were two engagement networks in place to bring together engagement officers and leads from a number of organisations across the wider system. The purpose of the networks was to share work underway and learning that came from that work. For example, the Worcestershire Local Authority work on the Asset Based Community Development agenda, who shared learning with the trust through their work with community builders who work at a very grass roots level. Another example was the sharing of ethnographic work undertaken by Public Health with communities and staff, to get a deeper understanding of the impact of the COVID-19 pandemic and how this impacted current needs. Learning was shared through the meetings but also through a shared library space that all partners had access to.

The Chief Pharmacist liaised with other Chief Pharmacists within the Integrated Care System and attended the weekly meetings. There was a strong working relationship between the acute NHS trusts within Herefordshire and Worcestershire with a good support network to share improved ways of providing care.

Our findings

The trust was transparent and open with stakeholders in regard to their position in the health and social care system and decisions about service developments and redesign had been widely communicated and consulted with stakeholders. However, we heard how some stakeholders had concerns about performance data on patient outcomes had not been transparently reported and the relationship between the two parties required further strengthening.

The trust began live streaming of their public board meetings, ensuring accessibility to a wide audience. The trust board summary document, strategies and key documents were available on the trust website. Trust accounts and assurance reports and audits were widely published along with national data on equality and diversity. Safeguarding had robust processes in place to ensure local stakeholders were informed of concerns and alerts.

Learning, continuous improvement and innovation

The organisation did not always cohesively or consistently react sufficiently to risks identified through internal processes. Learning by the trust was often reactionary following feedback from inspection. Where changes were made within services, the impact on the quality and sustainability of care was not embedded.

We heard how the trust had taken action in relation to concerns raised at inpatient mental health wards (Hillcrest and Stonebow Unit) following previous inspections. However, the trust risk register did not show these risks had been identified earlier by the service or responded to in a prompt and sufficient way to improve the service. Senior staff told us the risk summits had not been robust enough to drive improvement and the board had assumed action plans had been embedded rather than gathering evidence of sufficient information and intelligence around improvements. Learning from incidents was not always prompt or embedded across services. We saw incidents related to sexual safety on inpatient mental health wards, where learning had not been applied sufficiently to prevent recurrence.

The trust had a research programme which was an essential part of a continuing development of health and care services. The trust had recruited over 500 individuals into research programmes in 2022 to 2023. 27 new Research Collaborators (staff interested in research and evidence based practice) joined the research team's Research Collaborator Network since launching the role in 2022. 11 studies were open to recruitment, one of which was an income-generating commercial contract study.

The implementation of the trust's Clinical Strategy actively encouraged services to take part in accreditation schemes where available. Some services had achieved accreditation, for example, the Electroconvulsive Therapy teams and the Herefordshire Perinatal Team, accredited in 2022 with the Royal College of Psychiatrists and Perinatal Quality Network. The Worcestershire Perinatal Team were also accredited and underwent the re-accreditation inspection in January 2023; the team were awaiting an outcome at the time of this inspection.

The trust used improvement tools and methods for quality improvement. Staff were trained in how to use them and there were plans in place to further develop the quality improvement agenda within the organisation.

The trust's key strategies were based on organisational learning from successes and failures, as well as those of others. The governance structure in place with Committees and sub-groups had the capabilities to measure progress against the strategic goals, but we found that there was limited evidence which demonstrated the outcomes.

Finance and performance reporting provided information on which to measure performance. For example, the trust's Quality Account priorities for 2023 to 2024 were a result of discussions at the February 2023 meeting of the Quality and

Safety Committee. Here a number of priorities, based on governance data, information and shared learning experiences were agreed to be measured against National Institute for Health andCare Excellence (NICE) guidelines and nationally recognised best practice and patient outcome measures. This approach was adopted by the trust with the aim to have a positive impact on improving the experience and quality of care for those who use services.

There was many learning and training opportunities for pharmacy staff. The Pharmacy Education and Operational Lead pharmacist ensured that all staff had access to training and reminded staff when any mandatory training was due. The one issue identified by staff was that any face-to-face training was undertaken in Worcestershire which left any staff in Herefordshire feeling isolated as they could not always travel to Worcestershire. The pharmacy and medicine management team encouraged innovation amongst themselves. One example of improving medicines safety was the development of a patent insulin passport which was developed following a review of omitted insulin doses in the community. It was now well established within neighbourhood community teams. The mental health lead pharmacist had worked collaboratively with a doctor and a nurse to review and rewrite the rapid tranquillisation (RT) policy. It was now mandatory that all RT incidents were reported on the electronic trust reporting system. The team had also provided an online video for training purposes to junior doctors.

The trust had systems and processes in place to learn from deaths. The trust had a 'learning from deaths' policy which set out the processes to which the trust worked with the aim of providing assurance for transparency, governance, and learning outcomes from mortality. A learning from deaths group, chaired by senior leaders met every 3 months to review mortality data and learning from deaths. There was clinical representation at the meeting including patients and carer representation. The trust produced a mortality and learning from deaths annual report. The report provided data on the number of deaths over a 12-month period and compared this to previous years. There was a reducing trend in community hospitals, and an increased trend from 3 to 6 deaths in inpatient mental health wards. However, 3 of these were expected deaths in older adult mental health services. The report also highlighted trends in outcomes of structured judgement reviews conducted after each death. The outcomes were rated in terms of levels of care provided; very poor care, poor care, adequate care, good care and excellent care. Where there was deemed to be poor care or adequate care, learning had been identified. Most cases were reported to have received good or excellent care and good practice had been recorded in the report. None were recorded to have received very poor care.

We noted at the time of inspection, the annual report for 2022/23 had inaccurate reporting. For inpatient mental health mortality and community neighbourhood teams' mortality, the report stated Structured judgement reviews (SJRs) had not been conducted. When questioned, the trust later provided information which stated these had been completed and the report was to be amended.

The trust issued 64 initial letters for Duty of Candour to offer an apology when things went wrong. These were to acknowledge that an investigation was underway, who the investigating officer was the timeframes and a point of contact in the trust. 39 final Duty of Candour letters were sent over the 12 months prior to the inspection.

The trust used a variety of other methods to review performance and learning, but in practice, in some services, we saw incidents reoccur. Methods included feedback from managers on incident reports, MDT discussions, thematic reviews of incidents (for example, all reports on suicides were reviewed at the Suicide Prevention Group), as well as our shared learning with patients and carers as evidenced through the clinical records and our Duty of Candour letters and conversations. For example, in September 2022 a 'wrong site surgery' never event incident took learning across partner organisations and was presented at a national conference; learning from Ofsted inspections of Short Breaks services,

included implementation of a training needs analysis and training programme for staff; and, the trust now have 2 patient safety specialists actively involved in developing the trust approach to learning from serious incidents, by developing the process for implementation of the Patient Safety Incident Response framework (PSIRF) with partners in the ICB to be able to track a pathway of care for those who use services.

Services across the trust were encouraged to use away days to review team objectives and use the trust's Quality Improvement (QI) approach to develop ideas to improve services. Staff appraisal processes provided opportunity for staff to evaluate how they had contributed to service evaluation, QI projects, clinical audit and ways in which the trust could support staff to develop expertise in these areas.

The trust delivered 20 'Lunch and Learn' sessions with an attendance of over 250 people. These had guest speakers and delivered a series of 'Bitesize' QI tools of 60 minutes each, and tips to provide upskilling around a suite of easy-to-use QI techniques. All sessions were recorded and were available in the trusts Improvement Zone as a quick reference resource. The Bitesize sessions included practical advice and tips on using, for example the Model for Improvement and PDSA (Plan, Do, Study, Act cycle), Stakeholder Mapping (and Fresh Eyes), Measurement for improvement and SPC charts (Statistical Process Control), Demand and Capacity and Sustainability Modelling.

The research agenda within the trust was established. There were systems to support improvement and innovation work and the research department was effectively sponsored and supported by key members of the board.

There were 12 research projects in place, mostly within mental health services, and work which collaborated with ICB partners on projects to reduce health inequalities within the local community. For example, improved delivery of a vaccination programme. The trust research department had strong links with local universities and other stakeholders in the West Midlands clinical research networks. There was work to be done to finance research within the trust. We heard how research in the trust was currently sponsored by external funding programmes within the West Midlands portfolio. However, the trust had built into its strategy ways in which to bring funding in house to support and further develop the internal research agenda.

In June 2022, the trust hosted a Quality Improvement Conference week. It consisted of 16 sessions with 203 attendees with sessions delivered on the trust QI community, empowering staff to make changes, research, evaluation, audit or QI. The trust planned to repeat this in 2023.

Monthly Schwartz Rounds took place which were a multidisciplinary forum designed for staff to come together once a month to discuss and reflect on the emotional and social challenges associated with working in healthcare. Rounds provided a confidential space to reflect on and share experiences and to share results for improvement.

The trust had an established an 'Improvement Community', an open and easy-to-access forum. The Community was supported by over 50 people who had been trained in Quality Improvement (QI) expertise though the system wide Quality Service Improvement and Redesign (QSIR) programme. The trusts' standardised methodology had three distinct approaches to quality improvement. They were:

- Plan, Do, Study, Act (PDSA). This is a widely adopted simple approach for smaller scale changes delivered through individuals and teams at service level.
- Rapid Improvement Action. Used in projects to address 'problem areas' in a quick and efficient way.

- Transformation. This was used for transformational larger scale projects which required support from Improvement Mentors and wider trust senior management. For example, work to eliminate dormitory accommodation in acute mental health wards.

The trust used 'Change-makers' as staff who encouraged, enabled and supported teams to make small changes and improvements within services. There were 94 Change-makers building towards our longer-term target of 225 (approximately 5% of trust staff).

The trust had a new approach to further develop quality improvement called 'Mission Improvement'. This was a way to engage and communicate QI activity to enable as wide a range of staff to get involved. For example, there was an event for a Mission Improvement activity during May 2023 to look at the trust's Green Plan. This involved Change-makers spreading the word, placing posters and fliers around the trust sites, with a cryptic message and QR code that directed interested staff to a dedicated space in the Improvement Zone.

The trust had 33 Improvement Facilitators who worked as internal consultants to provide practical advice, technical guidance and facilitation support to promote and support QI activity across the trust. One of the QI Facilitators successfully completed the national assessment to become a QSIR trainer and a second QI Facilitator was planning to undertake the same nationally accredited programme later in 2023.

The trust also had QI Mentors who were the experts in the trust, with substantial experience of delivering and supporting QI activity. They coordinated leadership of the trust's QI approach, providing direct support to QI facilitators and oversight of Rapid Improvement and New Ways of Working QI projects. During 2023-24 the trust planned to recruit more people to the mentor tier of the Improvement Community. The trust had started discussions with NHS England's 'Mixed Methods Team' to look at how they provided upskilling to Improvement Coaching that the Mentors could use with their QI Facilitators.

There was a strapline called 'Making a Positive Difference' (MAPD) with its own MAPD stamp produced for colleagues to demonstrate that QI know-how, skills and expertise had been used to support particular areas of work. The intention was that trust used the stamp as a 'kite' mark to evidence successful use of QI to support, steer and guide project activity to make a positive difference.

As part of the Project Management Board (PMB) progress against the QI objectives was reported to the Quality and Safety Committee and trust board with presentations and specific development sessions.

The trust had an annual staff award ceremony which celebrated work undertaken by teams in the previous 12 months. Awards were themed into the categories of trust values and in 2022, the theme of the awards was 'making a difference'.

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 ↓ Jan 2024	Requires Improvement ↓ Jan 2024	Good ➔➔ Jan 2024	Good ➔➔ Jan 2024	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024

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 a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Community	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
Overall trust	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024	Good → ← Jan 2024	Good → ← Jan 2024	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Tudor Lodge	Requires improvement Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Requires improvement Aug 2019	Requires improvement Aug 2019
Overall trust	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024	Good → ← Jan 2024	Good → ← Jan 2024	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024

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

Rating for Tudor Lodge

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Requires improvement Aug 2019	Requires improvement Aug 2019

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate → ← Jan 2024	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024	Requires Improvement ↑ Jan 2024	Requires Improvement ↑ Jan 2024
Specialist community mental health services for children and young people	Good Jan 2020	Good Jan 2020	Outstanding Jan 2020	Good Jan 2020	Outstanding Jan 2020	Outstanding Jan 2020
Community-based mental health services for older people	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Wards for older people with mental health problems	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Wards for people with a learning disability or autism	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Community mental health services for people with a learning disability or autism	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Community-based mental health services of adults of working age	Requires Improvement ↑ Jan 2024	Good ↑ Jan 2024	Good ↑ Jan 2024	Requires Improvement → ← Jan 2024	Requires Improvement ↑ Jan 2024	Requires Improvement ↑ Jan 2024
Mental health crisis services and health-based places of safety	Requires Improvement ↓ Jan 2024	Good → ← Jan 2024	Good → ← Jan 2024	Good → ← Jan 2024	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024
Long stay or rehabilitation mental health wards for working age adults	Good Jun 2018	Good Jun 2018	Outstanding Jun 2018	Outstanding Jun 2018	Outstanding Jun 2018	Outstanding Jun 2018
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

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

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community end of life care	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Community health services for adults	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024	Good →← Jan 2024	Good →← Jan 2024	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024
Community health inpatient services	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018	Outstanding Jun 2018	Good Jun 2018
Community health services for children and young people	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Community dental services	Good Jan 2020	Good Jan 2020	Outstanding Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Overall	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement

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.

Community-based mental health services of adults of working age

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Safe and clean environment

All clinical premises where patients received care were safe and clean. However, not all areas were well equipped, well furnished, well maintained or fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Each community mental health base had an environmental risk assessment in place. Managers completed regular health and safety audits of buildings. This included an assessment of general building arrangements, site safety, fire procedures and emergency incident management.

All interview rooms had alarms and staff available to respond. Most interview rooms had either a fixed alarm or a portable alarm. Staff based at New Brook in Bromsgrove had access to portable alarms they could take into interview rooms if they felt this was needed. Reception staff at New Brook told us they were responsible for charging and testing alarms, however, we found staff did not keep a record of this. There was a standardised process to record these checks were taking place at the other services we visited.

There were enough staff to respond to alarms. Bromsgrove, Redditch and Hereford City neighbourhood mental health teams were co-located with other community mental health teams, who could also respond to alarms if needed.

Most clinic rooms had the necessary equipment for patients to have thorough physical examinations. However, the clinic room used by Redditch neighbourhood mental health team did not have all of the necessary equipment. For example, it did not have a blood glucose monitor or a fully operational blood pressure monitor. Although we saw there was a manual blood pressure cuff, there was no stethoscope available to effectively use this device. We were told as this team was based at Hillcrest hospital, staff were able to borrow equipment from the wards if needed.

Staff made sure equipment was well maintained, clean and in working order. Staff ensured clinic room equipment such as scales were correctly calibrated. Staff cleaned equipment in the clinic room after each use.

Each of the sites we visited appeared clean and tidy. Housekeepers visited the neighbourhood community teams 5 days a week and were responsible for the day-to-day cleaning of the sites. There was a housekeeping schedule in place which outlined the daily and weekly cleaning tasks to be completed.

Despite clinical and non-clinical areas being clean, not all were well maintained, well-furnished or fit for purpose. Community mental health teams in Hereford City were based at St Owen's Street. This building had dated décor, including old wallpaper and carpets. Much of the furniture including desks and chairs was in need of updating.

Staff followed infection control guidelines, including handwashing. Personal protective equipment (PPE) was available for staff and visitors. Staff followed guidance on using PPE and we observed staff practicing good hand hygiene.

Safe staffing

The service did not have enough staff and some teams had patients who were waiting to be allocated to a staff member. However, managers regularly reviewed the number of patients on the caseload of the teams, and of individual members of staff, to ensure this was not too high to prevent staff from giving each patient the time they needed. Managers regularly reviewed patients who were awaiting allocation to ensure they were safe.

Nursing staff

The service did not always have enough nursing and support staff. Neighbourhood mental health teams in Worcestershire and Herefordshire were developed as part of a national community mental health transformation pilot which aimed to ensure that patients could receive care and treatment in their local areas and that neighbourhood mental health teams were more closely aligned with the local GP surgeries, as part of primary care networks (PCNs).

Neighbourhood mental health teams in Herefordshire and the Worcestershire Wyre Forest and Malvern neighbourhood mental health teams were in 'phase one' and therefore further along the transformation programme. Managers had initially focused on recruiting staff to the teams in phase one and we saw that these teams had fewer vacancies. For example, the Wyre Forest and Malvern neighbourhood mental health teams had an overall vacancy rate of 17% and the Herefordshire community teams had an overall vacancy rate of 21%, compared with an overall vacancy rate of 47% for the remaining Worcestershire neighbourhood mental health teams who were in 'phase 2' of the transformation programme. These included the Redditch, Bromsgrove, Evesham and Worcester city neighbourhood mental health teams. The Redditch neighbourhood mental health team had the highest number of vacancies, with 61% of all posts vacant. We saw that 8.9 of the 12.3 (72%) full time equivalent band 6 mental health practitioner posts in this team were vacant.

The Herefordshire neighbourhood mental health teams had an average caseload of 26, ranging from 25 in the south and west neighbourhood mental health team to 27 in the north and west neighbourhood mental health team. The Worcestershire neighbourhood mental health teams had an average caseload of 19, ranging from 13 in the Bromsgrove neighbourhood mental health team to 28 in the Worcester city neighbourhood mental health team.

There was no clinical lead in the Redditch neighbourhood mental health team at the time of our inspection, however this post had been recruited to and the new clinical lead was going through the onboarding process. Clinical leads at other local neighbourhood mental health teams and another senior manager had stepped in to provide clinical lead support for the Redditch team in the meantime, and staff in the team told us that they had felt well supported.

Managers had reviewed the staffing requirements for the neighbourhood mental health teams in phase 2 of the transformation programme. Funding had been agreed for a total of 32 new posts in the phase 2 neighbourhood mental health teams, this included an additional 14.9 whole time equivalent band 6 mental health practitioner posts. Recruitment to these posts was ongoing through rolling job advertisements.

Senior leaders had reviewed the clinical lead requirements in Worcester and had determined that the Redditch and Bromsgrove teams required additional clinical lead support. There were plans to recruit a band 7 clinical lead practitioner role to the Redditch team This was a new role that was also to be piloted in the Wyre Forest team. In addition, a band 7 operational lead had been recruited and was due to provide support to both the Redditch and Bromsgrove neighbourhood mental health teams.

Managers had reviewed career progression pathways in neighbourhood mental health teams and had developed mental health practitioner posts that enabled staff to progress from a band 5 to a band 6.

Managers made arrangements to cover staff sickness and absence. They ensured that other members of the team were aware of staff absence and were able to make contact with patients as needed. There was a duty worker allocated for each day who patients could contact if their allocated worker was not available.

The service had reducing rates of bank and agency nurses. Data provided by the trust showed that the number of hours worked by bank and agency nurses had reduced from 1,044 hours in January 2023 to 895 hours in February 2023.The service had reducing rates of bank and agency nursing assistants. The data showed that the number of hours worked by bank and agency nursing assistants had reduced from 911 hours in January to 709 hours in February 2023.

The trust acknowledged that they could not provide the data to show the percentage of bank and agency staff used. This was because the community teams are not on the e-roster system so the trust could not compare the use of bank and agency staff with the use of regular staff employed by the trust.

Managers told us they used regular bank and agency staff as much as possible. We saw that regular agency nurses had worked in the Redditch neighbourhood mental health team for several years and were familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had high turnover rates. The overall turnover rate for neighbourhood mental health teams in Worcestershire and Herefordshire was 19.64% between August 2022 and January 2023. Overall staff turnover had slowly decreased from 21.2% in August 2023 to 18.03% in January 2023. The Rurals neighbourhood mental health team had the highest staff turnover rate. The average turnover rate for this team was 40.3% between August 2022 and January 2023.

Managers supported staff who needed time off for ill health. For example, one staff member told us they had felt well supported by their manager following a period of ill health and their manager had worked with them to agree reasonable adjustments to ensure they could comfortably and safely return to work.

We reviewed sickness data between August 2022 and January 2023 for each community team. Community mental health services had an average overall sickness rate of 2.9% between August 2022 and January 2023. The Redditch neighbourhood mental health team 2 had the highest sickness with an average of 15.1% from August 2022 to January 2023. The Rurals neighbourhood mental team had no sickness for the same period.

Medical staff

The service did not always have enough medical staff. There was a vacancy rate of 30% (1.1 WTE) for consultant psychiatrists across the Wyre Forrest and Malvern neighbourhood mental health teams and a vacancy rate of 17% (1

WTE) in the Redditch, Bromsgrove, Droitwich, Ombersley and The Rurals, Worcester city and Evesham, Pershore and Upton neighbourhood mental health teams. There was a vacancy rate of 47% (2.5 WTE) in Herefordshire. These were covered by locum doctors. Funding had been agreed for a further 2 full time equivalent consultant psychiatrists in the Worcestershire phase 2 neighbourhood mental health teams.

The service could get support from a psychiatrist quickly when they needed to. Staff told us that they had easy access to psychiatrists in the team. The crisis team provided emergency out of hours cover at evenings and weekends, staff referred to the crisis team when they needed to and told us this team was accessible.

Managers made sure all locum staff had a full induction and understood the service. Staff in Bromsgrove told us that the locum consultant had been working in the team for some time and understood the service and the needs of patients.

Mandatory training

The mandatory training programme was comprehensive and met the needs of patients and staff. It included training on information governance, fire safety, basic life support and safeguarding. Not all staff had completed and kept up-to-date with their mandatory training.

At the time of our inspection, training compliance for most individual courses was 81% or above. However, we found that some teams had below expected compliance with fire safety training and basic life support. Three teams had low compliance with fire safety training. Only 50% of staff in Herefordshire East and Wargrave, Belmont and Cantilupe (WBC) neighbourhood mental health teams and 60% of staff in South and West Herefordshire team were compliant with fire safety training.

Two teams had low compliance with basic life support training. Only 30% of staff in Worcester City and 60% of staff in the South and West Herefordshire neighbourhood mental health teams were up to date with this training. Managers did not always monitor mandatory training to ensure staff were up to date with their training.

Assessing and managing risk to patients and staff

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

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 9 care records and saw that staff had completed risk assessments for each patient when they were admitted to the service. Staff used a recognised risk assessment tool which was called the Galatean Risk and Safety Tool (GRiST).

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. We found crisis plans in each of the care records we reviewed and saw that staff updated these with the patient regularly.

Management of patient risk

Community-based mental health services of adults of working age

Staff responded promptly to any sudden deterioration in a patient's health. Staff discussed and reviewed patient risk during weekly multidisciplinary team meetings. Staff told us they could discuss any immediate concerns with the clinical lead.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. Worcester City, Redditch and Bromsgrove neighbourhood mental health teams operated a system for monitoring patients on holding lists who were awaiting allocation to a mental health practitioner. The holding list was in place because the high number of vacancies meant that there were not enough staff to ensure all patients were allocated to a staff member. As of 10 March 2023, there was a total of 37 patients on the Worcester City holding list and 13 patients on the Redditch and Bromsgrove holding lists. One patient had been on the Bromsgrove holding list since October 2022. However, managers regularly reviewed the needs and risks of patients on the holding list at a huddle meeting. The frequency of the huddle meeting varied across neighbourhood mental health teams but took place at least twice a week. Each team had a spreadsheet containing the details of patients on the holding list. We reviewed the spreadsheets for the Redditch, Bromsgrove and Evesham neighbourhood mental health teams and saw evidence that staff reviewed patient risk and decided how frequently they needed to make contact with each patient on the holding list. Contact ranged from telephone calls to home visits, depending on individual patient need and risk.

We reviewed the number of incidents that had occurred for patients on holding lists between December 2022 and February 2023 and found there had been a total of 8 incidents during this period. Seven of these had resulted in no harm to patients and related to administration issues. One incident related to a patient being referred to the incorrect pathway which resulted in a delay in allocation to a mental health practitioner. This issue was identified quickly, and the patient's appointment was brought forward.

Staff followed clear personal safety protocols, including for lone working. Staff understood the lone working procedure and checked in with administration staff at the end of each day to confirm they were safe and well. Some teams recorded the whereabouts of staff and any planned appointments on a board so it was visible to all staff. Other teams shared their whereabouts using electronic calendars. Staff told us that they were able to have support from a second staff member to undertake contacts with patients where there was a concern about risk.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Most staff in neighbourhood mental health teams were required to complete safeguarding children and adults training level 2. Managers and clinical team leads were required to complete level 3 safeguarding training. Staff kept up-to-date with their safeguarding training. At the time of the inspection, 90.7% of staff were up to date with safeguarding children level 1 and 87.5% were compliant with safeguarding children level 2. At the time of inspection, 88.3% of staff were up to date with their safeguarding adults level 2 training 66.7% were up to date with their safeguarding adults level 3 training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For instance, one staff member told us how they had ensured they referred to a patient using their preferred gender pronouns and had felt able to respectfully challenge colleagues who had not used the correct pronouns during a meeting. As of February 2023, 98% of staff were up to date with equality and diversity mandatory training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff told us that they were able to discuss safeguarding concerns with their colleagues and the clinical leads in the team. Staff also had access to the trust safeguarding team which provided advice and support. Staff told us this team was helpful and responsive to requests for advice. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes. We saw that managers were involved in serious case reviews and shared learning from these with staff during monthly business meetings. We saw that learning from serious incidents was a standing agenda item and staff discussed these monthly business meetings.

Staff access to essential information

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

Patient notes were comprehensive and all staff could access them easily. Records were stored securely. The trust had been impacted by a national cyber-attack issue affecting the electronic patient recording system. This meant staff had been unable to update patient records for an extended period but had been able to view historical records. The trust had developed an interim electronic patient records system, which staff had used to update patient records. Staff told us they had been able to access both systems and could find the information they needed. The system issue had been resolved at the time of our inspection and staff in the neighbourhood mental health teams were in the process of transferring patient records back onto the original system.

When patients transferred to a new team, there were no delays in staff accessing their records. For example, staff told us they could see updates in patients records if the crisis team had supported a patient over the weekend.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. We inspected 3 clinic rooms used by neighbourhood mental health teams and saw evidence that medicines were stored, dispensed, and disposed of correctly. The pharmacist completed audits in relation to the safe and secure handling of medicines.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff reviewed patient medicines during weekly multidisciplinary team meetings and told us they could request additional medicine reviews with the consultant when this was needed. We observed 2 home visits to patients and saw staff reviewed their medicines and provided appropriate information and advice about these.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff completed regular medicine reviews for patients who were prescribed antipsychotic medicines. Staff in each neighbourhood mental health team ran regular clinics to review medicines and physical health of patients who were prescribed clozapine or other antipsychotic medication administered by a depot injection. The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The pharmacist completed audits in relation to prescribing high dose and combined antipsychotics.

Staff completed medicines records accurately and kept them up-to-date. We reviewed 25 prescription cards and found staff had thoroughly and regularly reviewed these.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in locked cupboards and fridges. We saw the fridge lock in the clinic room at Bromsgrove was broken but the clinical lead had reported this to the facilities team for replacement. To ensure medicines were kept secure in the meantime, staff only ordered limited amounts of stock and the clinic room was kept locked.

Staff learned from safety alerts and incidents to improve practice. For example, the trust had shared information about room and fridge temperature monitoring with all staff in a weekly information bulletin.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. All staff including bank and agency staff had access to the trust incident reporting system.

Staff raised concerns and reported incidents and near misses in line with trust policy. We reviewed incidents that occurred in the neighbourhood mental health teams between August 2022 and January 2023. During this period there was a total of 162 reported incidents. The most common incident category was death of a patient, with 19 out of 162 incidents (12%) of incidents falling into this category. Eighteen out of 162 incidents (11%) related to either health and safety, or resources, staffing and telecoms issues.

Staff reported serious incidents clearly and in line with trust policy. We reviewed 4 serious incident investigation reports relating to patient deaths. Managers had investigated these incidents thoroughly and patient's family members were involved and supported throughout the investigations.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw evidence in each of the serious incident investigations we reviewed that staff had informed family members of incidents and offered appropriate support.

Managers debriefed and supported staff after any serious incident. We saw evidence that managers had offered appropriate support to staff in the serious incident reports we reviewed. Staff told us that managers were available to provide formal and informal support after incidents.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Staff discussed incidents and the outcomes of investigations during monthly business meetings.

Community-based mental health services of adults of working age

There was evidence that changes had been made as a result of feedback. For example, managers had started a project to review the risk assessment and management tool that was used by the neighbourhood mental health teams, in response to a serious incident investigation.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient. We saw evidence of this in the 8 care records we reviewed. Mental health practitioners and consultants ran regular assessment clinics and invited new patients to attend these.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. We saw evidence that staff assessed patients' physical health when they were admitted to the service in the care records we reviewed. Staff delivered specific clinics for patients who were prescribed antipsychotic medicines that were administered by a depot injection. Staff monitored patients' health and provided advice and support to patients about the potential side effects of their medicines during these clinics. Most teams also ran a physical health clinic, that ensured patients received an annual health check. We saw this clinic had been paused temporarily in the Bromsgrove neighbourhood mental health team due to staffing levels but there were plans for this to restart this. In the meantime, staff referred patients to their GP surgery for an annual health check.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery-oriented. Each of the care plans we reviewed were detailed and reflected patients' needs and goals. Staff regularly reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. However, these were not always accessible due to large waiting lists. They ensured patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service, in line with best practice and national guidance. Mental health practitioners ran various group interventions, which included dialectical behavioural therapy (DBT), cognitive behavioural therapy (CBT), emotional skills, building confidence and managing anxiety groups.

Community-based mental health services of adults of working age

The psychology team offered both group and individual pathways, however neighbourhood mental health teams had long waiting times for the 1:1 psychology. The Worcester, Evesham, Wyre Forest and Redditch teams had the highest waiting times. From August 2022 to February 2023 the total number of people waiting for 1:1 psychology had increased from 107 in August 2022 across all teams to 161 in February 2023. Due to this, staff prioritised group interventions to try and reduce patients' waiting times.

The neighbourhood mental health teams were linked to the early intervention in psychosis service. There was also a separate assertive outreach team in Herefordshire, this team worked with patients with severe and enduring mental health conditions. The assertive outreach function in Worcestershire had been incorporated into the existing neighbourhood mental health teams.

Staff ensured that patients had access to vocational activities and reablement support and could refer patients to the New Opportunities Worcestershire team (NOW). This consisted of technical instructors and peer support workers who ran regular group skill-building activities, including art, information technology and horticulture. The reablement team worked alongside the neighbourhood mental health teams and supported patients to access groups and activities in the wider community, and also delivered travel training and graded exposure interventions.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Some aspects of physical health monitoring, such as electrocardiograms (ECGs) were completed by the GP. Staff in the neighbourhood mental health teams had access to the GP's recording system and told us that GPs informed them of results.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. The trust offered a 12 week programme called Supporting Health and Promoting Exercise (SHAPE). Staff from the SHAPE team attended multidisciplinary team meetings and staff identified patients who would benefit from this service.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. Staff used the Health of the Nation Outcome Scale (HONOS) and Recovering Quality of Life (ReQoL) scales to evaluate care and treatment outcomes at the start and end of interventions.

Staff used technology to support patients. The majority of groups took place online. Groups had initially moved online during the COVID-19 pandemic and remained online at the time of inspection. Most staff told us they felt this had enabled more patients to access the groups and felt this worked well. Staff told us reasonable adjustments could be made for those patients who could not join a group online. For example, patients could be offered one to one sessions with a mental health practitioner.

Some neighbourhood mental health teams were evaluating the effectiveness of virtual groups in comparison to face to face groups. For example, the Wyre Forest neighbourhood mental health team had created a new trainee group programme lead post, who was responsible for evaluating the courses on offer and exploring the effectiveness of online groups.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives. For example, staff in the neighbourhood mental health teams had recently completed an audit of documentation relating to follow up care and participated in the annual National Clinical Audit of Psychosis (NCAP). Managers used results from audits to make improvements. For example, one action from the most recent NCAP audit was to provide ECG machines to the early intervention service. We saw that ECG machines had been ordered for the clinic room used by the neighbourhood mental health teams in Hereford.

Community-based mental health services of adults of working age

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of each patient. The multidisciplinary team consisted of consultants, clinical leads, psychologists and mental health practitioners. Mental health practitioners were qualified staff from a variety of clinical backgrounds, including qualified nurses and occupational therapists. Occupational therapists employed in the mental health practitioner role did not complete specific occupational therapy assessments and interventions as part of their role. The trust was in the process of reviewing the need for occupational therapy interventions in the neighbourhood mental health teams. We saw that a full time occupational therapist had been employed in the Wyre Forest team and they completed occupational therapy specific assessments and interventions. The trust was exploring if this should be rolled out to other neighbourhood mental health teams.

There were 4 psychology vacancies in Worcestershire and one vacancy in Herefordshire at the time of our inspection. We saw psychologists worked with patients across various teams to address the waiting list and to reduce the impact of these vacancies.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work. Staff attended a trust-wide induction and specific inductions to their teams. Staff told us they had opportunities to shadow the team before they were given a caseload.

Managers supported staff through regular, constructive appraisals of their work. 85 percent of staff in Herefordshire and Worcestershire community mental health teams had received their annual appraisal.

Managers supported staff through clinical supervision, but this varied between teams. The trust provided clinical supervision rates for a one-month period of December 2022 to January 2023. Only 22.2% of staff received clinical supervision in the Bromsgrove neighbourhood mental health team, 50% in the Redditch neighbourhood mental health team and 57.1% in the Worcester neighbourhood mental health team. The Redditch neighbourhood mental health team did not have a clinical lead at the time of our inspection, however the staff we spoke to in this team told us they had access to regular supervision. Other teams had higher supervision rates with 100% of staff in Herefordshire East neighbourhood mental team receiving clinical supervision, 100% in the Herefordshire WBC neighbourhood mental health team and 90% in the Herefordshire south and west neighbourhood mental health team.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Staff told us they had regular business meetings. We reviewed meeting minutes and saw that business meetings happened monthly, teams discussed performance and learning from incidents in these meetings. Managers shared the meeting minutes with staff who were unable to attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, some clinical support workers told us managers had arranged for them to complete venepuncture training to enable them to take patient blood samples as part of physical health clinics. One staff member told us their manager supported them to complete a post graduate course and had been able to secure funding for this.

Community-based mental health services of adults of working age

Managers made sure staff received any specialist training for their role. Staff in the neighbourhood mental health teams had access to specialist training courses including trauma informed care, self-harm awareness and Dialectical Behaviour Therapy essential skills training.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers offered support to staff and referred to occupational health or followed disciplinary procedures when required.

Multidisciplinary and interagency team work

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

Staff held weekly multidisciplinary meetings to discuss patients and improve their care. We observed 2 multidisciplinary meetings and found these were well attended by a range of professionals across different disciplines.

Staff had effective working relationships with other teams in the organisation. They worked closely with professionals from reablement, employment and vocational teams and they regularly attended multidisciplinary meetings. Patients in the community mental health teams could access these services alongside their treatment but staff could also signpost people who were not eligible to the team to these services.

Staff had effective working relationships with external teams and organisations. The trust was in the process of aligning and integrating neighbourhood mental health teams into the local primary care networks, as part of the community mental health transformation programme. Some teams had developed close links with the GP surgeries in their primary care networks. For example, managers in the Wyre Forest neighbourhood mental health team had set up a biweekly multidisciplinary meeting with GPs from the surgeries in the local primary care network. These meetings were attended by various professionals including consultants, mental health practitioners and social prescribers from the GP surgeries. Some mental health practitioners also completed their assessment clinics within their local GP surgeries.

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

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

Mental Health Act training was part of the mandatory training programme for staff. We requested mandatory training data from the trust, but they did not include information about Mental Health Act compliance. However, the staff we spoke with had a good understanding of the Mental Health Act and the guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff told us they could get support from their managers or the trust Mental Health Act administration team. Staff followed clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy. Staff told us they could refer patients to independent mental health advocacy services and that the mental health act administration team supported with these referrals.

Community-based mental health services of adults of working age

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

We reviewed the records for 1 patient subject to a Community Treatment Order (CTO), and saw that staff completed all statutory records correctly. Staff told us Mental Health Act administrators sent them emails to remind them when they needed to submit paperwork. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Care plans clearly identified patients subject to the Mental Health Act and identified the section 117 aftercare services they needed. We reviewed the record of 1 patient who was eligible for section 117 aftercare services and saw staff had clearly documented this and were supporting the patient to arrange aftercare.

Staff completed regular audits to make sure they applied the Mental Health Act correctly. The trust completed an annual audit of Mental Health Act documentation.

Good practice in applying the Mental Capacity Act

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

Mental Capacity Act training was part of the mandatory training programme for staff. We requested mandatory training data from the trust, but they did not include information about Mental Capacity Act compliance. However, the staff we spoke with had a good understanding of the Mental Capacity Act and the 5 principles.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff knew where to get accurate advice on Mental Capacity Act. Staff could seek advice from their clinical leads and the wider multidisciplinary team.

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

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We reviewed the care record for 1 patient who lacked capacity to make decisions about their care and treatment and saw evidence that staff had involved the patient and their family members in decision making as much as possible.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. The trust completed an annual audit of the Mental Capacity Act.

Is the service caring?

Good ↑

Community-based mental health services of adults of working age

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. We spoke with 15 patients, who told us that staff treated them well and behaved kindly. We observed 2 home visits and saw positive interactions between staff, patients and their families.

Staff gave patients help, emotional support and advice when they needed it. For example, we observed staff discussing the potential side effects of substance and alcohol misuse with patients and providing information about support they could access about healthy lifestyles. Staff understood and respected the individual needs of each patient. For example, 1 patient told us their mental health practitioner had supported them to develop and maintain their relationship with their children.

Staff supported patients to understand and manage their own care treatment or condition. Patients told us staff provided them with advice around their medicines including the nature, purpose and potential side effects.

Staff directed patients to other services and supported them to access those services if they needed help. For example, staff referred patients to reablement and employment support teams if this was required.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff. The staff we spoke to were knowledgeable about safeguarding issues and knew how to raise concerns. Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates. However, staff did not always ensure patients had access to their care plans.

Involvement of patients

Care records showed staff involved patients in their care and treatment. However, 5 of the 15 patients we spoke with told us they had not been given a copy of their care plan and 1 patient told us that they did not know what a care plan was.

Staff made sure patients understood their care and treatment. Most patients told us staff involved them in decisions about their care and treatment.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Seven of the 15 patients told us that they had been involved in decisions about the service and had been able to give their feedback through questionnaires.

Staff made sure patients could access advocacy services. Staff invited the local advocacy service to multidisciplinary meetings and referred patients to this service when needed. Three patients we spoke to told us that they had accessed advocacy services.

Involvement of families and carers

Staff supported, informed and involved families or carers. We saw that staff had offered additional support to one carer to help them to understand their family member's condition and to be involved in their care. We observed that staff had discussed with a patient how they could involve family members in their care and treatment during a home visit.

Staff helped families to give feedback on the service. One carer told us they had been able to give feedback on a survey.

Staff gave carers information on how to find the carer's assessment. Staff could refer carers to the local carers association for a carers' assessment. We saw that staff invited the carers association to multidisciplinary meetings.

Is the service responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and waiting times

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

The service had clear criteria to describe which patients they would offer services to. Neighbourhood mental health teams provided a service to anyone over the age of 17 years and 6 months who was registered to a GP surgery within the geographical area, with mental health needs that could not be met by the Healthy Minds team or specialist mental health community teams, such as the early intervention in psychosis team.

Some patients in Bromsgrove, Redditch and Worcester city neighbourhood mental health teams had to wait to be allocated to a mental health practitioner after their initial assessment and were placed on a holding list. Staff maintained regular contact with patients on the holding list.

The service now met trust target times for seeing patients from referral to assessment and assessment to treatment. Staff ensured that patients were seen in a timely manner and supported by the service. Staff were generally able to make initial contact with patients within the national 4 week timeframe between referral and initial assessment. We saw that no patients had been waiting for longer than 4 weeks as of 20 February 2023. We saw that this had significantly improved since July 2022, where 49% of patients in neighbourhood mental health teams waited 6 weeks or longer for their initial assessment.

However, the trust had long waiting lists to access both individual and some group psychology pathways in Worcestershire. As of 1 February 2023, there were 161 patients waiting for individual psychology interventions. 116 patients (72%) had been waiting for more than 6 months from their initial screening assessment. The number of patients on this waiting list had steadily increased each month, from 57 in March 2022.

As of 1 February 2023, 178 patients were on the waiting list for the understanding trauma psychology group. 83 of these had been waiting for more than 6 months, however this had reduced from 118 in December 2022. There was a smaller wait for the understanding emotions psychology group. Seventy four patients in total were on the waiting list for this group, 50 patients had been waiting for more than 6 months, which had reduced from 73 in December 2022.

The service operated an overall waiting list for each psychology pathway, rather than separate waiting lists for each neighbourhood mental health team. This ensured patients could be assigned to the next available member of staff, to reduce waiting times. Staff were able to offer online individual and group sessions to some patients in other neighbourhood mental health teams to reduce their waiting times if this was deemed to be appropriate and if the patient agreed to this. Staff also reviewed whether some patients on the individual pathway would be suitable for group sessions, to reduce their waiting time.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Patients had some flexibility and choice in the appointment times available. Staff offered patients a variety of appointments to support their attendance. For example, some staff told us that using software to do virtual appointments had helped to engage patients who would not ordinarily attend face to face appointments. Staff tried to contact people who did not attend appointments and offer support. Managers monitored appointment attendance during regular huddle and multidisciplinary meetings and ensured that staff contacted patients to check on their welfare and offer an alternative appointment.

Staff generally worked hard to avoid cancelling appointments and when they had to, they usually gave patients clear explanations and offered new appointments as soon as possible. Staff ensured patients had the contact details for the duty worker and crisis team so they could access support if their allocated staff member was unavailable. However, one patient told us that one of their appointments had been cancelled due to the doctor being unwell and staff had not contacted them to let them know.

The service used systems to help them monitor waiting lists. Managers used a database to keep track of patients who were awaiting allocation to a mental health practitioner and reviewed this during regular huddle meetings. The psychology team kept a separate database to monitor how many patients were on waiting lists.

Staff supported patients when they were referred and transferred between services or needed physical health care. For example, managers in neighbourhood mental health teams attended a weekly interface meeting with professionals from the primary care network, specialist community teams and the acute pathway. The purpose of this meeting was to keep track of patients who were referred between community mental health teams. We saw evidence that staff discussed transfer of care arrangements for patients who moved between these services. The service followed national standards for transfer.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms did not always support patients' treatment, privacy and dignity.

Community-based mental health services of adults of working age

The service had a full range of rooms and equipment to support treatment and care. We visited the buildings used by community mental health teams in Bromsgrove, Redditch and Hereford. Each building had a range of rooms used for patient appointments and group activities.

St Owen's Street was the main base for community mental health teams in Hereford city. Specialist community mental health teams including the assertive outreach team were based here. The local neighbourhood mental health teams were based at another building, but this was an office base and was not equipped for patients to visit. Therefore, the teams regularly visited St Owen's Street to use the meeting rooms and clinic room.

Two staff members told us the St Owen's Street building needed updating and was not fit for purpose. We observed that furniture in meeting rooms was in need of updating. One staff member told us they spent a lot of time travelling between their office base and St Owens Street and felt this was not always a good use of their time.

Interview rooms in the service did not always have sound proofing to protect privacy and confidentiality. Interview rooms used by staff in the Bromsgrove and Redditch community teams were not soundproof and we overheard discussions from meetings held in rooms at both of these services. Interview rooms at St Owen's Street were also not soundproof.

Meeting the needs of all people who use the service

The service did not meet the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service did not always support and make adjustments for people with communication needs or other specific needs. Staff could present information in different languages or easy read format if this was needed. However, the St Owen's Street building was not fully wheelchair accessible. Wheelchair users could only access meeting and therapy rooms on the ground floor of the building as there was no lift. Corridors were quite narrow, and a staff member told us wheelchair users would have to be escorted through the reception office to access the group therapy room. The building was grade 2 listed, which limited the changes that could be made to internal and external fixtures and fittings.

Hereford City neighbourhood mental health team was based in an office building and staff had to book the interview rooms at St Owen's Street to see patients or visit them in their own homes. Staff told us the St Owen's Street building was not easily accessible due to lack of parking and that the building was not conducive to patients' recovery.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Information on how to access these services was displayed on notice boards in the service. Patients told us that staff gave them information about how to complain. The service provided information in a variety of accessible formats so the patients could understand more easily.

The service had information leaflets available in languages spoken by the patients and local community. Staff told us they could provide information in a different format when this was required. Managers made sure staff and patients could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

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

Community-based mental health services of adults of working age

Neighbourhood mental health teams had received 333 complaints between January 2022 and February 2023. Of these, 2 were upheld and 21 were partially upheld. 20 had no outcomes recorded. 79 out of 333 (24%) of complaints related to patient care, 43 (13%) related to communication, and 35 (11%) related to appointments. 59 (18%) were categorised as 'other'.

Patients, relatives and carers knew how to complain or raise concerns. 12 out of 15 patients we spoke with knew how to raise a complaint. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. One carer told us that they had raised a complaint and had received feedback about this.

Staff protected patients who raised concerns or complaints from discrimination and harassment. The patients we spoke with told us they would feel confident to complain if they needed to.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers discussed the outcome of complaints with staff during monthly business meetings.

The service used compliments to learn, celebrate success and improve the quality of care. A total of 22 compliments were made regarding the neighbourhood mental health teams between January 2022 and January 2023.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

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

Staff told us clinical leads were knowledgeable and approachable. Staff in the Redditch neighbourhood mental health team did not have a clinical lead at the time of our inspection. We saw that clinical leads from other local neighbourhood mental health teams had provided cover.

The service manager in Worcestershire had also regularly supported the Redditch team by providing clinical lead cover. Staff in various neighbourhood mental health teams told us they felt well supported by their clinical leads and the service managers.

Managers had a good understanding of the key issues affecting the service. For example, managers in the Worcestershire neighbourhood mental health teams regularly reviewed the holding lists that were used to keep track of patients who were awaiting allocation to a mental health professional.

Community-based mental health services of adults of working age

Managers attended a weekly interface meeting with other specialist community teams, including the assertive outreach team and the early intervention team. The purpose of this meeting was to discuss and manage internal referrals between teams. This helped to ensure that patients were referred or transferred most the most appropriate team and helped to promote joint working between community mental health teams. Service managers attended monthly clinical governance meetings.

Vision and strategy

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

Staff we spoke with were aware of the trust's values of Courageous, Ambitious, Responsive, Empowering and Supportive. These were displayed in the buildings used by the neighbourhood mental health teams. We observed 2 home visits to patients and saw that staff empowered and supported patients to be involved in their care and treatment.

Staff had the opportunity to contribute to discussions about the strategy for their service. For example, we saw staff had participated in virtual events to share their views on phase one and phase 2 of the transformation programme. Staff told us they felt they had opportunities to give feedback on the service during supervision and annual appraisals.

Culture

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

Staff told us that managers were respectful and supportive. Staff had opportunities to progress, some staff were participating in the trust's development programme to become a band 6 practitioner and a staff member in the Wyre Forest team had been supported to progress from a band 3 to a band 4 role. Staff were aware of the whistleblowing procedure and told us they felt able to raise concerns without fear of repercussions.

However, some staff in the Redditch team told us that lots of experienced mental health practitioners had left recently and this had impacted on staff morale.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were mostly managed well apart from oversight of supervision and mandatory training compliance.

Managers completed regular audits which included clinical documentation and physical health monitoring. However, managers did not always have effective systems and processes in place to have oversight of staff compliance with supervision and mandatory training.

Managers had good oversight of patient risk, multidisciplinary meetings were well organised and included detailed discussions about patient risk. Staff held separate huddle meetings at least twice a week to review patients who were awaiting allocation to a mental health practitioner.

There was a clear framework setting out what needed to be discussed at a team and directorate level to ensure that essential information was disseminated to staff at all levels. Learning from serious incidents, complaints and audit results were discussed at monthly business meetings and clinical governance meetings.

Management of risk, issues and performance

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

Staff had access to the risk register at directorate level and staff concerns matched those on the risk register. Staff we spoke with were aware of the staffing shortages in the neighbourhood mental health teams. This was recorded as a high level risk on the risk register and was identified as the trust's highest priority for recruitment.

The service had plans in place to improve recruitment and retention of staff. This included rolling recruitment adverts and career path progression opportunities, such as band 5 development roles and introducing a new band 7 senior mental health practitioner role.

The service had plans in place in place to maintain the safety of patients despite staffing shortages. This included regular huddle meetings to review and manage patients who were awaiting allocation to a mental health practitioner, and regular staff supervision to manage caseloads and manage capacity within teams.

Information management

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

The trust had been impacted by a national cyber security issue which had affected access to the patient recording system. Staff had been unable to update patient records on this system for several months. Staff told us they could still access the system to view historical records but could not add updates. The trust had developed an interim patient recording system. Staff told us they had access to both systems and that managers had kept them updated about the system issues.

The cyber issue had impacted on manager's ability to collect data on the performance of the service. However, managers in the neighbourhood mental health teams kept a referrals spreadsheet to maintain oversight of performance, including waiting times and attended appointments. These were stored on a shared drive so clinical leads and senior managers could have access. Managers reviewed the referrals spreadsheet regularly during huddle meetings.

Staff made notifications to external bodies, such as the CQC as needed.

Engagement

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

Staff had access to up-to-date information about the work of the trust. Staff had been invited to engagement sessions about the community mental health transformation project and received updates through a monthly newsletter.

Community-based mental health services of adults of working age

Patients and carers had opportunities to give feedback on the service. Patients told us that they could give verbal feedback during appointments and via feedback forms. Representatives from advocacy and the local carer's association were invited to attend multidisciplinary team meetings.

Managers had access to feedback from patients, carers, and staff, this was discussed by teams in monthly business meetings and by senior leaders in clinical governance meetings.

Directorate leaders engaged with external stakeholders, such as commissioners and Healthwatch.

Learning, continuous improvement and innovation

The community mental health transformation project was progressing. Teams in phase one of the transformation had built effective links to GP surgeries in the primary care networks and had trialled new roles. The service had commissioned a local partnership organisation to evaluate the impact of the transformation programme on staff and patients. Clinical leads in phase 1 and phase 2 shared learning at a monthly clinical lead meeting. The Wyre Forest neighbourhood mental health team invited staff from other teams to shadow for a day to gain further understanding of the transformation model.

Staff had opportunities to participate in research. For example, staff in the early intervention in psychosis team were participating in 2 research projects with universities at the time of our inspection. One of these related to the use of antidepressants following first episode psychosis and the other related to the assessment tool used to assess people at high risk of experiencing psychosis.

Mental health crisis services and health-based places of safety

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

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

Safe and clean environments

Some clinical premises where patients received care were not safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety did not always meet the requirements of the Mental Health Act Code of Practice.

Staff did not always complete and update risk assessments of all areas, remove or reduce any risks they identified. Environmental risk assessments were available at all sites. The temporary interview room in the Herefordshire therapy room used by the Hereford crisis team had not been included in the ligature risk assessment. The staff team updated this when we raised this with them during the inspection.

All interview rooms did not have alarms. None of the sites had alarmed interview rooms. Staff carried portable alarms into the interview rooms. All sites had arrangements for staff to respond quickly in an emergency.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. They were clean, appropriately stocked and audited for correct fridge and room temperatures. Emergency equipment was regularly serviced and checked by staff to ensure it was in good working order.

All areas except the Elgar Suite and Portacabins used by the Herefordshire team were clean, well maintained, well-furnished and fit for purpose. The Herefordshire Crisis and Home Treatment Team joined the trust in April 2020 with all other Herefordshire mental health services when the Worcestershire and Herefordshire services merged. The crisis and home treatment were already a combined team and they remained within their base in the Stonebow Unit until August 2022 when they were temporarily moved to the Portacabins whilst building work was undertaken to create new bespoke premises. Staff felt unsafe working in the evening in the cabins because a patient had threatened staff with a knife. They had requested a perimeter fence, but this work had not yet been completed. In the last year staff raised concerns about poor lighting and were still waiting for this to be addressed.

Staff made sure cleaning records were up to date. Cleaning records were available on all sites.

Staff followed infection control guidelines, including handwashing.

Health-based places of safety

The trust had two health-based places of safety. One based in Worcestershire called the Elgar Suite based in Newton Hospital site and one based in Herefordshire. The standard of the two significantly differed.

Mental health crisis services and health-based places of safety

The health-based place of safety in Herefordshire was purpose-built and of a good standard. However, the health-based place of safety in Worcestershire did not meet the guiding principles of the Mental Health Act 1983 Code of Practice because it was not safe and secure for patients including those under the age of 18.

The Elgar Suite consisted of three separate rooms. Room one had full CCTV (closed circuit television) coverage so staff based in the office could monitor patients. It was furnished with a mattress on the floor. The other two rooms did not have any CCTV coverage or beds/mattresses. Staff could only see fully into these rooms by standing directly outside the viewing panel in the door of each room. This meant that patients were at risk of self-harm without the staff being aware. For example, one young person in 2022 had sufficient time unobserved to eat parts of a carpet whilst in room three. In Herefordshire all rooms had CCTV coverage so staff could easily monitor patients in the room to ensure they were safe.

Room two and three in the Elgar Suite were used as assessment rooms and were furnished with a couch and chair. These rooms did not meet the standards on the use of section 136 of the Mental Health Act 1983 (England and Wales) (July 2011 Royal College of Psychiatry) and the guiding principles of the Code of Practice. For example, these standards state that rooms must have good exits with consideration being given to there being two doors at opposite ends of the room; the doors should open outwards for the safety of staff. There was only one door to each of the suites – one had access to the outside space. Staff said there had been 3 occasions where challenging patients had become violent outside of the rooms and they have not felt safe. This was further compounded by the suite not having an airlock access. The suite in Herefordshire had airlock access and there were no incidents of patients becoming violent in the staff office.

The standard states rooms should have fixed chairs in a washable fabric; furniture and fittings should be chosen so they cannot be used to cause injury by offering a weapon of opportunity. The chairs in both room two and three could easily be picked up and thrown. In Herefordshire, the furniture and fittings met this standard.

The standard states rooms should have a system to enable good communication with others and a have a panic alarm system. In the Elgar Suite, there was not a two-way intercom system for patients to easily attract the attention of staff. Communication would have to be made by shouting through the door.

The rooms in the Elgar Suite were in a poor state of repair. Room three was extremely cold and there was a loud noise emanating from a large air conditioning unit situated outside the room. This would impact upon patients trying to rest peacefully. The rooms were in a poor state of repair and would not promote recovery. The paint on the walls was scuffed and the carpet was dirty, damaged and torn in places.

None of the three rooms in the Elgar Suite could be locked. This meant that patients detained in the suites could leave their rooms at any point. In the Herefordshire suite there was a door lock to each room in the suite. In Worcestershire, staff were not clear about whether the doors could be locked. The managers thought the doors could be locked whilst the staff said they couldn't be locked. The absence of a lockable door potentially posed a risk to young people detained whilst in the same suite as adults. For example, when three patients were detained at the same time, they could easily bump into each other in the corridor area or have access each other's rooms. Between November 2022 and February 2023 there were 8 instances where there was more than one patient in the health-based of a space of safety at any one time. In December 2022, there was 1 occasion where there were 3 detained patients. During this three-month period there were 5 occasions where young people were detained in the suite. Staff told us young people had witnessed distressing scenes. The AMHPs (approved mental health practitioners) were particularly concerned about the risk posed to young people in these rooms.

Mental health crisis services and health-based places of safety

The lack of available local mental health beds meant patients at the Worcestershire health-based place of safety were admitted on section 136 for over 72 hours. The suite was used as a bedroom using section 140 of the 1983 Mental Health Act. The Elgar Suite was not appropriate as an inpatient bedroom because there was a potential risk that patients did not receive the appropriate care and treatment to promote recovery. For example, the Elgar Suite did not have a television, and there was no access to activities, and there were limited treatment interventions.

Safe staffing

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

Nursing staff

All teams had enough nursing and support staff to keep patients safe. Where there were staff vacancies the trust ensured that staff were quickly in post. Staff spoke positively about the trust's recruitment drive in 2022 to reduce vacancies across the service.

The service had low vacancy rates. The average vacancy rate was 4% across the teams. For example, in the Hereford crisis team currently had no vacancies. The Worcestershire Crisis Resolution team had two band 6 vacancies and one band 3 but interviews for these posts had taken place.

The service had low rates of bank and agency nurses and support workers. Managers limited their use of bank and agency staff and requested staff familiar with the service. They made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low turnover rates. For example, in the Bromsgrove Hub, the home treatment team staff had worked there for many years. In the Redditch and Wye Forest teams, the turnover rate was 5.9%. In the South in the Worcestershire Crisis Resolution Team, it was 5.8%.

Managers supported staff who needed time off for ill health. Levels of sickness were low. The average across all teams was 4%.

Managers used a recognised tool to calculate safe staffing levels and the number and grade of staff matched the provider's staffing plan.

Medical staff

The service had enough medical staff.

Managers could use locums when they needed additional support or to cover staff sickness or absence. They made sure all locum staff had a full induction and understood the service.

Mental health crisis services and health-based places of safety

The service could mostly get support from a psychiatrist quickly when they needed to. Young people accommodated in the Herefordshire health-based place of safety did not have to routinely stay overnight. There was sufficient staff for them to be seen by CAMHS (Child and Adolescent Mental Health Services) Consultant if they were admitted outside working hours. In the Worcestershire health-based place of safety there were not always sufficient staff available to assess a young person outside working hours. This meant young people had to then stay overnight.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The overall training compliance rate was 96% across the teams. The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training was provided through both e-learning and face to face sessions. The electronic system sent an email alert to staff and their managers three months before a course was due for renewal. Managers received regular reports regarding training compliance.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff did not complete risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. In the majority of teams there were comprehensive risk assessments in place which protected patients. However, in the Worcestershire health-based place of safety there were no risk assessments in relation to young people being detained alongside adults in rooms that could not be locked and where there was no CCTV in place.

Staff used a recognised risk assessment tool. The trust had a nationally recognised risk assessment tool called GRiST (Galatean risk and safety technology). They were in the process of developing it further to assist mental health practitioners.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. There were no waiting lists within the service.

Staff followed clear personal safety protocols, including for lone working. Staff had developed systems such as checking in when they had completed a visit and safe words to alert staff, when they may need assistance.

Safeguarding

Mental health crisis services and health-based places of safety

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

Staff received training on how to recognise and report abuse, appropriate for their role. They kept up to date with their safeguarding training. Safeguarding training across the teams was 98%.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

There was good joint working in identifying those who were more at risk. This was evident at the morning meetings and multidisciplinary team meetings. All staff we spoke with understood the process for making a safeguarding referral.

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

Staff worked closely with the local authority safeguarding team, safeguarding leads in the local acute trust, the police, and local stakeholders to identify and protect children and families from harm.

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

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Patients notes all were up to date and of a good standard.

The trust experienced a cyber security attack in August 2022 that prevented staff updating the electronic patient records system. The teams used a temporary system, but they had responded quickly to transferring information from the temporary system back to the previous electronic system.

There was no delay in transferring notes over should someone move to a different team, as the electronic system allowed for confidential transfer of notes.

Records were stored securely, and documents were password protected and encrypted.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. Medication management was in line with NICE (National Institute for Health and Care Excellence) guidelines. Nurses in the teams had access to the duty doctor for advice.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. They completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely. They followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice. They ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Patient's files included information about side effects, and these were discussed with the patient.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Managers investigated incidents thoroughly. Patients were involved in these investigations. All managers we talked with said they had very few incidents, but they were monitored to identify any themes or trends. For example, in Herefordshire there were 3 reported incidents in 2022. One concerned staff safety as a patient had knocked at the portacabin in the evening and threatened staff. Staff now worked in the evenings in the hospital reception area until a security fence was put in place.

Incidents were discussed during team meetings to ensure lessons were shared across the service.

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

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

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers gave examples of letters that they have written to patients.

Managers debriefed and supported staff after any serious incident. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

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

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. For example, staff identified that the GRiST (Galatean risk and safety technology) tool that supported mental health clinicians with patient risk assessments and management planning was too complex, difficult

to use and cumbersome. This was the most frequently cited issue in the trust serious incident investigation over 2022. A review of the trust's current risk assessment and management tool had been undertaken by a senior leader. A task and finish group commenced in April 2023 to review the trust's current risk assessment policy and implement any changes agreed upon.

There were no recent never events within the service. Managers received national alerts about never events that happened elsewhere and shared learning with staff through emails and handovers.

Is the service effective?

Good 

Our rating of effective remained the same. We rated it as Good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient. We reviewed 17 patient records across all teams. Each contained sufficient information to ensure safe care and treatment of patients.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems, this included baseline physical health observations. There was ongoing physical health care for patients who remained under the care of the team for extended periods.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans and management plans were up to date and there was clear evidence of carer and patient involvement documented within the assessments. They were personalised, holistic and recovery orientated. For example, within the crisis team there was evidence of referrals and correspondence with other teams as necessary when patients were discharged from the team. These included referrals to home treatment teams, other secondary mental health teams, drug and alcohol services and GP practices. Staff regularly reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

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

Mental health crisis services and health-based places of safety

Staff delivered care in line with best practice and national guidance. Staff referred patients for longer term psychological therapies, as recommended by National Institute for Health and Care Excellence (NICE). They followed NICE guidelines in relation to recognising and management of personality disorders, treatment and management of psychosis, violence and aggression, depression in adults, self-harm assessment, management and preventing the parents and service user experience in adult mental health.

All the Wyre Forest, Redditch and Bromsgrove home treatment teams were signed up to the national Mental Health Crisis Care Concordat for emergency services and healthcare providers for 24/7 access support for people experiencing mental health crisis. (The concordat ensures patients can get help when they need it, 24 hours a day and when they ask for help, they are taken seriously).

Staff made sure patients had support for their physical health needs, either from their GP or community services. Patients' physical healthcare needs were routinely assessed, monitored, and supported. Staff used the National Early Warning Score (NEWS) for assessing patients' risk of deteriorating. The Royal College of Physicians advocates use of NEWS for assessment and response in acute illness. Some staff in the teams were trained to take blood samples from patients. This ensured that patients who were not well enough to go to their GP or hospital able to have physical health tests. There were monitoring arrangements in place for prescribed antipsychotic medication. Staff recorded physical health care assessments and monitoring in care plans on of the electronic database.

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

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. For example, staff used the Recovering Quality of Life (REQOL) outcome measure, (This is the recovering quality of life for users of mental health services). It is a patient recorded reported outcome measure which helps staff decide what support services patients require and to measure and improve the quality of care and treatment that patients have received).

Staff used technology to support patients.

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

Managers used results from audits to make improvements. For example, the Herefordshire crisis and home treatment team benchmarked against the home treatment accredited service (HTAS). They were in the process of arranging electrocardiograph (ECG) equipment to be available for patients' home so patients could still receive the service even if they were too unwell to leave their own home.

Skilled staff to deliver care

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

The service had a full range of specialists to meet the needs of the patients on the ward. Across the teams these included occupational therapists, nurses, social workers, support and recovery workers, doctors, approved mental health professionals, consultant psychiatrists and administrators.

Mental health crisis services and health-based places of safety

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

Managers gave each new member of staff a full induction to the service before they started work. Newly appointed staff received appropriate inductions and shadowing experienced staff.

Managers supported staff through regular, constructive appraisals of their work. The appraisal rate was 98% across all the teams.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work. The supervision rate was 97% across all teams.

Managers supported medical staff through regular, constructive clinical supervision of their work. Managers made sure staff attended regular team meetings or gave information from those they could not attend. All teams met regularly and staff who could not attend were given copies of the minutes.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received specialist training for their role. For example, in the Herefordshire Crisis Resolution Team, the trust had a quality improvement plan to train healthcare assistants to deliver physical health checks. They had purchased portable ECG equipment so patients could receive checks in their own home and staff training had commenced. Other training included nurse prescribing, dialectical behavioural therapy training (DBT) and cognitive behavioural therapy training (CBT).

Managers recognised poor performance, could identify the reasons, and dealt with these. Whilst there were no examples raised at the inspection by managers, they spoke about how they could identify and deal with poor performance.

Multidisciplinary and interagency teamwork

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

Staff in all teams held regular multidisciplinary meetings to discuss patients and improve their care. For example, the Herefordshire Crisis and Home Treatment Teams held three multidisciplinary meetings each week with the consultant psychiatrist to discuss patients' needs and treatment.

Staff in all teams worked closely with other agencies including the police, ambulance staff and approved mental health practitioners. For example, the home treatment teams met with the police twice a month to discuss more complex patients.

Staff in all teams made sure they shared clear information about patients and any changes in their care, including during transfer of care. Information was clearly documented patients care records.

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

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

Mental health crisis services and health-based places of safety

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff compliance rates were 95% across all services. They had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support. They had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed. Staff completed regular audits to make sure they applied the Mental Health Act correctly.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the 5 principles. Staff compliance rates were 95% across all services. Staff across all teams demonstrated clear understanding of the Mental Capacity Act 2005. They completed MCA assessments. They attended and contributed to patient's best interest meetings.

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

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. In all teams they clearly recorded specific decisions in relation to, for example, patients managing their finances and medication.

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

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. They audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary. Staff knew how to apply the Mental Capacity Act to patients aged 16 and 18 and where to get information and support on this.

Mental health crisis services and health-based places of safety

Is the service caring?

Good ➔➔

Our rating of caring remained the same. We rated it as Good.

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it. Patients we spoke with were unanimous about their positive interactions with staff. They said they were kind and caring and tried to relate some of their own life experiences to assist them in recovery. One patient said they were the reason they remained alive after suicidal thoughts.

Staff supported patients to understand and manage their own care treatment or condition. For example, in the home treatment teams they would visit a patient several times a day to ensure they could understand and manage their own care and treatment safely. Patients spoke of staff visiting them on Christmas Day to ensure they were safe.

Staff directed patients to other services and supported them to access those services if they needed help. Staff worked closely with agencies and attended appointments with patients if required.

All patients we spoke with said staff treated them well and behaved kindly. They were unanimously positive about the kindness of staff. In Bromsgrove one staff member had been nominated by patients for a prize in the local newspaper.

Staff understood and respected the individual needs of each patient. Staff felt they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. Staff did not wear uniforms and discretely wore their identification badges when visiting patients to protect their patients' confidentiality from neighbours and the general public.

Involvement in care

Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed. Staff informed and involved families and carers appropriately.

Involvement of patients

Staff involved patients and gave them access to their care plans. All patients we spoke with had seen and contributed to their care plans.

Mental health crisis services and health-based places of safety

Staff made sure patients understood their care and treatment. Patients said staff supported them with their immediate mental health crisis and their recovery by referring them to longer term interventions, such as psychological therapies and the mental health recovery teams.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. The service used the Friends and Family Test (FFT). Questionnaires in a wide range of formats were available and patients' feedback was discussed in team meetings.

Staff supported patients to make advanced decisions about their care. They made sure patients could access advocacy services. Packs containing useful information were given to patients at initial appointment visits. This included information about the service and about other useful local services such as advocacy and voluntary groups.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed, and involved families or carers. For example, in the Herefordshire Crisis and Home Treatment Team they were developing the role of support workers to directly work with carers. They have separate assessment for carers as they saw them a priority to assess their needs and signpost to appropriate support and information services.

Staff helped families to give feedback on the service. Staff gathered information verbally and by using formal questionnaires. They used the information to improve their service. For example, carers requested a carers group and a support staff member was in the process of arranging these at the time of this inspection.

Staff gave carers information on how to find the carer's assessment. For example, in the home treatment teams as part of their assessment staff looked at additional support they could offer to carers and referred them to the Worcestershire Association for carers for further assessments. This ensured patients had access to carers groups and one-to-one support. There were groups on managing mental illness and staff tried to match the group to the patients' relative's needs.

Is the service responsive?

Good 

Our rating of responsive remained the same. We rated it as Good.

Access and discharge

The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated people promptly. Staff followed up people who missed appointments.

The service had clear criteria to describe which patients they would offer services to and patients. The teams did not have waiting lists.

Mental health crisis services and health-based places of safety

The trust set, and the service met, the target times seeing patients from referral to assessment and assessment to treatment. Staff saw urgent referrals quickly and non-urgent referrals within the trust target time. The teams were commissioned to respond with a triage service within one hour and emergency referrals seen within four hours. Data available to managers confirmed over 95% of patients were seen within 4 hours.

The access team was managed by an external third party provider which had a history of supporting people with mental health concerns. There was a telephone triage service within the crisis resolution team (CRT) based at the Elgar unit that was funded by the trust. They worked in partnership with the CRT to answer and triage incoming calls to the team 24 hours a day, 365 days of the year. The team of wellbeing practitioners used the UK Mental Health Triage Scale (UKMHTS) to determine whether the caller had a mental health related problem, the urgency of the situation and the most appropriate service response. They signposted patients to appropriate mental health services and support. Referrals to the access team came from anyone who was concerned about a person's mental health crisis including the patient themselves.

Mental health professionals or GPs made referrals to the crisis teams using a dedicated professional's line answered by the crisis teams. Staff across all teams expressed concerns about this new arrangement. Some staff felt this was appropriate as they were mental health trained and the staff who were part of the triage team did not always possess the same knowledge and experience. Other staff felt it impacted upon their daily schedule to meet the needs of their current patients. They felt this had not been thought through sufficiently by senior managers. Senior managers stated this move towards a dedicated professional's line was a direct response to feedback received from concerns raised by professionals and stakeholders about professionals' access to the service.

The crisis team had skilled staff available to assess patients immediately 24 hours a day, seven days a week, and responded quickly when patients called. After 10pm at night, home visits were not routinely carried out, but patients could speak to dedicated crisis team staff using the free phone telephone number.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. For example, the Worcestershire crisis teams worked alongside other services such as the ambulance service to assess and assist patients in the community. Staff met patients in a wide variety of venues to encourage them to attend appointments. The team tried to contact people who did not attend appointments and offer support. Patients had flexibility and choice in the appointment times available. The teams mostly visited patients in their homes. Patients could choose to meet staff in the interview rooms at the team offices. In Worcestershire there was a dedicated interview suite. In Herefordshire staff used some of the interview rooms in reception and also used an art therapy room. They considered patients choice and risk factors. If a patient preferred it, they could be seen in local cafés or in the community.

Patients who presented themselves at a general hospital emergency department were seen there. Specific rooms were provided in the emergency department for patients so they could be seen in a way which maximised their privacy and dignity. In Worcestershire, paramedics brought patients over to the interview suites. Patients were also seen by the mental health liaison teams who worked closely with hospital staff to find patient beds in hospital or support in the community.

Staff ensured appointments ran on time and staff informed patients when they did not.

Staff supported patients when they were referred, transferred between services, or needed physical health care. The service followed national standards for transfer.

Mental health crisis services and health-based places of safety

Facilities that promote comfort, dignity and privacy

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

The service mostly had a full range of rooms and equipment to support treatment and care. With the exception of the Elgar Suite and the temporary portacabin used by the Herefordshire Crisis Resolution Team, the service had sufficient rooms to support treatment and care. The portacabin was temporary and staff were told by the trust they would be in bespoke accommodation within the next 18 months.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work and supported patients.

Staff helped patients to stay in contact with families and carers. Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with a disability and those with communication or other specific needs. There were adapted toilets and washing facilities. Interview rooms were on the ground floor to assist wheelchair users. However, at the site of Redditch and Bromsgrove Home Treatment, Redditch, Worcestershire the toilets were not wheelchair accessible as doorways were narrow. We were unsure how wheelchair users would be able to access the toilet.

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

The service provided information in a variety of accessible formats. The service had information leaflets available in languages spoken by the patients and local community. These were available in reception areas and staff took out leaflets to patients' homes.

Managers made sure staff and patients could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

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

Patients, relatives, and carers knew how to complain or raise concerns. Staff provided patients and carers with information about the complaints procedures and were open to receiving both positive and negative comments.

Mental health crisis services and health-based places of safety

Across all teams there was a low number of complaints. For example, in the Bromsgrove Hub there were five complaints in 2022. One complaint was partially upheld. This complaint was about communication between the health treatment team and the community team. None were referred to the Parliamentary and Health Service Ombudsman. In the Worcestershire Crisis Resolution Team in 2022 there were 31 complaints. 29 were not upheld and two were partially upheld.

The service clearly displayed information about how to raise a concern in patient areas. These were available in reception areas and staff gave patients complaints leaflets on visits.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

Themes for complaints included managing patients' expectations, communication and follow-up post discharge from the home treatment teams.

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care. For example, in the Bromsgrove Hub a staff member had been nominated by a patient for a local healthcare ward run by a local newspaper. The team were also nominated by their students for an award by Worcestershire University.

Is the service well-led?

Requires Improvement 

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

Leadership

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

Senior managers in the organisation were visible within the teams. Staff were able to give examples of when these managers had visited the teams. For example, the Deputy Director of Nursing and Director of Nursing had visited the Herefordshire Crisis Team.

Vision and strategy

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

All staff spoken with knew the trust values and were able to relate them to their work within the team.

Mental health crisis services and health-based places of safety

Staff were clear about their roles and responsibilities in preventing patients' hospital admission or facilitating early discharge from hospital.

Culture

Staff did not all feel respected, supported and valued. However, they said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Not all staff felt respected supported and valued. Some staff felt the service they provided in the home treatment crisis teams was working well and described themselves as a shining light. But they raised concerns about the management of patients after they left the home treatment teams and whilst they were happy to extend their service for another fortnight to ensure patients were not put on long waiting lists for community teams, they were concerned about the impact this might have on the delivery of their own service.

The Crisis Resolution Team in Worcestershire were concerned about the length of stay of children in the 136 health-based place of safety suites which were not set up for young people to remain for long periods. They were also concerned about the amount of time they spent managing the access service run by an external partner due to the access teams' staffing vacancies. They felt particularly impacted upon as a Hereford team who were a longer distance away. However, staff were proud of the way they had pulled together despite these challenges and the way they tried to ensure young people were cared for in the Elgar Suite despite their concerns that they were placed there. This was also the case in the Herefordshire Suite.

Staff were concerned about the impact of the closing of admissions to one of the local inpatient units. Staff felt pressure from senior management in the trust's bed management to override clinical decisions for patients be discharged and admitted into home treatment. Although the majority of staff felt they could challenge these decisions.

Staff were unanimously confident in their immediate managers and felt supported by them, but some staff did not feel that more senior managers were aware or managed the risk to patients in the community.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Whilst regular audits were undertaken throughout the service, including audits of infection prevention and control, buildings condition, ligature risks, and the quality of care and treatment records. They had not identified the missing ligature audit and that some areas of the service were in poor condition.

There were no clear guidelines or oversight about the management of children and young people who stayed in the health-based place of safety beyond 24 hours.

The trust did not have a system in place to ensure that the health-based place of safety was in line with the Mental Health Code of Practice.

The oversight of the access service run by an external partner had only just started with one audit of the consistency of the assessments.

Patient records were randomly and routinely audited by each team every month.

There were not always governance processes in place to manage quality and safety within the service. Managers attended local meetings where trust wide incidents were reviewed, service quality and risk were discussed, and audit results were considered. The information was then discussed with staff at team meetings and in supervision sessions to ensure consistency and mostly make improvements to the service.

Management of risk, issues and performance

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

We were concerned that senior managers had not fully ensured that safety of young people when they had been admitted to the Worcestershire health-based place of safety. Risk assessments had not been in place and young people had witnessed distressing incidents. Trust staff and Approved Mental Health Practitioners were very concerned about the length of time young people stayed in an environment which was not conducive to their well-being.

Overall, the access to information to provide safe and effective care and management of risk was good across the teams. For example, in the Bromsgrove Hub team, staff could see every professional input made by other teams or GPs within the patient's care records. Records had an alert box to identify any patient safety risks like allergic reactions or a dangerous home environment.

All teams had integrated governance meetings where senior managers reviewed all risks and service held a risk register. However, the register was incomplete. For example, it did not include all the concerns about the Elgar Suite raised by staff at this inspection.

Managers had not ensured there were risk assessments in place for young people being accommodated next door to adults. The longest stay for a young person detained in the Elgar Suite in the previous 3 months was 7 days.

Information management

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

Staff in all teams could access the trusts policies and procedures on their intranet. The information was clear and accessible.

Engagement

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

There were effective multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety.

Mental health crisis services and health-based places of safety

Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis, regardless of the setting.

Learning, continuous improvement and innovation

Managers of the service worked closely with partner agencies like the ambulance service. For example, the manager of the Worcestershire Crisis Team had initiated and embedded daily practice in the crisis teams of joining twice-daily the trusts ambulance stack calls. Since the beginning of January 2023, they joined calls with the ambulance service control room, integrated community services (neighbourhood teams) and the GPs to discuss patients waiting for an ambulance to be dispatched. In the first week they diverted 6 ambulances and mental health teams picked up these calls. This reduced pressure on the ambulance service and patients received a timelier service as they did not have to wait for an ambulance to attend to assess the situation.

Teams were either accredited through the Royal College of Psychiatrists' Home Treatment Accreditation Scheme (HTAS) or were working towards this accreditation. This meant that they were subject to rigorous peer review and assessment which encouraged quality improvement.

The home treatment teams had extended the service by 2 weeks for patients moving to community teams to ensure patients had continuity whilst waiting for a service.

Community health services for adults

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

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

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Training was delivered through a combination of face-to-face sessions and e-learning. Staff described good access to mandatory training, and most indicated they were up to date with all mandatory training. Data provided by the service showed that, for example, overall training compliance for nursing, health care assistants, occupational therapy and physiotherapy staff was at 87% at the time of inspection. Most areas of mandatory training was over 85%, including 92% for fire safety, 91% for information governance, and 96% for equality and diversity training. Basic life support training had a compliance of 78% and moving and handling training was at 80%.

Managers monitored mandatory training and alerted staff when they needed to update their training. They received monthly mandatory training reports from the quality team, and these were discussed as an agenda item at monthly integrated governance meetings.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had training on how to recognise and report abuse but they knew how to apply it.

Not all staff had received training specific for their role on how to recognise abuse but knew how to report it. Safeguarding adults level 2 training was at 90% compliance overall, however, level 3 safeguarding adults was at 70% with compliance ranging month on month between 62% and 78%. Safeguarding children was 91% overall but was only level 1 training. This did not follow national guidance on safeguarding children training.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They were aware of their responsibility to keep people safe and report any safeguarding concerns they had.

Staff knew how to identify adults and children at risk of or experiencing significant harm and worked with other agencies to protect them. They gave examples of when they had identified possible abuse and what action they had taken.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were policies in place for safeguarding children and adults which managers reviewed and updated regularly. The policies clearly set out safeguarding processes and signposted staff to internal safeguarding teams and local authority adult social care services.

We reviewed a sample of safeguarding referrals and saw good communication with local authorities. Staff worked with external agencies to identify and formulate action plans. Safeguarding advice was available from the quality team, and staff told us they provided them with appropriate support to follow up on issues of concern. The quality team had oversight of all safeguarding referrals and ensured new referrals were detailed and submitted in a timely manner.

Staff said they discussed any learning from safeguarding incidents during team meetings and handovers.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean. However, not all staff kept up to date with infection control training.

Staff had completed training in infection control and were aware of the protocols in place to keep patients, themselves and others protected from infection. At the time of inspection 87% of staff were up to date with infection prevention training. River team had the highest with 100%, with the Upton and Pershore team having the lowest at 70%.

Most hubs did not have clinic rooms or facilities to see patients on site. The Redditch and Bromsgrove hub had a clinic which was used for leg ulcer and blood transfusion care. This contained a couch, sink, pulse oximeter, and medication cupboard. We found this room to be well maintained and all equipment was cleaned to a high standard. Staff completed expiry checking of stock and kept a log to evidence this. Oxygen and a first aid kit were present and in order.

Staff followed infection control principles including the use of personal protective equipment (PPE). They told us they had adequate supplies of PPE. We observed staff wearing full PPE during home visits and within on-site clinics.

Managers had implemented measures at the time of COVID-19 to try limit the spread of infection, and some of these measures were still in place. For example, the Evesham community team had a one-way system in place within the hub. Staff entered and exited the hub through separate doors and washed their hands each time they did so.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment was labelled and cleaned appropriately. Clinic room equipment was portable appliance tested (PAT), and staff maintained clear records of this. Managers completed monthly audits to check the clinical environment, hand hygiene, and that staff were bare below the elbow.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.

The service had enough suitable equipment to help them to safely care for patients. The clinical nursing store was well stocked, with all equipment in date including swabs, dressings, and syringes.

Staff disposed of clinical waste safely and patients and carers were provided with appropriate bins in their homes. The clinic room had colour coded bins for general and clinical waste.

Community nursing staff said there were no problems getting equipment such as standard pressure relieving cushions, hospital style beds, pressure relieving mattresses and commodes in a timely manner.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. This included Waterlow scoring to calculate the risk of pressure ulcers developing.

Staff completed risk assessments for each patient following referral, and reviewed these regularly, including after any incident. Pressure ulcer assessments and checklists, clinical frailty scores, and nutrition and hydration assessments were present where appropriate within the records we reviewed. Staff knew about and dealt with any specific risk issues. Risks for the patient groups included pressure ulcers and risk of falls. Records showed that staff routinely ensured tissue viability input when needed and arranged mobility assessments and occupational therapy input when required. Staff were clear about the observations necessary and processes to follow to prevent patients developing sepsis, deep vein thrombosis, and pressure ulcers.

The service had 24-hour access to mental health liaison and specialist mental health support and staff told us they could contact the crisis and home treatment teams if they were concerned about a patient's mental health. At some hubs, mental health teams were located within the same building, which staff said made communication easier.

The service had lone working policies and guidelines. Staff were not routinely provided with lone worker alarms, but where risks had been identified prior to a visit, staff took appropriate measures including working in pairs, and alerting other staff of where they were. Managers monitored home visits and appointment timetables regularly and had good oversight of where staff were and how to ensure they were safe.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff referred patients to other health professionals when needed. We saw examples of patients being referred to their GPs for advice, as well as for urology, podiatry, dietitians, and psychology services.

Staff shared key information to keep patients safe when handing over their care to others. Teams held daily huddles which were attended by clinical and operation leads. We observed 3 handovers and saw that these gave clinicians the opportunity to discuss completed appointments, confirm whether care was undertaken as planned, or identify whether further action was needed.

Staffing

The service had enough staff with the right qualifications, skills, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Nevertheless, some staff told us that staffing capacity was sometimes an issue and said they worked hard to ensure urgent and non-urgent appointments were completed.

Managers accurately calculated and reviewed the number and grade of registered nurses and healthcare assistants needed for each shift in accordance with national guidance. The trust was working alongside a national strategy to develop safer staffing levels within community services. This included training all staff to assess the acuity and complexity of appointments and visits, and to plan these more effectively.

The number of registered nurses and healthcare assistants matched the planned numbers. Managers had some capacity to adjust staffing levels daily according to the needs of patients. Some hubs had multiple teams on site which meant they could provide cross cover if needed. There was a standardised system in place for prioritising home visits and appointments for patients. The service had some vacancies. At the time of inspection, an average of 11% of posts were vacant. The Cityside team had the highest with 20%. Upton and Pershore and Cityside were fully staffed and had no vacancies. The Redditch and Bromsgrove hub held large scale recruitment events which were widely advertised on social media and the NHS jobs website. They tried to hold these at flexible times, including at weekends to maximise interest in the events. The events were held as walk in sessions whereby potential employees could be interviewed on the day. Managers were able to make candidates conditional offers, subject to the appropriate employment checks and applications were then completed retrospectively. Leaders spoke positively about this and described how the Redditch and Bromsgrove hub had managed to fill 70 vacancies through these events. Due to their success, this was being rolled out across other hubs within the service and there were 2 further events planned for April 2023.

The service had seen a slight increase in average turnover in comparison to the previous 12 months. Average turnover was 18% as of January 2023 compared with 17% in February 2022. The Redditch neighbourhood team had the highest turnover at 33%, with Glades and EBBI neighbourhood teams having the lowest at 11%.

The service had low sickness rates. Data for the previous 12 months showed an average of 6.5% sickness. The Redditch neighbourhood team had the highest sickness rate, with an average of 14%, with the Forest neighbourhood team having the lowest at 3%.

The service had slightly increased levels of bank and agency nurses. Data showed that the number of hours worked by bank and agency nurses had increased from 3,104 hours in December 2022 to 3,407 hours in February 2023. Data also confirmed that bank and agency nursing assistant usage had increased from 1,277 hours in December 2022 to 1,382 hours in February 2023. However, the trust could not provide data to show the percentage of bank and agency staff used. This meant we could not compare the use of bank and agency staff with the use of regular staff employed by the trust.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Records were maintained electronically. All staff had tablets, so that they could record patient notes whilst out doing visits. Some staff described intermittent issues with IT connectivity, particularly whilst visiting patients living in rural areas. This sometimes meant that records did not update until they returned to the office.

We reviewed 21 sets of care records. We noted that all patients had risk assessments in place, and these were kept up to date. Care plans included wound and pressure area management, long and short-term condition management, medicines management and chronic disease management. Care records were clear, detailed, and person-centred with goals and actions, making them clear to staff who were not familiar with any patient.

Palliative care plans were detailed, clear and involved palliative end of life care for the holistic management of symptoms including bladder and bowel issues, pain, pressure areas, shortness of breath, poor sleep, and emotional support.

The electronic records system was shared across the organisation which meant when patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely, with all electronic devices encrypted and password protected.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. The service had a medicine management policy in place which was reviewed and updated regularly. Staff undertook training and competencies in prescribing or administering medicines according to their role.

Staff reviewed each patient's medicines regularly. Patients and carers we spoke with confirmed they were given advice and information about their medicines. Medicines records were accurate and up to date. Advanced Clinical Practitioners completed regular prescribing audits to check for medicine errors. Staff stored and managed all medicines and prescribing documents safely. All prescribers undertook supervision for prescribing medicines to ensure accuracy and compliance with guidance.

Staff learned from safety alerts and incidents, and data was collated and reviewed during monthly quality meetings to improve practice. This data included breakdowns of medicine error categories to enable staff to understand the reasons for errors and implement changes to reduce these.

Advanced Clinical Practitioner's prescribing data was collated and monitored by the medicines management team within the trust to ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. There was oversight of this data from pharmacists and senior managers. Prescribing competencies were also monitored during annual reviews.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Community health services for adults

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff received training on incident reporting during their induction. Staff we spoke with knew what incidents to report and how to report them. Managers had good oversight of incidents and kept a log of incidents which monitored incident type, causes, harm level, and action taken. These were discussed and reviewed during Integrated Community Services (ICS) Service Delivery Unit (SDU) Quality meetings, ICS Integrated Governance meetings and safety huddles.

There were no never events within the previous 12 months for the service. Managers received national alerts about never events that happened elsewhere and shared learning with staff through emails and handovers. Discussion with staff, and observation of staff handover meetings and patient records indicated that staff reported serious incidents clearly and in line with trust policy. Serious incident investigations were reviewed monthly by a serious incident panel. Managers reported notifiable incidents to the CQC as required. They investigated incidents thoroughly, using a root cause analysis approach, involving patients and their families in these investigations where possible. Staff confirmed that managers debriefed and supported them after any serious incident.

Staff understood the duty of candour. Records prompted staff to give patients and families a full explanation when things went wrong. We reviewed a sample of letters sent to patients and families and saw that these were comprehensive and set out what investigation the service had completed, and any learning that had been identified.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff received feedback from investigations of incidents during handover meetings, at team briefings and routine general nursing meetings, and were aware of learning from recent incidents. Staff described a positive learning culture, where it was safe to acknowledge when they had made a mistake and share learning about this with the team. Staff received feedback from investigation of incidents, both internal and external to the service.

Managers attended quality meetings where they reviewed the previous months incidents. Data for January 2023 confirmed a total of 369 reported incidents. The data categorised incidents into types and sub types which assisted managers to identify themes and trends. Most incidents reported related to pressure ulcer concerns.

Each team held regular meetings which had a quality slot where learning from incidents was discussed. Discussions with managers and staff confirmed that clinical leads within each team had good oversight of incident management and were responsible for disseminating and acting upon learning.

Staff met to discuss the feedback and look at improvements to patient care, and there was evidence that changes had been made as a result of feedback. For example, learning shared with staff from a recent incident identified that escalation of safeguarding concerns could have taken place quicker, and that documentation around carers and family contact needed to be more robust.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff followed National Institute for Health and Care Excellence (NICE) guidance and received regular bulletins and emails from managers providing updates. Organisational policies and procedures quoted NICE and other professional guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Occasionally staff visited mental health wards to treat leg ulcers or provide catheter treatment. Those staff we spoke with told us they could identify whether patients needed mental health support and could contact the trusts' crisis and home treatment teams if this was necessary.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. Staff followed a standardised format for home visits which comprised of 4 stages: situation, background, assessment, and recommendation (SBAR). This prompted staff to assess how patients were presenting and report any concerns with their psychological and emotional state. Clinical records in particular showed evidence that staff provided ongoing support for patients on palliative care who were struggling with their condition. Managers held periodic pressure ulcer incident panels (PURPs) whereby staff reviewed reported pressure ulcers and reviewed the needs of each patient. We reviewed meeting minutes for the previous 2 months and saw that staff had identified actions to take forward. This included reminding staff about escalation processes if equipment was not available and additional learning around Waterlow assessments. Learning from PURGs was disseminated via bulletins which managers shared with staff.

Pressure ulcers of grade 3 and above were reviewed by pressure ulcer review groups (PURGs). Staff complete serious incident investigations for grade 3 pressure ulcers and above during PURG group meetings, in line with NHS England guidance.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff used the Malnutrition Universal Screening Tool (MUST), a nationally recognised screening tool to monitor patients at risk of malnutrition. The records we reviewed showed that patients' nutritional needs were being met effectively.

We observed staff asking patients how much they had eaten and drank during visits and recording the responses. Catheter care plans included instructions to drink a specified amount of water daily, and to monitor bladder and bowel function daily.

Specialist support from staff, such as dietitians and speech and language therapists were available for patients who needed it. Staff contacted GP practices if these were required, and the GP then made the referrals.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff undertook pain assessments and pain management interventions during home visits and appointments. Patients told us that staff were quick to respond to requests for support with pain relief and consulted them about their preferences.

Care records showed that staff prescribed, administered, and recorded pain relief accurately. Patients received pain relief soon after requesting it and no patients reported delays in receiving this.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Managers and staff used results from audits to improve patients' outcomes. The service completed mortality reviews, which consisted of an audit of 5 sets of clinical notes in each team to measure the quality of clinical care prior to a patients' death. The mortality review checked whether staff recorded patient's do not attempt cardiopulmonary resuscitation (DNACPR) status, and whether Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms were present. The ReSPECT form creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. The mortality review also audited whether staff offered patients the appropriate emotional support, documented their views and wishes, and whether appropriate liaison with the palliative care team had taken place. Learning from the mortality review meant that managers could flag any concerns identified and share this with staff.

Information about the outcomes of people's care and treatment was routinely collected and monitored to improve patient care. Staff used outcome measures to monitor patient progress including pressure ulcer risk and nutrition scoring. Outcomes for patients were positive, consistent, and met national standards. This included measuring performance against the Adult Social Care Outcomes Framework (ASCOF). For example, the service monitored the proportion of patients over 65 who were still at home 91 days after discharge, with data showing this figure was at 85% as of December 2022.

The service worked within the NHS England 'ambitions for palliative and end of life care', a national framework to improve end of life care. Staff could describe how they adhered to this framework, for example, by ensuring patients had access to end-of-life medication to maximise comfort and wellbeing, and by seeking patients' individual wishes around their care.

The service participated in relevant national clinical audits. Each audit resulted in the development of an action plan which was monitored and reviewed by managers. Annual audits included clinical record keeping, safe and secure handling of medicines, and mental capacity audits. Malnutrition screening and leg wound audits were repeated quarterly. Managers used information from the audits to improve care and treatment. For example, following an intensive support audit, managers identified actions including the need for additional e-learning and potential improvements to care plan formats. Managers shared and made sure staff understood information from the audits through clinical governance meetings, the minutes of these meetings were shared with staff.

Community health services for adults

At the time of the inspection the open caseload for neighbourhood community teams was 18,677 patients. The Bromsgrove hub had the largest number of patients, with 1,300, with the Glades hub having the fewest at 577. Caseloads varied due to geographic locations and differing population densities between the hubs.

Competent staff

The service made sure staff were competent for their roles. Managers did not always appraise the work performance of staff and did not always hold supervision meetings with them to provide support and development.

Staff were experienced and qualified to meet the needs of patients. The service employed a range of registered nurses, healthcare assistants, occupational therapists, and physiotherapists. Those staff we spoke with were competent and knowledgeable.

The service had staff with diverse specialisms including specialist tissue viability and palliative care nurses. Specialist staff held study and training days at hubs and provided updates through link nurses. Managers and staff confirmed there were good pathways for career development for health care assistants and nurses to develop skills and progress to higher grades.

Staff were required to complete competency assessments in a number of relevant areas before undertaking tasks independently. This included intravenous therapy, wound care and leg ulcer management, compression care, catheter care, bowel management and venepuncture (to take blood samples). Manager kept and maintained a log of staff competencies and described how they arranged relevant training to increase the skillset of their staff. The competency log was used to inform the triage and planning of home visits and appointments to ensure that appropriately skilled clinicians attended.

Managers gave all new staff a full induction tailored to their role before they started work. The induction process provided a range of face to face and remote training sessions over a 12-week period. Staff shadowed appointments before being signed off for each clinical competency.

Annual appraisal compliance varied across the service. For example, 98% of staff within the Riverside, and Cityside teams had received an annual appraisal. For the Kingfisher team this was 95%. However, for other teams, compliance was much lower. The Forest team had a compliance of 70%, with Upton and Pershore and River teams having compliance of 67% and 66% respectively.

Managers did not always support staff to develop through regular, constructive clinical supervision of their work. Staff should have received non-clinical one to one sessions with their manager every 8 weeks and managers also held monthly group supervision for staff within each banding group. However, data provided by the trust showed that clinical supervision compliance was 65% at the time of the inspection. The Bromsgrove team had the lowest at 28%. The Nightingale team had compliance of 34%, and for Kingfisher team this was only 50%. The River team had the highest at 91%.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings included peer group supervision and case study discussions. We reviewed a sample of meeting minutes at the Evesham hub and saw these took place every 3 months and were well attended. Meetings followed standardised agendas, including discussions about staffing, incidents, and recent learning. Meeting minutes were available on shared drives and circulated to staff by email.

Staff told us they were supported to gain further qualifications relevant to their role. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Development opportunities were available for staff at all levels. Band 3 and 4 staff could complete 2-year apprenticeships to enable them to receive qualifications and progress through the pay bands. Development roles including trainee nurse associate, register nurse associate, community prescribing nurse, and district nurse specialist practitioner courses. There was also a business management course which staff could enrol in. Physiotherapy assistants could undertake a 4-year apprenticeship to training as physiotherapists and occupational therapy assistants could undertake a 2-year course to develop into assistant practitioners.

Managers identified poor staff performance promptly and supported staff to improve. Managers explained how they developed action plans to develop clinical skills. Managers also described how they referred staff with work related stress to the occupational health team and counselling services where needed. Managers regularly reviewed clinical records to assess the quality of clinical note taking and where necessary offered support to individual staff.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff we spoke with told us they worked effectively with acute hospital services, GP practices and other health and social care providers. They told us they were able to refer patients into secondary care when needed.

We found examples of effective multidisciplinary working both within and across teams. Staff we spoke with at all levels described good multidisciplinary working amongst colleagues and local health professionals including the local hospital. Handover meetings were held daily for each team, and we were able to attend 3 of these during the inspection. Each involved a clear detailed discussion of all patient visits completed that day including issues around wound management, skin integrity, pressure ulcers, medicines management, pain, and diabetes management. They also discussed issues relating to carers and family members supporting patients. Staff discussed liaison with other agencies including social workers, occupational therapists, dietitians, and GPs. We noted there was good discussion between the team members, who appeared confident in raising concerns.

Teams held weekly multidisciplinary meetings to discuss patients under the intensive support service. Teams usually had between 2 and 10 patients under this team. There were also monthly multidisciplinary meetings for complex patients requiring input from multiple services. This enabled staff from those services to collectively discuss patients physical, mental, and social care needs and to plan discharges or transfers of care effectively.

We reviewed 4 sets of multidisciplinary meeting minutes and found these demonstrated that staff communicated effectively and holistically with internal and external professionals about patients physical and mental health and wellbeing. Staff escalated areas of concern and ensured that relevant agencies were reviewing care.

Staff referred patients for mental health assessments when they showed signs of mental ill health. For example, in one record staff had identified a patient with a learning disability had a history of depression and that risk indicators were present. They had taken the appropriate action including making a referral to the social work team and developed an interim action plan to manage the patient's care.

Health promotion

Community health services for adults

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles. Clinical records showed evidence that staff offered high calorie food advice or support with diabetes management to those patients who required this.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

We requested mandatory training data from the trust, but they did not provide information about Mental Capacity Act compliance. However, the staff we spoke with had a good understanding of the Mental Capacity Act and the 5 principles. Clinical records showed that staff recorded patients' capacity status for specific decisions and there were detailed capacity assessments within records. This included assessing the capacity of carer or family understanding of being able to carry out caring responsibilities and taking action to support them with social needs if needed.

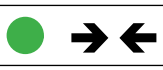
Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed there was evidence of patients being asked for verbal consent recorded in their care records and patients we spoke with confirmed this was the case.

Care records showed that when patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available and care records showed that staff explained different options and treatments to patients to enable them to do so.

Staff clearly recorded consent in the patients' records including when they sought the consent of patients ahead of each intervention. We saw good examples of this, with the reason for the visit and intervention explained clearly and recorded in patient notes.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act they knew who to contact for advice. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Good 

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

Compassionate care

Community health services for adults

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Feedback from people who used the service, and those close to them was overwhelmingly positive about the way staff treated people. We spoke with 27 patients and 8 relatives or carers of patients using the service. Without exception they told us that they could not fault the staff who were supporting them, and although they had a number of different staff visiting them, they were all excellent.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients told us that no matter how busy staff were, they made time to find out how they were, and how relatives or carers were managing.

Patients said staff treated them well and with kindness. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff followed trust policy to keep patient care and treatment confidential, checking with patients before sharing any details with their relatives.

People's emotional and social needs were seen as being as important as their physical needs. Community nurses involved patients in their care. They communicated well with them and provided them with clear information on how to manage their condition and options of treatments available. Patients and relatives told us staff answered all their questions, and if needed would ask another member of the team to telephone them to explain further.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients we spoke with said staff met their emotional needs by listening to them, by providing advice when required, and responding to their concerns. A relative told us staff went the extra mile by phoning to see how they were, on days that they were not visiting.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Patients and carers felt emotionally supported and reassured by the community nursing visits. Relatives of patients who receiving end of life care, spoke very positively of support provided by the community nurses in their relative's care.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients, families, and carers told us that staff talked to them in a way they could understand and used communication aids when necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service used the Friends and Family Test (FFT), a short, standardised service user experience survey, to collect patient experiences of care. This could be delivered in a range of formats designed to meet the needs of different patient and service user groups. Data generated from these surveys was disseminated to staff, managers and leaders. Paper questionnaires were the preferred option for most users of community nursing services, as we were told by staff that patients often fed back they did not know how to access the survey using the QR code. Staff told us the survey was becoming solely electronic to reduce paper usage. Nevertheless, results from the survey showed that staff continued to offer paper surveys to patients if this was appropriate.

The annual results for the FFT survey showed that 95% of those survey described care received as good or very good. 4% reported that care received was neither good nor poor, or said they did not know. Less than 1% of those surveyed gave poor feedback on the service.

Is the service responsive?

Good 

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

Service planning and delivery to meet the needs of the local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The service covered clusters of GP practices within the geographical area, using 12 community health teams, and other specialist services. Patients with complex needs were discussed between services and a coordinated multi-disciplinary plan of care was agreed.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff described how these contacts were easily accessible through the trust's switchboard. The service had systems to help care for patients in need of additional support or specialist intervention.

Managers monitored and took action to minimise missed appointments. The service had recently completed a quality impact assessment which analysed how prioritising urgent visits had an impact on planned visits. The findings of the assessment were that prioritising urgent appointments did not impact patient outcomes. For example, they told us that prioritising urgent care appointments did not result in an increase of pressure ulcer incidents, admission to general hospital or any other benchmark that would suggest an impact on care. Managers told us these were the initial findings from the assessment and they planned to complete the impact assessment again.

There were clear processes in place for the triage of urgent and planned work. Teams allocated a shift lead nurse who monitored appointments due that day and created actions, including re-arranging appointments if needed.

Managers ensured that patients who did not attend appointments were contacted, although staff said this was quite rare, as patients were mostly visited in their own homes and appointments were planned in advance.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There were learning disability nurses within teams, and staff completed appointments at learning disability care homes. Staff supported patients living with dementia and learning disabilities by using 'this is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment.

The service could arrange for information leaflets to be translated into languages spoken by patients in the local community. They could also arrange for staff, patients, and relatives or carers to have help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Any identified cultural needs were recorded in a patient's records as part of the care and treatment plan.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers monitored waiting times to try and ensure patients could access services when needed and received treatment within agreed timeframes and national targets. Urgent referrals had a 2- hour response time. Data for the previous 12 months showed that staff saw an average of 85% of patients with 2 hours.

For occupational therapy, the most recent data showed that 96% of patients were seen within the 18-week target. However, for physiotherapy only 74% were seen within 18 weeks, and only 48% of patients received a falls assessment within the 18-week target. We discussed this with managers during the inspection and they described how vacancies across teams had contributed to the delays.

There was a single point of access to the service. Triage arrangements were in place to ensure referrals were prioritised appropriately. Referrals were triaged immediately, and the workload allocated accordingly. The community nursing component prioritised patients on a daily basis, particularly those requiring time-sensitive medicines, and end of life care.

Appointments were flexible and staff worked around patients' requests and availability. This included facilitating evening visits where required. Night-time visits were in place for patients under the intensive support team, for example those patients who required support at bedtime or needed medication during the night.

Managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. The electronic triage system identified any appointments that needed rescheduling and prompted staff to do so. Nurses checked their caseloads regularly to ensure this had been actioned.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Care records showed evidence of discharge planning, including multi-agency working to plan packages of care. Some patients were discharged when they returned to clinical baselines, whereas others, often elderly patients or those on end-of-life care remained under the service until their death. Staff supported patients when they were referred or transferred between services. Where patients were discharged to care homes, staff arranged joint visits with carers.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Most patients, relatives and carers knew how to complain or raise concerns by telephone. Patients were given information on admission about the Patient Advice and Liaison Service (PALS) including a contact number if they wanted to make a complaint.

The staff we spoke with understood the policy on complaints and knew how to handle them. Staff could explain the stages of investigations into complaints including an initial acknowledgement, contact with the complainant, 'round table' meetings, and the development of an action plan.

Formal complaints were investigated by either clinical or operational leads from another team or other managers of that grade or above.

In the previous 12 months, a total of 14 complaints were received, of which 2 were upheld, 6 partially upheld, and 6 not upheld. We reviewed 3 complaints and saw these were investigated fully and that patients received feedback from managers after the investigation into their complaint. For example, one complaint included multiple concerns including appointment delays and pain relief management. The investigating officer wrote a detailed response to the patient outlining the outcome of investigation into each concern raised, whether each had been upheld, and any identified learning. The outcome was shared with the team and senior leaders and managers arranged a reflective session to the complaint.

Managers investigated complaints and identified themes. Complaints data was an agenda item at quality meetings. Managers shared feedback from complaints with staff and learning was used to improve the service. For example, one complaint highlighted communication difficulties between the urgent care response team and a GP practice during the weekend. Managers investigated this and raised it with the GP practice. This resulted in the development of a joint protocol to ensure effective communication.

Is the service well-led?

Requires Improvement 

Community health services for adults

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

All staff we spoke with said senior staff were very approachable. Local team leadership was effective, and staff said their direct line managers were supportive. We found staff were consistently positive, friendly, helpful and approachable.

Staff morale within the teams was generally good, despite staff describing having to work hard to meet appointment and home visit timescales. Some staff were less familiar with other members of the senior executive team, but most staff knew who they were.

Leaders had the skills, knowledge, and experience to perform their roles. They had the opportunity to complete a variety of leadership courses and training to help enable them to be effective. Managers received complaints management training to support them in the investigation and management of complex complaints. Managers were trained to complete mortality screening tools to enable them to complete in depth reviews of care and treatment received prior to a patient's death. There was also a business management course which managers could enrol in.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Herefordshire and Worcestershire Health and Care NHS Trust had a board of executive and non-executive directors who were accountable for setting the strategic direction of the trust.

The trust had a 3-year strategy in place which set out 5 key priorities to help deliver the vision. These included the improvement of health outcomes, reduction of inequalities, and working with partners to add value and collectively develop healthier, more inclusive communities. Managers were aware of and could access the strategy. They described the various workstreams that were ongoing to improve the quality of care delivered. Senior leaders delivered a weekly brief which included strategic updates.

The trust vision incorporated 5 trust values. We found that staff at all levels were able to describe these values and how they applied to their roles. Managers reviewed these values during appraisals and had discussions with staff about how they met these when carrying out their roles. Information about trust vision and values was on display at each of the teams we visited.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt respected, supported and valued. There was a strong culture of teamwork and a focus on improving patient outcomes, reducing hospital admissions and pressure ulcer incidents.

Staff told us they felt comfortable and able to raise concerns without fear. They knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian. Information about this was on display.

All staff we spoke with felt supported by colleagues and managers. They told us their teams would go above and beyond for patients, and they had room for professional growth.

Staff had access to equality, diversity and inclusion training and materials and felt that equality principles were promoted by the service and leaders in their actions and behaviours.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a system of governance meetings which enabled the escalation of information upwards and the cascading of information from the management team to frontline staff.

We looked at meeting minutes, including integrated governance, quality and team meetings. These were forums to review incidents, performance issues and planning, amongst other topics.

Frontline staff had daily handover meetings in the neighbourhood teams where all relevant safety information was shared with the teams, and these were supplemented by weekly briefings and team meetings. Staff told us they found team meetings useful as it was a means of keeping up to date with local and organisational matters. Staff were positive about team meetings and valued them as a source of feedback and the opportunity to discuss and escalate issues.

We were not assured that the governance process to support the monitoring of mandatory and statutory training was sufficient to monitor staff training compliance. The trust could not provide evidence during the inspection that staff had complied with Mental Capacity Act training. There was a lack of oversight of compliance with staff supervision and appraisals and a lack of improvement made to address physiotherapy and falls assessment wait times.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Although teams could not easily access the risk register. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Teams demonstrated good management of risk for their individual location and patient group. Frontline staff were aware of key risks and worked hard to ensure they prioritised the treatment of patients within urgent response teams. Areas of risk or concern were discussed during daily handover, multidisciplinary meetings, and team meetings.

We found team managers did not always have immediate access to the risk register, although they knew who to contact to access this and were able to do so quickly during the inspection.

The key risks described to us included waiting times for physiotherapy referrals, and a risk to service delivery due to workforce vacancies and new initiatives within the service which had increased demand. We reviewed the risk register and saw that the risks described by staff matched those on the risk register. Risk control measures were in place, which were reviewed regularly by senior managers. Managers we spoke with were very aware of these risks and could describe how they worked to minimise them as far as possible.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff showed us where they could find the provider's policies and procedures on the intranet. We reviewed information on the intranet and saw the information was clear and accessible. The intranet was available to all staff and contained links to current guidelines, policies, and procedures.

The service had recently changed electronic recording systems and staff described both positive and negatives impacts to this change. Whilst the new system meant staff created shared records with GP practices, staff told us it was challenging to obtain data or reports from the new system. For example, information breaking down individual caseloads by category or accessing waiting lists for falls assessment was not always readily available. To mitigate this, work was ongoing to train all staff to use the system in the same way, which managers said would enable useful data and reports to be collated. Regular process mapping meetings were taking place to standardise these processes and managers spoke positively about these.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Patients and carers had opportunities to give feedback on the service, although some patients, families and carers told us they found the electronic feedback survey difficult to use.

Staff, patients, and carers had access to up-to-date information about the work of the provider and the services they used through the intranet, bulletins and newsletters. Staff could meet with members of the provider's senior leadership team to give feedback.

Senior staff in neighbourhood teams told us that communication with staff was seen as a priority. A newsletter had helped to keep staff informed of what was happening across the organisation. Staff also had access to monthly broadcasts from the leadership team to keep them up to date with developments in the organisation.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Community health services for adults

We saw a range of quality improvement initiatives that were taking place across the service including a catheter project. This project involved senior community nurses reviewing the activity of the patients receiving catheter care and identifying reasons for any increased unexpected activity. The project aimed to implement more efficient monitoring of catheter care and enable staff to be more responsive to individual need. The project had seen an improvement in patient outcomes including a reduction of patient reported infections, and a reduction of unplanned visits.

Other recent projects included the introduction of a falls pathways group. This group worked with external services to look at collaborative working and the most efficient way of managing demand for patients who had called emergency services following a fall and agreeing individual and joint responsibilities. This work was ongoing, and managers told us they were confident this would have a positive impact on patient outcomes.

Staff were given time and support to consider opportunities for improvements and innovation and this led to changes. The service had recently created triage lead roles, which they felt had had a positive impact and created a consistent triage process across the service.

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

Requires Improvement ↑

Is the service safe?

Inadequate →←

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean care environments

Not all wards were safe, well equipped, well furnished, well maintained and fit for purpose. However, all wards were clean.

Safety of the ward layout

In three out of the four wards we inspected staff completed and regularly updated thorough risk assessments of all wards areas, and removed or reduced any risks they identified. On Mortimer ward we requested to see the environmental risk assessment, the ward manager and staff were not aware that an assessment was in place. However, the matron confirmed there was one in place. Not all staff with spoke with, on other wards knew about any potential ligature points. We were concerned that the staff were not aware of any environmental risks including any potential ligature points.

On Holt ward and Hadley ward staff could observe patients in all parts of the wards. Staff on Mortimer ward had a process in place to support nursing observations. Patients were supported with daily observations. Staff reported that reviewing and maintaining safe observations levels was a priority. We saw that curved mirrors were in place and closed-circuit television camera monitoring on the ground floor with an overview of the communal corridors and garden. We noted that there was no closed-circuit television camera monitoring on Mortimer Ward and the footage of the garden area was of poor quality. At Hillcrest Hospital it was not possible to observe all parts of the ward due to the size and layout of the building. The identified mitigation for these risks was 'closed circuit television' (CCTV), which is not an alternative to staff presence. CCTV monitors were based in the nursing office, where staff were not dedicated to observing. Staff must be present and directly monitor patients in high-risk areas. CCTV can only be used to augment, but never replace, monitoring. Mitigation for the risks identified would require additional staff observations both via mental health and zonal observations. However, Managers had identified there were still blind spots. We were told more cameras had been ordered to eliminate these areas and the hospital was awaiting delivery.

Whilst the layout of the wards within the service complied with guidance on mixed sex accommodation, staff did not comply with the same guidance as they did not sufficiently monitor and observe single sex spaces.

The layout of the wards had males and females with separate bedroom corridors and there were systems in place to ensure that these spaces were protected. All wards we visited followed guidance around same sex accommodation and had spaces set aside that were exclusively used by female patients.

Staff did not sufficiently monitor and observe single sex spaces. Due to the layout of Hillcrest ward, it could be difficult to manage the gender mix of the ward and ensure males and females did not enter each other's corridors and single sex spaces. When we visited the female ward area, we observed a male patient entering the female ward area, staff

intervened and escorted the male patient away. Staff told us during the early morning of our visit the same male patient had walked onto the female ward area. A male patient told us male and female patients usually walked around single sex spaces. We observed patients being unobserved for periods long enough to enable them to walk into single sex spaces.

Trust data for the previous 12 months showed there were no mixed sex accommodation breaches. This data was incorrect as CQC had been notified of a serious sexual harm incident in April 2023 where the police had been involved. The sexual safety policy was being reviewed by the sexual safety group. We were told a working draft would be available from 30 June 2023. At the 4 May 2023 inspection on Mortimer ward staff had still not ensured that the mixed sex ward was laid out, utilised, and monitored to mitigate associated risks and prevent sexual safety incidents. Following this inspection managers confirmed a review of patient observation levels for vulnerable sexually inappropriate patients by the 7 May 2023. We were told the policy for patient observations would be circulated to the ward teams and reviewed at the next team meeting to refresh staff knowledge and best practice, by 31 May 2023.

Whilst staff had taken action in some areas there were still potential ligature anchor points in the service. Mortimer ward had ligature environmental risk assessment included ligature points and remedial action taken. For example, patients' bedrooms were identified as high risk as some furniture items were not anti-ligature. Managers were not acting to minimise the risk. When reviewing the assessments, we found staff had not fully completed them, timescales had not been identified for the work to be completed, they lacked detail and had no review dates.

Staff had easy access to alarms and patients had easy access to nurse call systems. On all the wards we inspected we noted staff had easy access to alarms and patients had access to nurse call systems. When visitors attended the wards there were enough alarms for them to use.

Maintenance, cleanliness and infection control

Ward areas were clean, but not well maintained, well-furnished and fit for purpose. Hillcrest had damaged furniture and a broken television in the main lounge area. Mortimer ward was not well maintained and there were areas of damage throughout the ward. There was also a problem with the heating system which meant the male bedroom corridor was uncomfortably warm while the female corridor was uncomfortably cold. As a new unit was being built during our inspection, staff could not give us an indication of if and when repairs would take place.

At Mortimer Ward building work was ongoing just outside the hospital that was extremely loud which resulted in patients wearing ear defenders throughout the day. The work was part of the estates programme to eradicate dormitory accommodation.

On the 4 May 2023 during our visit to Mortimer ward we found the patient communal phone had been broken for one week and being repaired during our visit. Staff told us there were no hands-free phone available. On the men's side of Mortimer ward two men's stand-alone showers were out of order for over 7 weeks due to external guttering work. In the lounge the television was not working and not boxed in to hide brackets and cables for patient safety. This could be a potential ligature risk. In one bedroom the ensuite shower drain cover was broken and the extractor fan was excessively noisy. Outside another bedroom the nurse call bell point wire mesh cover was broken, sharp and protruding, this could have been a hazard to patients. These issues we raised were followed up by the ward manager and we were told all work was due to be completed by 15 May 2023.

On the female side of Mortimer ward, in the sitting area the main lights were not working. This had been reported numerous times but the ward manager had received no response from the estates department. The laminated

composite material around the patients' kitchen sink area was peeling off the wall. The water cooler in the lounge was leaking on the floor. Two accessible bathrooms were unavailable for use, and they were being used as storage rooms. We were told the kitchen was due to be fixed by 6 May 2023 and the ward manager ordered a new water cooler during our visit.

Staff made sure cleaning records were up-to-date and the premises were clean. We saw cleaning records that demonstrated that cleaning was undertaken regularly in all the wards we visited. We also observed cleaning and maintenance staff were available on the wards throughout the day at all sites we visited. At the 4 May 2023 CQC visit to Mortimer ward we saw the ward was exceptionally clean. A regular cleaning team worked across the week.

Staff followed infection control policy, including handwashing. There was clear guidance around the use of masks. Staff were required to wear masks at all times when in patient areas and we observed that staff complied with this throughout our inspection. Masks were available at the entrance to all wards and there were hand washing and sanitising stations available for staff to use when entering and exiting the ward areas. There was also signage to direct staff and visitors to wash their hands upon entering the wards.

Seclusion room

Mortimer ward and Hillcrest ward did not have seclusion rooms. Senior managers told us they felt they did not need seclusion and managed with de-escalation rooms, which were suitably furnished with sofas and safety pods.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. We found that clinic rooms were well equipped and had calibration stickers but did not have clean stickers on to direct staff when they needed to be cleaned. We found that fridge and room temperatures were monitored regularly, and records were kept in the clinic rooms to document checks.

Staff checked, maintained, and cleaned equipment. We saw that equipment was cleaned regularly by clinical staff and the rooms were part of the cleaning staff's responsibility. Cleaning records demonstrated that clinic rooms were cleaned regularly.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. We saw evidence in the rotas that Hillcrest, Holt ward and Mortimer ward ran under establishment levels on more than one occasion in all rotas we viewed. Establishment levels on both wards were for three qualified nurses on a day shift. We found in the period from 23 January 2023 to 19 February 2023 Hilcrest ward ran with one qualified nurse on nights on two occasions and two qualified nurses on the day shift once. Holt ward ran with two qualified nurses on the day shift once and Mortimer ward ran with only two qualified nurses on the day shift once.

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

Vacancy rates across all locations we inspected were high. All locations had an average vacancy rate of above 25% in the 12 months prior to our inspection with Holt ward having the highest average vacancy rate of 39.57%. There were periods throughout the year when Hillcrest ward and Holt ward reached vacancy rates of above 45% for a single month.

At the 4 May 2023 visit to Mortimer ward the ward manager told us they continued to have high staffing vacancies. The trust held a safe staffing review in April 2023 which led to an increase in registered nurses and healthcare assistants. Mortimer ward had 17 nurses, with 7 vacancies (41%) and 16 healthcare staff and 5.5 vacancies (34%). A recent nurse recruitment closed 15 May 2023. A second recruitment and retention event were planned. The ward manager told us they had already recruited 4 nurses to commence work September 2023. Development posts for nurses' band 5, 6 and 7 had been agreed and out to advertisement.

The service had high rates of usage of bank and agency nurses and nursing assistants. Agency and bank usage was consistently high across all services we inspected. Hillcrest ward had the highest use of bank and agency staff across all four services we inspected. This was due in part to raised levels of observations.

Following the 4 May 2023 visit to Mortimer ward we looked at the staff roster for 1 to 31 May 2023. We saw regular bank and agency nurses and healthcare assistants covered across day, night, and weekends shifts. Day shifts included 3 nurses and 4 health care assistants. Night shift included 1 nurse and 3 healthcare assistants. The first week in May 2023 the ward had maintained safe staffing levels. The second week in May 2023, day shifts were short staffed between 1 to 3 staff. One night-time staff was short on 13 May 2023. On the third week of May 2023 3 days out of 7 were short staffed on the day shifts, between 1 and 4 staff. On the fourth week 4 day shifts were short staffed with between 1 and 3 staff. On 27 May 2023, 1 night-time shift were 2 staff short.

We were told by managers we spoke with that where possible the service tried to use bank and agency staff who were familiar with the service. We also saw examples where agency staff were placed on long term contracts so that they could ensure that consistent approach.

Following the 4 May 2023 visit to Mortimer ward we looked at staffing data and saw continued high uses of bank and agency staff. However temporary staff were regular to the service. The number of shifts filled by bank and agency staff to cover sickness, absence or vacancies over a 12-month period from April 2022 to March 2023 overall average was 11%. From April 2022 to September 2022 the number of shifts filled by bank and agency was low between 5% to 6%. Between October 2022 to March 2023 this increased to between 11% to 13%.

The number of shifts not filled by bank and agency staff to cover sickness, absence or vacancies over a 12-month period April 2022 to March 2023 overall average 11%. From April 2022 to March 2023 the number of shifts not filled by bank and agency varied. The highest were in April and July 2022 at 14%. Between January to March 2023 varied between 7% to 8%.

Staff on Mortimer ward told us substantive staff worked mainly Monday to Friday day shifts and occasional night and weekend shifts. Regular bank and agency staff worked days, nights, and weekends. The ward manager arranged block bookings for agency staff for continuity and consistency.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. All bank and agency staff we spoke with told us they had received an induction prior to starting work in the service and that they understood the service and service user group before starting their shift. However, Mortimer ward we saw two induction checklists for temporary staff and students did not include information around ligature risks and anchor points.

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

The service had high turnover rates. All wards we inspected had turnover rates above 10% for most months in the year prior to our inspection. Hadley ward had the highest overall turnover rate at 24% and Holt ward had the lowest at 13%. The trusts target was 12%. Staff told us they were concerned about the high staff turnover rates and how this impacted patients. Some staff told us they were not taking regular breaks and felt fatigued. Staff told us they were not able to keep up with their work for example patient record keeping tasks. They frequently asked for support from other wards.

Levels of sickness were high across the service. Within the last year there was an upwards trend in sickness, the highest rate of sickness was on Mortimer ward, at its highest it was 21% against a trust target of 4%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift and adjusted staffing levels according to the needs of the patients. Staffing was calculated using a trust wide tool. All mangers told us they could adjust staffing levels depending on ward requirements without the need to seek permission from senior managers. The Mortimer ward manager said they could seek additional staff from the 2 acute wards on the Hereford hospital site.

Patients had regular one to one sessions with their named nurse. All patients we spoke with told us that they had regular time with their named nurses. We also saw good levels of interaction between patients and staff while we were on the ward.

Patients sometimes had their escorted leave or activities cancelled when the service was short staffed. Some patients informed us they had had leave cancelled or delayed due to a lack of staff.

Staff shared key information to keep patients safe when handing over their care to others. During the inspection we reviewed handover records and attended handover meetings which showed us that key information was handed over as required.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Medical cover was provided in line with trust policy. On the 4 May 2023 visit to Mortimer ward staff told us a senior manager, a consultant, a junior doctor were on call seven days a week.

Managers could call locums when they needed additional medical cover.

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

Mandatory training

Most staff had completed and kept up to date with their mandatory training. The trust had set a compliance target rate of 90%. There were 9 core mandatory training courses for example, infection control, fire safety, equality and diversity. For July, August, September 2023 training compliance rates were between 90 and 94%. Two training programmes were below the trust target, fire safety 70% and Mental Health Act 22% for unqualified staff, with an action plan in place to address Mental Health Act training.

The mandatory training programme did not meet all of the needs of patients and staff. We looked at the mandatory training calendar and the subjects covered for each employment profile was in line with best practice. The ward psychologist on Mortimer ward provided trauma informed care training for all staff and offered one to one and group

psychology each day. However, following the inspection the trust confirmed that sexual safety training was not in place. The trust was designing their own training package based on national standards. The planned launch would be September 2023 when it will be marked as essential training for adult inpatient wards. Managers also confirmed a plan of immediate action across the Mortimer ward with ongoing attendance for managers and deputies to attend trust monthly sexual safety planning meetings.

Managers had access to a dashboard which displayed individual staff training using a red, amber, green (RAG) rating. This meant that whist managers could easily monitor staff compliance with training, they had not acted when compliance with training had reduced for certain topics.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well or followed best practice in anticipating, de-escalating and managing challenging behaviour. **Staff did not always use restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.**

Assessment of patient risk

Staff did not always complete risk assessments for each patient on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. We found at Hillcrest ward these were not always completed fully. We found information missing and documentation was not always stored in the same place in the care record making it hard to find.

On the 4 May CQC visit to Mortimer ward we examined 8 risk assessments. We saw risk assessments were brief with information missing. Seven out of 8 patient risk assessments were completed prior to admission. One patient had been admitted on 21 April 2023, their risk assessments were updated the day of the CQC visit. The patient had been deemed sexually vulnerable with a history of previous abuse prior to their admission. This was not included in their risk assessment, or care record progress notes.

A second patient had been involved in a sexual safety incident on the 19 April 2023. Staff had not recorded this in the patient's crisis risk assessment or care record progress notes. Their risk assessment had not been updated since 14 February 2023.

A third patient told us they felt sexual harassment from other patients on the ward. This was not included in their risk assessment, care plan or care record progress notes or reflected in their observation levels.

We looked at the trust's policy for admissions to the service with no reference to providing single sex wards only for patients with known sexual abuse risk or sexual vulnerability.

Staff used a recognised risk assessment tool. Staff across the service used the Galatean Risk Screening Tool (GRiST).

Management of patient risk

Safety was not a sufficient priority. Staff did not always know about any risks to each patient and acted to prevent or reduce risks.

Staff did not manage sexual safety risks well. Patients on the wards did not always feel safe in relation to sexual safety. Staff and patients told us about examples of sexual safety incidents that they did not feel the ward team and managers had adequately responded to. This included incidents of sexually inappropriate behaviours, exposure, safeguarding concerns, and sexual disinhibition. Although these incidents were reported to registered staff, they were not always recorded on the incident system and staff did not always take action to respond and mitigate risks. In one case a patient had reported a sexual safety incident to the police as they did not feel staff had taken their concerns seriously. Staff had not developed robust risk management plans following this.

We spoke to managers about the incidents and were informed that staff had discussed and assessed the risks as low. However, we found limited recording in the care records of these discussions, associated decision making, and a lack of consideration of safeguarding in response to the incidents. Staff did not always update risk assessments and develop risk management plans following disclosure of sexual safety incidents.

Following on the 4 May 2023 visit to Mortimer ward managers provided a plan of immediate actions for Mortimer ward. We were told of plans that by the 7 May 2023 the deputy ward manager would set up a sexual safety notice board and would be completing sexual safety care plans for patients. Ward managers would review all patients' electronic records and update by the 9 May 2023, in line with trust's monthly quality metrics programme.

On the other wards we inspected staff we spoke with had good knowledge around patient risk and were able to talk us through individual prevention and reduction strategies.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff handed over when an individual's risk profile had changed however, we found that this information wasn't always updated in the patients care records in a timely way. On Hillcrest ward, risk assessments were not always being updated following an incident, and the patient's risk assessment was not being used as a live document. We reviewed 10 incident records on Hillcrest ward. Ten records showed that the GRiST had not been updated in a timely way post incident, with 5 records not updated at all. The remaining records had been updated between 2 days and just over 3 months post incident.

Observation and line of sight was good for all wards we inspected except at Hillcrest ward.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff told us during the patient's admission they would explain to patients on occasions they may need to search patients' bedrooms, belongings, and a list of restricted items and items of concern. We saw in the patient's welcome pack a list of prohibited items and information around searching patients.

Use of restrictive interventions

Levels of restrictive interventions. Overall, the service had 498 periods of restraint in the 6 month period of which 2 were prone restraints that were unavoidable. All restraints had been reviewed by staff external to the ward teams as per trust policy.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. There was a trust wide system of training and refresher training that used external providers to ensure that it met national guidance. However, in reviewing CCTV footage of 49 incidents on Hillcrest, we identified 3 incidents had

occurred that demonstrated techniques were used by staff that did not fall within approved techniques. During one incident staff could be seen using inappropriate holds on a patient. Managers were asked to review CCTV footage of the incident to observe areas of concern and identify required learning. The ward had reviewed the incident and had identified learning. They had also addressed the issue with the nursing agency staff involved.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. During our inspection we saw examples, in person and via CCTV review, of staff using de-escalation techniques and supportive interactions to avoid the use of physical restraint.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Training included theory sessions that equipped learners with knowledge of the Mental Capacity Act and how it applied to the use of restraint.

Staff followed NICE guidance when using rapid tranquilisation. Following the 4 May 2023 visit to Mortimer ward trust data showed in the previous 12 months there had been 27 incidents of rapid tranquilisation. A breakdown of information was not provided.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

Safeguarding

Not all staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. At the time of our inspection, the trust had met its own key performance indicators in relation to safeguarding training. All staff attended safeguarding training as part of their mandatory training. Healthcare assistants trained to safeguarding level two and qualified staff trained to level 3. Staff who had direct responsibility for managing or monitoring safeguarding were given training specific to their role.

Staff kept up to date with their safeguarding training, 90% of staff has been trained.

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

Staff followed clear procedures to keep children visiting the ward safe. Each ward we visited had designated visiting areas which meant that any children visiting the wards did not have access to the main ward areas.

Most of the staff knew how to make a safeguarding referral and who to inform if they had concerns. The majority of staff, apart from Mortimer ward staff we spoke with, could identify safeguarding leads and told us that they would feel comfortable to raise a safeguarding issue if one arose.

At the 4 May 2023 inspection 1 staff member told us they had reported sexual safety incident in April 2023 to qualified staff but told the incident did not need to be reported to safeguarding. In addition, staff told us about an incident late at

night before the 4 May 2023 visit when a male and female were found in the female lounge with the lights off kissing and cuddling, and staff intervened. We asked the ward manager to follow this up. Following our visit, the ward manager fed back earlier the same day the same male and female patients were seen cuddling in the garden courtyard. There was no update of action taken for both incidents in respect of safeguarding referrals.

Data provided by the trust between 14 August 2022 and 26 January 2023, for Mortimer ward showed there had been 4 sexual incidents with 3 patients on patient incidents and 1 involved 1 patient and staff member. It was unclear if staff were confident in how to recognise and report abuse to keep patients safe.

Managers took part in serious case reviews and made changes based on the outcomes. We saw examples of changes to working processes as a result of serious case reviews and incident reviews. There had been a number of changes to working practice as a result of our previous inspection at Hillcrest ward which all staff could talk us through.

Staff access to essential information

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

Patient notes were comprehensive and all staff could access them easily. Patient notes were held on a trust wide electronic system.

When patients transferred to a new team, there were no delays in staff accessing their records. If a patient transferred between services within the trust, staff on their new service could access their clinical notes immediately.

Records were stored securely. Only staff who required it had access to patients notes on the electronic system.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. These were in line with guidance set out by the National Institute of Health and Care Excellence (NICE).

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw evidence from minutes and patients notes that medicines were routinely discussed at multi-disciplinary team meetings and ward rounds. We observed one patient join the ward round and discussed their medication and physical health.

Staff completed medicines records accurately and kept them up to date. However, we found examples where medication charts did not contain information about a patient's legal status. Though this information was readily available in patients notes it is best practice that medication charts also hold this information.

Staff stored and managed all medicines and prescribing documents safely. In all clinic rooms we checked we found that medication was stored correctly and, where required, temperatures were monitored. A trust pharmacist regularly visited the ward weekly and audited medicine management.

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

Staff learned from safety alerts and incidents to improve practice. We saw that safety alerts were posted in clinic rooms on notice boards to ensure that staff that required it, had access to them.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We observed staff discussions at the ward around patients' behaviours and review of medicines. Systems were in place to monitor the use of medicines from feedback from patient's monthly feedback meetings, ward rounds, multidisciplinary meetings, and serious incidents.

We saw clinicians carried out medicine management audits in 2022 for example, prescribing high dose and combined antipsychotics on adult psychiatric wards, The use of melatonin and monitoring patients prescribed with lithium, with action plans shared.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. We observed staff discussions at the weekly ward round with the multidisciplinary team addressing patients' physical health care including fluid and food intake. Patients mental and physical health checks were carried out regularly and recorded, to ensure the medicines were safe and effective for them to take.

Track record on safety

The service did not have a good track record on safety.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff did not always recognise incidents to report and how to report them.

Staff did not always raise concerns and report incidents and near misses in line with trust policy. The trust provided a summary of all incidents, trends and themes within the monthly quality report for the service.

Following the 4 May 2023 visit to Mortimer ward we asked the trust for data around serious incidents in the previous 12 months. The trust provided some data from April 2022 to March 2023 and reported on incidents for March 2023 only.

Trust data for 1 March 2023 to 31 March 2023 across inpatient services showed the 4 most common types of incidents were self-harming behaviour, violence, abuse and harassment towards staff, medication and health and safety. The 4 incident types covered 81% of the total number of incidents.

Trust data for April 2022 to 31 March 2023 showed there were 210 incidents of harm on Mortimer ward but did not include a breakdown of types of incidents. The trust provided a breakdown of incidents for 1 March 2023 to 31 March 2023 with 4 incidents self of harming behaviour, 5 incidents of violence, abuse and harassment towards staff, 4 involved the same patient. There was one unexpected patient death in 2022.

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

Data showed in the previous 12 months there were 2 moderate incidents of harm related to COVID-19 infections, and 4 incidents of sexual safety for 3 patients and 1 incident patient to patient. The trust did not provide a breakdown in numbers of other incidents, or description types.

The service had no never events on any wards.

Staff understood the duty of candour. They gave patients and families a full explanation if and when things went wrong. We saw a number of examples where duty of candour had been applied. Ward managers responded to families around 3 incidents 1 patient death and two moderate harm incidents due to COVID-19 infections.

Managers reported that there were systems in place staff to be debriefed and supported staff after any serious incident. This included staff having access to psychology support. However, we were informed, by several members of staff that we spoke with, that the service had not been supportive after incidents and that staff felt that they had been left to deal with matters on their own. On Mortimer ward, the ward psychologist told us they looked at supporting staff wellbeing and circulated a short survey to find out what support staff preferred. Following this they introduced reflective practice, increased presence on the ward and availability for debriefs, but found staff had not taken up these opportunities.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. However, during the 4 May 2023 inspection we spoke with a carer who us they had been an incident and because past communications with staff had been unreliable the family preferred to speak via the Advocate.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw that staff received feedback from incidents through daily handovers, huddles, electronic communications “Focus on” cards, staff bulletins and email updates.

Staff met to discuss the feedback and look at improvements to patient care. All wards we visited had regular staff meetings and handovers where incidents were routinely discussed. However, the staff on Mortimer ward, told us team meetings were frequently cancelled.

There was evidence that changes had been made as a result of feedback. On Mortimer ward there was an unexpected patient death in 2022 there was shared learning with the ward manager who cascaded learning to the team and through group supervision. The shared learning included standard operating procedures, care planning and the involvement of the patients’ family or carers where consent had been given.

Managers shared learning with their staff about never events that happened elsewhere. The organisation shared trust wide information about incident reviews via emails which all full time staff had access to.

Is the service effective?

Requires Improvement 

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

Assessment of needs and planning of care

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

Staff did not always assess the physical and mental health of all patients on admission. They did not always develop individual care plans which were not always reviewed regularly through multidisciplinary discussion and updated as needed. Care plans did not always reflect patients' assessed needs, and were not personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. All patients had undergone a Galatean Risk and Safety Technology (GRiST) assessment included as part of their initial assessments upon entering the service, However, we found that not all GRiST assessments had been completed fully.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. All patients had undergone a physical health assessment as part of their initial assessment upon entering the service. Where required we found that patients with ongoing physical health challenges had a care plan in place related to these needs.

Staff did not always develop a comprehensive care plan for each patient that met their mental and physical health needs. We found that not all care plans were complete. Of the 27 care plans we checked across all wards we visited we found six records that had information missing, stored in the wrong place within the record or had assessments that had not been undertaken or reviewed.

Staff did not always review and update care plans when patients' needs changed. We found three examples where care plans had not been updated quickly when patients transferred between services.

Best practice in treatment and care

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

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

Staff delivered care in line with best practice and national guidance.

Staff identified patients' physical health needs and recorded them in their care plans. We found, in patients notes, that physical health assessments were undertaken upon admission and when required. Staff regularly updated these assessments when required.

Staff made sure patients had access to physical health care, including specialists as required. We saw in care plans that, where required, specialists had been identified in relation to individuals' physical health care needs.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. This included dietary needs linked to beliefs or culture. The wards also had access to dieticians to ensure that healthy diet plans were created as and when required.

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

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. These included Health of the Nation Outcome Scales (HoNOS) and The Model of Human Occupation Screening Tool (MOHOST).

Staff used technology to support patients.

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

Managers used results from audits to make improvements.

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included psychiatrists, psychologists and occupational therapists. We also saw that specialists were also available to attend multi-disciplinary team meetings.

Managers did not always ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. However, staff underwent an induction upon starting with the service and there was a complete mandatory training calendar in place.

Managers supported staff through regular, constructive appraisals of their work. Annual appraisals were in place and all wards we visited, accept Mortimer ward had met trust set key performance indicators of 95% compliance. Mortimer ward compliance was 80%, 4 staff had not had their appraisals completed.

Qualified nurses should have received regular monthly clinical supervision and care assistants should have received clinical supervision every 6 weeks. Though we were told that often there was not time to undertake clinical supervision on a one-to-one basis. However, substantive qualified staff member said they could not remember when they last received staff supervision. We asked the trust for staff supervision rates but did not receive any data.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We identified staff who had undertaken specific training that was linked to their personal development plans. We were told by staff the trust offered role specific training to staff as and when required.

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We attended a multidisciplinary team meeting during our inspection and found that staff discussed all points of care and all staff were actively involved in the discussions. Decisions made at the multidisciplinary team meeting were recorded and stored correctly and any actions resulting from the meetings were updated in patients care records.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We attended handover meetings which demonstrated that information was passed between shifts. This included any changes to patient care.

Ward teams had effective working relationships with other teams in the organisation and external teams and organisations.

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

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Training on the Mental Health Act and code of practice was included in staff mandatory training annually.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Each ward had an identified Mental Health Act lead and staff we spoke with knew who to contact to get support.

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

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. All organisational policies were store electronically and all staff had access to them.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Information about patient advocacy services were posted on notice boards in patient areas at all services we visited.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Patients care records demonstrated that patients' rights were read to them and that this was repeated as and when required.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Though we were told that there had been instances where this had not been possible due to a lack of staff.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

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

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. All documentation relating to patients care, apart from medication charts, was stored electronically and staff could access them when required. In the case of medication charts we found that, when required, relevant information relating to the Mental Health Act was attached.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

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

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

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Training in The Mental Capacity Act made up part of the mandatory training calendar and was refreshed annually. We did not receive this data.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. All organisational policies were stored electronically and staff could access them.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Each ward we visited had a safeguarding lead and staff could identify who this was and were able to access support as and when required.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. All staff we spoke to understood capacity and could talk us through how support should be offered.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We saw from patients notes that staff assessed capacity and updated records if and when there were changes.

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

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

Staff did not always treat patients with compassion and kindness or respect patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were not always discreet, respectful, and responsive when caring for patients. We saw incidents of inappropriate restraint when reviewing CCTV footage at Hillcrest. However, we did observe some positive interactions between staff and patients on all wards we visited. It was clear that staff had developed and were maintaining professional relationships with patients. Most patients we interviewed were very positive about the staff working on the wards. Some patients told us that they felt more comfortable with full time members of staff and that agency staff were sometimes more difficult to communicate to communicate with.

Staff gave patients help, emotional support and advice when they needed it. We saw staff supporting patients if they were upset or frustrated. Levels of interaction were high and the language used was very supportive. However, we reviewed CCTV footage where staff did not appropriately support patients when they became upset, or use de-escalation techniques effectively.

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

Staff directed patients to other services and supported them to access those services if they needed help. We saw that staff were encouraging of patients to access independent advocacy services for example.

Staff understood and respected the individual needs of each patient. Staff we spoke with could describe the individual needs and requirements of patients and had good knowledge of the patient group.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. All staff we spoke with told us that they would feel comfortable to raise any issues or concerns if they needed to.

Staff followed policy to keep patient information confidential.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff also provided patients with a welcome pack on admission that contained information about the service and local services the patient could access if required.

Staff involved patients and gave them access to their care planning and risk assessments. We saw from patients notes that they had been involved in the creation of their own care plans where possible.

Staff made sure patients understood their care and treatment. They took their time to explain their care in a way that helped them understand it and ask questions.

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

Patients could give feedback on the service and their treatment and staff supported them to do this. We saw that the wards held regular patients meetings where patients were encouraged to raise any concerns.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. All carers we spoke to told us that they felt included and involved.

Staff helped families to give feedback on the service.

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

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

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

The service had no/low out-of-area placements.

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

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

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. We saw from patients notes that, when a patient had been transferred between services there was a clear rationale.

Staff did not move or discharge patients at night or very early in the morning. Discharges always occurred between the hours of 9am and 5pm.

The PICU was in a central location within the trust footprint and there were beds available when we visited. Bed occupancy in the six months prior to our inspection showed that they were at 100% occupancy through November and December 2022 but below 90% occupancy for the other four months.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. We saw that patients all had their own bedrooms. We found that, due to the risks presented by the patient group, Hillcrest ward bedrooms contained very little furniture. This meant that patients were keeping personal property and clothing in bags or folded and stacked on a chair. It was difficult for staff to monitor the amount of property in patients' bedrooms and reviews had not been undertaken to ensure that bedroom spaces did not become overly cluttered.

Patients had a secure place to store personal possessions. All wards we visited had an area off the main ward that contained patients' lockers where they could securely store property. Patients did not have secure storage in their bedrooms.

Staff used a full range of rooms and equipment to support treatment and care. All wards we visited had a full range of rooms including rooms for occupational therapy, practice kitchens and rooms for activities.

The service had quiet areas and a room where patients could meet with visitors in private. All wards we visited had quiet rooms and rooms for visitors. We also found all wards we visited complied with guidance on mixed gender accommodation by providing rooms specifically for females to use if they required time in a female only space. However, this was not always maintained in practice by staff.

Patients could make phone calls in private. Patients were able to access their own mobile telephones and, if they did not have one, staff could arrange for patients to make telephone calls in private.

The service had an outside space that patients could access easily. All wards we visited had outside space that patients could use. At Hillcrest ward there was work ongoing in the outside areas to ensure that it was fit for purpose. At Mortimer

ward work was underway to build a new unit. The outside areas had a low fence at the perimeter which meant that patients could access the building site if they were to go over the fence. This was pointed out to the ward manager at the time of our inspection. Although we acknowledge that there had not been any incidents of this happening prior to our inspection.

Patients could make their own hot drinks and snacks and were not dependent on staff. Except on Hillcrest ward where we found that, due to an ongoing risk, the room containing access to hot water was locked and patients had to ask a member of staff to open it for them if they wanted a hot drink.

The service offered a variety of good quality food.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients.

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

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

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Areas had been identified on all wards that had increased access for disabled people and there was access to a range of other support, for example sign language interpreters.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. All wards we visited contained notice boards in the patient areas that contained lots of information from how to make a complaint to accessing local services. Patients were also given a welcome pack on admission that contained similar information.

The service had information leaflets available in languages spoken by the patients and local community. All of the documents we saw were printed in English, but we were informed by staff that they were available in other languages and easy read if required.

Managers made sure staff and patients could get help from interpreters or signers when needed. The trust had a contract with an interpreter agency and had had access to sign language interpreters if required.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

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

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

Patients, relatives and carers knew how to complain or raise concerns. Data provided by the trust showed us that there had been 24 complaints made about the service in the 12 months prior to our inspection. 21 were not upheld and 3 were partially upheld.

The service clearly displayed information about how to raise a concern in patient areas. We saw the information in notice boards.

Staff understood the policy on complaints and knew how to handle them and how to acknowledge complaints. They ensured that patients received feedback from managers after the investigation into their complaint. We saw examples of duty of candour in the trust's responses to patients after complaints or when things had gone wrong.

Managers investigated complaints and identified themes.

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

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

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints was shared with staff at staff meetings as a standing agenda item.

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

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Not all leaders had the skills, knowledge and experience to perform their roles. They did not always have a good understanding of the services they managed. They were visible in the service and approachable for patients and staff.

Staff told us they could identify senior leaders within the trust and that they were visible. Staff told us that, at a local level leadership was visible on the wards and that mangers were helpful and approachable. The staff survey had identified training needs for managers and leaders and this work was ongoing.

Managers received training which was specific to their role and had the experience and knowledge for them to be able to be effective.

Managers had access to a dashboard which contained all the information they needed to maintain a detailed understanding of the service. This included information about incidents, training and supervision, staffing and bed management.

Not all managers could locate information, including on the managers dashboard. In addition, we saw a lack of leadership. One manager did not have the experience of the service they delivered or capability to lead effectively. For example, they were not confident in managing gender separation on a mixed sex ward. One staff member had escalated concerns about leadership on Mortimer ward.

Vision and strategy

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

Managers we spoke with knew and understood the visions and values of the trust and were able to talk with inspectors about how they promoted these values throughout their staff groups. We saw the providers vision and values were on display in reception and Stonebow Unit waiting areas.

Culture

Staff did not consistently feel respected, supported and valued. However, they said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Comment referring to Ardliegh staff removed

Some staff told us that they felt valued and respected, however we did talk to a number of staff who did not feel that managers listened to them. We were told when staff were away from the service through either illness or injury, managers did not maintain contact with them or check in to see how they were doing.

We were also told by some agency staff they felt that senior staff had not made an effort to get to know them even though they were doing a lot of shifts on the wards. They felt they were not treated as a part of the nursing team.

On Mortimer ward not all staff felt empowered and supported. Staff satisfaction was mixed. Staff frequently said they were "firefighting" (a phrase they used to describe the fast pace of work and challenges of patient acuity on the ward). The ward manager told us staff regularly came onto the ward tearful and overwhelmed with work and were not always taking regular breaks. Most staff had a good understanding of the service they provided and felt they could raise concerns.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level across the service and that performance and risks had not been managed well.

Whilst environmental audits had been completed, managers had not ensured that staff were aware of potential risk areas within the service and that they understood what mitigation was in place. In addition, there were no processes on place to ensure that wards and furniture were well maintained.

Managers did not have a system in place for the oversight of patients care records. As we found that not all patients had fully completed risk assessments.

Although there was a training dashboard for managers to monitor staff compliance with mandatory training it was not being used effectively. We found that two training session were below the trust target.

We requested data following the inspection. Whilst we received the information it did not include a breakdown of it. There for we could not be sure that manages across the service had access to the correct information to make positive changes for people that received care particularly around incidents.

We were concerned that we had not received information in relation the managers oversight of compliance with clinical supervision, even though we had requested.

Managers did not have systems in place to ensure that Mortimer ward complied with guidance for mixed sex accommodation. Managers did not ensure that patient felt safe in relation to sexual safety and that staff sufficiently monitored and observed single sex spaces.

Management of risk, issues and performance

Some teams had access to the information they needed to provide safe and effective care and used that information to good effect. Whilst some teams management of risk was positive other teams risk was not well managed.

Leaders and teams used systems to manage performance effectively, although on Mortimer ward this was not the case as outlined in other key questions. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. All services we visited had regular staff meetings, with the exception of Mortimer ward; staff development days to ensure that all staff had updated knowledge to undertake their role.

We found on 4 May 2023 CQC visit to Mortimer ward that managers had not dealt risks and issues appropriately. They had not ensured that staff were not aware of the ward environmental risk assessment. This meant staff did not know about any potential ligature anchor points or had mitigated the risks to keep patients safe.

We were not assured that managers on Mortimer ward had reported risk incidents in relation to sexual safety. The trust told us there had been no mixed sex accommodation breaches. We were told of 1 incident the night before our visit where a male was found in the female lounge at night with the light off. Following our visit managers provided a plan of action for sexual safety on the ward.

Across the service managers had not ensure that staff had assessed, monitored or managed risks well to patients who use the services. Patients risk assessments were not all complete or updated regularly including after an incident.

Managers had not ensured that staff managed sexual safety risks well. There were low numbers of safeguarding referrals, restraint incidents. It was unclear if staff were confident in how to recognise and report abuse to keep patients safe. Incident reporting were vague, and it was uncertain if staff recognised incidents and reported appropriately.

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

Information management

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

The trust collected data and analysed it. However, not all managers had access to it in order to take action improve outcomes and performance. Some trust incident reporting, restraint, safeguarding referral data were unreliable, did not provide a breakdown and showed inconsistencies and anomalies.

Engagement

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

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw high levels of patient and carer engagement throughout our inspection from staff and managers. We were told by patients and carers that we interviewed that staff were considerate and helpful. They also stated that they would be confident to contact the mangers to give feedback about the service.

However, following the 4 May CQC visit to Mortimer ward we spoke with one patient's family member. They told us engagement with staff on the ward were difficult, they were not invited to multidisciplinary meetings, staff did not always return their telephone calls, they were not consulted or asked for feedback.

Learning, continuous improvement and innovation

Managers of the service described to us at inspection that learning from concerns and complaints was difficult until the team were stable and there was a substantive team in place. They described that ongoing work to improve communication around learning was needed. Managers also described how they had links with other organisations to learn how sexual safety was managed to see if anything could be implemented in this service. We heard from senior leaders that a new management team were brought in to address concerns in the service.

Herefordshire Council

Title of report: Work programme 2024/5

Meeting: Health, Care and Wellbeing Scrutiny Committee

Meeting date: 25 March 2024

Report by: Statutory Scrutiny Officer

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose

To consider the draft work programme for the Health, Care and Wellbeing Scrutiny Committee for the municipal year 2024/25.

Recommendation(s)

That:

a) The committee agree the draft work programme, which will be subject to periodical reviews, as the basis of their primary focus for the municipal year.

Alternative options

1. The committee could decline to agree a work programme for its future committee meetings. This would likely result in unstructured and purposeless meetings.

2. The committee could also decline to determine who they would like to invite to participate in meetings, or which evidence they wish to receive in advance of the meeting. This would likely result in an inefficient use of their committee time.

Key considerations

3. A fundamental part of good scrutiny is planning and agreeing a programme of work for the committee to undertake. A well-considered work programme:

    a. identifies priorities for the committee's work that align with corporate and partnership priorities, as well as reflecting community concern;

b. ensures that each identified topic has clear objectives that focus the committee's work;

c. creates a timetable for the committee's programme of work so that the committee carry out its work at the optimal time; and

d. provides officers and partners with requirements for evidence that will support the committee in providing evidence-based scrutiny.

Community impact

4. Effective scrutiny enables the committee to reflect community concern, one of the four purposes of scrutiny as outlined by the Centre for Governance and Scrutiny.

Environmental impact

5. This report contains no direct environmental impacts. However the work that the committee will undertake resulting from agreeing this work programme may have direct impacts. Reports arising from or supporting this work will outline their potential environmental impact.

Equality duty

6. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services. This report contains no direct equality impacts. However the reports and issues that the committee will consider may have direct impacts. Reports arising from or supporting this work will outline any associated equality impacts for committee consideration.

Resource implications

7. This report constitutes part of the typical function of this committee. Similarly, a programme of work undertaken by committee is an integral part of the council's 'business as usual'. There is no resource implication in setting or agreeing a work programme. However agreed topics in the work programme, in particular any requests for bespoke research or the involvement of outside experts or community groups, may incur resource costs. These will be contained in any reporting or planning of agreed topics within this work programme.

Legal implications

8. The remit of the scrutiny committee is set out in part 3 section 4 of the constitution and the role of the scrutiny committee is set out in part 2 article 6 of the constitution.

9. The Local Government Act 2000 requires the council to deliver the scrutiny function.

Risk management

10. There are no risks identified in the committee agreeing an effective and timely programme of work. However, there is a risk to the council's reputation if committees fail to set a work programme, or set a programme of work that does not address local authority, partnership or community priorities.

Consultees

11. In drafting this work programme, consideration has been given to:

a. The previous work of the Health, Care and Wellbeing Scrutiny Committee;

b. Priorities suggested by members of the committee; and

c. Herefordshire Council officers

12. This work programme is subject to ongoing review, which may involve additional consultees.

Appendices

Appendix 1 - Health, Care and Wellbeing Scrutiny Committee draft work programme 2024/25

Background papers

None.

25 March 2024, agenda publication 15 March 2024

Topic and Objectives	Evidence required	Attendees*
Update on outcomes of Care Quality Commission Inspection of Herefordshire and Worcestershire Health and Care NHS Trust o Scrutinise the CQC inspection report and progress on delivering the action points in response to the inspection report.	CQC Inspection report Committee background briefing	NHS Trust • Director of Strategy and Partnerships • Director of Finance and interim CEO • Director of Nursing • Associate Director Comms
Work programme o Review work programme		• Statutory Scrutiny Officer

20 May 2024, agenda publication 10 May 2024

Topic and Objectives	Evidence required	Attendees*
Care Quality Commission Inspection of Wye Valley NHS Trust – The County Hospital o Scrutinise the CQC inspection report	CQC Inspection report Committee background briefing	NHS Trust - Managing Director - Head of Nursing
Work programme o Review work programme		• Statutory Scrutiny Officer

29 July 2024, agenda publication 19 July 2024

Topic and Objectives	Evidence required	Attendees*
Supported housing for working age adults with additional needs o How do we forecast, commission and meet the housing needs of adults with a learning or with a severe and enduring mental health problem? o How do we work with developers to provide the required housing?		• Service Director – All Ages Commissioning • Head of Housing

Supporting care leavers ○ How do we identify and meet the housing and support needs of care leavers? ○ How do we ensure that the council's looked-after children leave its care with good life skills? ○ Where needed, how does the council ensure a smooth transition from children's to adults services?		• Head of Service, Corporate Parenting • Service Director – All Ages Commissioning • Head of Community Commissioning
Work programme ○ Review work programme		• Statutory Scrutiny Officer

30 September 2024, agenda publication 20 September 2024

Topic and Objectives	Evidence required	Attendees*
West Mercia Police "Most Appropriate Agency" policy ○ Scrutinise the impact of the change in West Mercia policy regarding responses to welfare, mental health incidents and missing persons. ○ Further scrutinise the effectiveness of the council response to the policy	West Mercia Police "Most Appropriate Agency" policy Herefordshire Council policy	• West Mercia Police • Service Director – Social Care Delivery
Work programme ○ Review work programme		• Statutory Scrutiny Officer

*The Corporate Director, Community Wellbeing and Cabinet Member Adults, Health and Wellbeing, both have a standing invitation to the meeting.

Long list items

- Technology Enabled Living
- Discharge to Assess, in partnership with Hoople Cares and Wye Valley NHS Trust
- The development of a Homeshare model in Herefordshire
- Informal discussions with care providers to discuss challenges and opportunities
- Task and finish group terms of reference: home care solutions