Good

Birmingham and Solihull Mental Health Foundation Trust

Adult Community-Based Services

Quality Report

50 Summer Hill Road
Birmingham
B1 3RB
Tel: 0121 301 2000
Website: www.bsmhft.nhs.uk

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Trust Headquarters	RXTC1	Zinnia community mental health team	B11 4HL
Trust Headquarters	RXTC1	Handsworth community mental health team Ladywood community mental health team Aston and Nechells community mental health team	B19 1BP
Trust Headquarters	RXTC1	Erdington community mental health team Kingstanding community mental health team	B23 6DW
Trust Headquarters	RXTC1	Newington community mental health team	B37 7RW

Summary of findings

Trust Headquarters	RXTC1	Lyndon community mental health team	B92 8PW
Trust Headquarters	RXTC1	Early intervention service East community team Early intervention service North community team Early detection intervention and treatment community team	B6 4NF
Trust Headquarters	RXTC1	Youth clinical support team Leaving care community team	B6 4NF

This report describes our judgement of the quality of care provided within this core service by Birmingham and Solihull Mental Health Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Birmingham and Solihull Mental Health Foundation Trust and these are brought together to inform our overall judgement of Birmingham and Solihull Mental Health Foundation Trust.

Summary of findings

Ratings

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

Overall rating for Adult community-based services	Good
Are Adult community-based services safe?	Good
Are Adult community-based services caring?	Good
Are Adult community-based services effective?	Good
Are Adult community-based services responsive?	Good
Are Adult community-based services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Birmingham and Solihull Mental Health Foundation Trust provides services to support people with a range of mental health needs. These included: the community mental health teams, early intervention service, early detection and intervention team, youth clinical support team and the leaving care community team.

This service was safe. There were strong safeguarding and incident reporting mechanisms in place. Some teams could also access safety information through the care first service and RiO (the electronic patient records system). In addition, we saw that risk assessments and care plans were updated and reviewed on RiO. However, the new single point of access service reported that there were some issues with the service's capacity.

The service was effective. The care and treatment records that we saw for people under a Community Treatment Order (CTO) were comprehensive. They showed that people were involved in their care and that the records were reviewed by the multidisciplinary team. People received a comprehensive assessment by medical and nursing staff on initial contact with the service. However, the trust needed to make improvements in the youth clinical support team to make sure that shared care arrangements were in place with GPs. There was a good range of evidence-based psychological therapies offered by other community teams. The managers undertook audits of the service and fed the results into the trust's management teams. People were complimentary about the teams and valued the service they received.

The services provided were caring. People told us that they were treated with dignity and respect. We found that staff were skilled and knowledgeable, and that the language they used was compassionate, clear and simple. People who used the services had access to appropriate literature and information. Staff also provided support for social and domestic issues where there were gaps in community resources.

The service was responsive. Community teams met the needs of people who required urgent care out-of-hours. While we saw that there were waiting lists, these were small and well managed. Services had been developed in consultation with local people. In most cases, people accessed services at the team base. People knew how to access help out-of-hours. During our visit, we observed teams working well together and examples of good working relationships.

The service was well led. Staff were dedicated and felt well supported by their managers. Some staff told us that they were able to go to consultation meetings about the service improvement plan. These events, and the examples of team and management meetings that we saw, demonstrated to us that staff were consulted about the trust's future plans. The trust's intranet was also updated as the plans changed. We saw that there was a supportive culture within teams. A trust-wide risk register was in place to monitor and identify risks to the trust, staff and people using the services. Staff were regularly supervised and knew how to access advocacy services for people.

Summary of findings

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

Are services safe?

Good

This service was safe. There were strong safeguarding and incident reporting mechanisms in place. Some teams could also access safety information through the care first service and RiO (the electronic patient records system). In addition, we saw that risk assessments and care plans were updated and reviewed on RiO. However, the new single point of access service reported that there were some issues with the service's capacity.

Are services effective?

Good

The care and treatment records that we saw for people under a Community Treatment Order (CTO) were comprehensive. They showed that people were involved in their care and that the records were reviewed by the multidisciplinary team. People received a comprehensive assessment by medical and nursing staff on initial contact with the service. People who attended clinics for long-acting intramuscular injections and blood monitoring had their physical health routinely checked. However, the trust needed to make improvements in the youth clinical support team to make sure that shared care arrangements were in place with GPs. There was a good range of evidence-based psychological therapies offered by the community teams. Staff were also encouraged to undertake further training and qualifications. The trust sought feedback from people using services on a regular basis and results of the managers' audits were fed into the trust's management teams. Managers also monitored caseloads and capacity through supervising staff on a monthly basis. The trust had established induction and supervision systems for new staff.

Are services caring?

Good

The services provided were caring. People told us that they were treated with dignity and respect. We found that staff were skilled and knowledgeable, and that the language they used was compassionate, clear and simple. People who used the services had access to appropriate literature and information. Staff also provided support for social and domestic issues where there were gaps in community resources.

Are services responsive to people's needs?

Good

Community teams had access to people's preferences for people needing urgent care out-of-hours. While we saw that there were waiting lists, these were small and well managed. Services had been developed in consultation with local people. In most cases, people accessed services at the team base. People also knew how to access help out-of-hours. During our visit, we observed teams working well

Summary of findings

together and we saw examples of good working relationships. We also saw evidence of trust-wide learning from complaints and incidents. The teams talked to the crisis team about people that they were particularly concerned about, and made sure that information was available if the crisis team was contacted by them out-of-hours from them. People needing urgent assessment were directed to use the bed management team who acted as a triage and access to crisis services.

Are services well-led?

Good

Staff were dedicated and felt well supported by their managers. Some staff told us that they were able to go to consultation meetings about the service improvement plan. These events, and the examples of team and management meetings that we saw, demonstrated to us that staff were consulted about the trust's future plans. The trust's intranet was also updated as the plans changed.

At a local level, we saw that audits of records were completed for the Care Programme Approach (CPA). Staff said that managers could monitor and review these electronically. In addition, staff training was up-to-date and monitored regularly. A trust-wide risk register was in place to monitor and identify risks to the trust, staff and people using the services. Staff were regularly supervised and knew how to access advocacy services. People were regularly asked for their comments and opinions about the service provided.

Summary of findings

Background to the service

Community mental health teams

These services work with people with a wide range of mental health difficulties and help people to cope with periods of mental illness and severe distress. They offer support to people with a GP who need short-term intervention, as well as people who need longer term care plans. The service is available to people aged 18 to 64 years.

Early intervention service and early detection and intervention team

The early intervention service supports people aged 14 to 35 years who have had a first episode of psychosis, or previously untreated psychosis which lasted less than a year.

The early detection and intervention team (EDIT) teams offer a tertiary service to young people aged 16 to 35 years who are in distress and considered at ultra-high risk of developing a first episode of psychosis.

The services aim to prevent or delay the onset of psychosis and reduce the duration of untreated psychosis across Birmingham. The teams we visited were based at Miller Street, Newton.

Youth clinical support team

The service is available to people aged 16 and 17 years old who are (or are entitled to be) registered with Birmingham GPs and who have severe and persistent mental disorders that are associated with significant disability.

Leaving care community team

This service supports young people aged 18 years and over, and their families, in planning for their care and support needs. The service works alongside young people's social workers to advise them on what is available and then will be introduced to the young person in order to take responsibility for support to them when they reach 18. The team we visited were based at Miller Street, Newton.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Care Quality Commission (CQC)

The team that inspected these services included: a CQC inspector, Mental Health Act commissioners, nurses, social workers and an Expert by Experience who was a person who had previously used mental health services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health inspection programme.

How we carried out this inspection

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

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

Summary of findings

We carried out unannounced visits to the adult community-based service from 13 to 15 May 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.

During our inspection, we visited the teams' bases and held focus groups with a range of staff who worked within the service, including nurses, doctors and therapists. We observed how people were being cared and reviewed their care and treatment records. We also met and spoke with people who used services who shared their views and experiences of the core service.

Birmingham and Solihull Mental Health Foundation Trust provides four early intervention service teams. We reviewed and inspected the east and north early intervention service community teams. The trust also provides a youth clinical support team and leaving care community team, which we visited. These were based at Good Hope Hospital where the north early intervention team was based.

What people who use the provider's services say

People told us that they received compassionate and professional care from staff. They told us they were involved in the planning and treatment of their care. They could consent to their care and treatment, as well as discuss and agree treatment options with medical staff.

We saw examples of how people were consulted and we saw that the outcomes of surveys about the services provided were displayed for people to see. We saw that there was a high satisfaction rate with the services delivered.

Good practice

- Non-medical prescribing leads were in place for prompt assessment and treatment.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure that improvements are made to demonstrate that the teams and the pharmacy audited the stocks of medicines given to people, so that they are stored safely at all times and that appropriate stocks of medicines are stored on site.
- The trust should work closely with commissioners to make sure that there are shared care arrangements with GPs in the youth clinical support team.

Birmingham and Solihull Mental Health Foundation Trust

Adult Community-Based Services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Zinnia community mental health team	Trust Headquarters
Handsworth Community mental health team Ladywood community mental health team Aston and Nechells community mental health team	Trust Headquarters
Erdington community mental health team Kingstanding community mental health team	Trust Headquarters
Newington community mental health team	Trust Headquarters
Lyndon community mental health team	Trust Headquarters
Early intervention service East community team Early intervention service North community team Early detection intervention and treatment community team	Trust Headquarters
Youth clinical support team Leaving care community team	Trust Headquarters

Detailed findings

Mental Health Act responsibilities

We saw information about the MHA was available in areas that people accessed. We saw this was made available in different languages and an interpreter service was available to people.

Records we looked at for people under a Community Treatment Order (CTO) were comprehensive with evidence of people's involvement and multi-disciplinary review. The records seen showed us that staff had received training in this Act.

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

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were aware of their responsibilities under the Mental Capacity Act and were able to demonstrate through some of the treatment records seen, how they recognised, responded and raised issues about mental capacity. The records seen showed us that staff had received training in this Act.

Good

Are services safe?

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

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

Summary of findings

This service was safe. There were strong safeguarding and incident reporting mechanisms in place. Some teams could also access safety information through the care first service and RiO (the electronic patient records system). In addition, we saw that risk assessments and care plans were updated and reviewed on RiO. However, the new single point of access service reported that there were some issues with the service's capacity.

Our findings

Trust Headquarters Community Mental Health Teams

Track record on safety

Staff were trained in safeguarding vulnerable adults and children. Staff were knowledgeable about their responsibilities in regards to safeguarding. They described the process for referring any identified potential or actual concerns to the relevant department. The trust policies and procedures were accessible on the trust's own intranet site. Some staff gave examples of safeguarding concerns they had reported and described the process for completing this. They told us concerns were discussed with line managers where appropriate in the first instance. Safeguarding referrals were made to Birmingham City Council. We noted that in the City of Birmingham teams the local authority had removed the social care staff they employed from the community mental health teams. Some teams still had social workers who were team managers. Staff said this had not impacted upon the safeguarding referrals the teams made, but there were concerns over the delays in receiving a response form the City Council about safeguarding referrals made being acknowledged and resources allocated. We were not told about any individual risks to patients as a result. In Solihull the social care staff had remained within teams and took the lead in safeguarding as well as contributing to the duty system. Staff told us they valued the input from their social care partners as this provided a balanced and cohesive working partnership.

Staff confirmed that the trust had an on-line reporting system to report and record incidents and near misses. We saw that staff had access to this system via 'password' protected computers. The trust wide evidence provided showed us that the trust were reporting concerns through the National Reporting and Learning System (NRLS). The levels of reporting were within expectations for a trust of this size.

Learning from incidents and improvingsafety standards

The trust's serious incident data showed us that trust wide learning from serious incidents had been reviewed by the Governance Intelligence Team and disseminated throughout the trust. Staff confirmed this and reported that the lessons learnt from these incidents had been discussed within their specific team and disseminated through the trust. For example, we saw copies of the trusts on line safety bulletins. This provided information and guidance for staff to follow. Most members of staff spoken with were aware of the safety bulletins and we were told they were discussed at larger team meetings. Further trust wide learning was evidenced through the trust's on line newsletter. This included updates and 'key messages' for staff. The evidence seen showed us that the trust had embedded learning from incidents within the organisation.

Staff confirmed that they had received risk assessment training and told us that they felt well supported by their line manager following any safety incidents.

Staff told us they used the trusts electronic incident reporting system, Eclipse for reporting any incidents, concerns or near misses. Feedback regarding incidents reports they had made was variable across and within the teams. Feedback from serious untoward incidents was fed back to the individuals involved and wider trust incidents distributed by email throughout the trust. Lessons learnt from incidents relating to the team and in wider trust were included in the agenda for monthly team meetings. Managers told us action plans were developed from investigations and lessons learnt circulated across the trust with feedback given to specific teams. Staff told us they were supported and debriefed by their manager following any incidents that occurred when they felt unsafe. Managers were described as supportive.

Good

Are services safe?

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Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We saw there was information displayed in the team and patient's facilities on-site about the trust's safeguarding adult's policy. We also saw the on line safeguarding policy and procedure and patient safeguarding information leaflets. This meant that patients and staff had been given the required guidance in order to support them to raise concerns when these were identified.

Staff were aware of the trust's safeguarding and other polices. They told us that they knew how to raise any safeguarding concerns. This was demonstrated by some of those individual treatment records seen. These showed us that risk assessments had been completed and identified if people were at risk of exploitation or vulnerable due to their mental health needs. Staff were also aware of their responsibilities under the Mental Capacity Act and were able to demonstrate through some of the treatment records seen, how they recognised, responded and raised issues about mental capacity.

Staff were aware of the trust's whistleblowing policy and confirmed that they felt able to raise concerns with their direct line manager. Some staff told us that they had raised concerns through their line manager. For example, in relation to their individual work load and recent managerial and other staff changes linked to the service improvement plan. Staff informed us they felt that were included in the focus groups about the service improvement plan and there was a regular update on developments on the trust's intranet.

We saw that medication was appropriately administered, securely stored and the keys were stored safely. Medicines management was seen to be effective with yearly audits undertaken by pharmacy. We found that whilst there were suitable medicines management system in place for the receipt, storage, administration and recording of information. The monitoring systems in place should be improved. Examples were seen of depot injections for intramuscular injection being ordered to be kept on site for use by community staff on site or in people's homes. This included medicines prescribed and supplied by the trust as part of people's treatment. In some teams medicines removed from safe storage to be administered to people were signed out and back in by community staff to ensure medications were handled appropriately. These arrangements were not consistent across the teams. The evidence seen showed us that improvements should be made by the trust to demonstrate that the teams and the pharmacy audited the stocks of medications for administration to people, so medicines are stored safely at all times.

Records management was electronic and used the RIO system. The staff said they had good access to patient information and could record a detailed picture and background of individual risks to staff.

Assessing and monitoring safety and risk

We observed handovers is some of the teams. These appeared well planned and organised. Each person currently receiving care was discussed, including any new referrals for follow up. Appropriate sharing of information to ensure continuity and safety of care was observed. On receipt of a referral the duty worker would make an appointment for assessment. Referrals were accepted by the recently formed single point of access team. Bed management team, GP' or self-referral if known to the team.

We reviewed 12 electronic records overall. Safeguarding and abuse issues were /are considered within the assessment document. We saw that staff joint worked with other agencies and across services to promote safety. Caseloads and capacity were monitored by the team manager through monthly supervision. These sessions included discussion around discharges which established capacity for new referrals. Levels of caseloads had agreed limits in the yet to be introduced service improvement plan. We saw case loads of up to 35 people in some teams.

Understanding and management of foreseeable risks

Electronic records seen showed us that people who had recently been assessed by the single point of access team had an initial risk assessment completed over the telephone to determine which service they would be directed to and what the level of risk determined how quickly they could access services. When referred to the CMHT we saw evidence that people who had been triaged as needing to be seen in one to seven days were then given an appointment outside of this timescale due to team capacity. We were told these decisions were based on discussions between the individual team managers and consultant psychiatrist. We did not see or receive any examples of these decisions impacting upon people's

Good

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health or wellbeing. Each team had a duty system in operation. We saw from our observations that the duty worker was able to follow up on the more urgent referrals and could offer an earlier assessment.

Risk assessments were seen in those other records reviewed and these included assessments of the person's physical health and their risks to self or others where appropriate. Evidence was seen of the active involvement of the person in assessing risks for themselves. For example, linked to their discussions with their community mental health nurse, care co-ordinator or consultant psychiatrist. These assessed identified risks had a clear and relevant care plan in place that showed the involvement of the patient themselves.

We saw good examples of risk assessments and subsequent care plans linked to those Community Treatment Orders (CTO) reviewed during our inspection.

Staff told us that they had received induction and training to prepare them for their role and were supported by their line manager. Each member of staff spoken with told us that they received supervisions and annual appraisals from their line manager as required. This meant that staff received the appropriate levels of support from their immediate manager.

Staff confirmed that systems were in place to monitor staff sickness and that they had access to occupational health support. Most staff told us that they felt well supported by their line manager.

Trust Headquarters Early Intervention service, Early detection and intervention team, Youth clinical support team and Leaving care community team

Assessing and monitoring safety and risk

Records we were shown to us included risk assessments which gave consideration to risks to themselves, staff or from other people. There was a process in place to work positively with the person to enable them to recognise triggers and signs that would indicate they were at risk. We saw plans in place to describe what actions staff and the person could take if there were elevated risks. We saw that all risks were recorded and the plans in place to minimise and manage risks.

We found that the trust's safeguarding systems were robust and were understood by staff. Staff confirmed they received training in safeguarding people which was regularly updated. Staff we spoke with were knowledgeable about their responsibilities in regards to safeguarding. They described the process for referring any identified potential or actual concerns. Trust policies and procedures were accessible on the trust intranet site. A single point of had been introduced but it was too early to tell how this would impact upon the team. Staff told us they used the trusts electronic incident reporting system, Eclipse for reporting any safety incidents, concerns or near misses.

The youth clinical support team and leaving care community team reviewed adverse incidents as a team and felt that incidents of self-harm may be unreported. As a result we saw they had included this on the risk register.

Learning from incidents and improving safety standards

Feedback regarding incidents was notified through the Eclipse system and lessons learned shared in team meetings and through weekly emails on local and national incidents. Staff gave an example of a recent incident they had reported. The groups of staff we spoke with described a robust investigation in which they had been fully involved, learning from the incident discussed and the staff member supported by the team. Action plans were developed from the investigations and changes to team working were implemented directly as a result. One staff member said, "We always feel safe" and others commented they benefited from the support of their colleagues and team manager.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Safeguarding concerns were referred through the local authority as social care staff were no longer located in the team. Staff said they believed this could cause delays in referrals and outcomes being known. They told us they were not always sure of what had happened to their referrals but team mangers monitored referrals. The referral system to the local authority is paper based and the teams use the Trust electronic RIO system to record referral details and investigation and outcome. We saw reports that the concerns around social care staff being removed from teams and actions of safeguarding referrals were known and discussed as part of the Trust governance system.

The trusts lone working policy was adhered to within the team. Staff knew how to access the policy via the trusts intranet site. Systems were in place for staff to be alerted to any concerns or risks regarding visits or contacts people.

Good

Are services safe?

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Assessing and monitoring safety and risk

Records we were shown to us included risk assessments which gave consideration to risks to themselves, staff or from other people. There was a process in place to work positively with the person to enable them to recognise triggers and signs that would indicate they were at risk. We saw plans in place to describe what actions staff and the person could take if there were elevated risks. We saw that all risks were recorded and the plans in place to minimise and manage risks.

We looked at three records and attended a multi-disciplinary team meeting. We found risk assessments had been updated in a timely manner to reflect current risk as described in the progress notes. Risk assessment and care planning involved the person and their family and we saw examples of good person centred information.

Staff described a good relationship between the two and with other teams with a clear understanding of how they could make referrals.

They told us that they work in partnership with other teams to move people on safely form their service but delays in transferring people to other teams was a problem. This meant young people remained on team caseload beyond the three year people were expected to stay with the team and it could take two years to transfer a person to other teams such as Assertive Out Reach. However people remained safe as they were supported by the team until transfer as national guidance is people can remain with such teams for up to five years. This was recognised through the trust's governance system and the report we saw from the trust recognised this was a service wide issue.

Caseloads and capacity were monitored by the team manager through monthly supervision. When we visited caseloads in the EIS team were around 20:1, which is outside of the national recommended caseload size for EIS, which is 15:1. The manager told us they discuss capacity and caseload management in supervision. Staff we spoke with said they had manageable caseloads and could approach the manager at any time if capacity compromised patient safety or care. No concerns were reported by the early detection and intervention team.

Understanding and management of foreseeable risks

Staff told us senior managers were receptive to any concerns raised. Any disruption to staffing levels incurred due to staff sickness was dealt with through cross cover amongst the team to fill any gaps and limited any impact upon people using services.

Are services effective?

Good

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

Summary of findings

The care and treatment records that we saw for people under a Community Treatment Order (CTO) were comprehensive. They showed that people were involved in their care and that the records were reviewed by the multidisciplinary team. They showed that people received a comprehensive assessment by medical and nursing staff on initial contact with the service. People who attended clinics for long-acting intramuscular injections and blood monitoring had their physical health routinely checked. However, the trust needed to make improvements in the youth clinical support team to make sure that shared care arrangements were in place with GPs. There was a good range of evidence-based psychological therapies offered by the community teams. Staff were encouraged to undertake further training and qualifications. The trust sought feedback from people using services on a regular basis and results of the managers' audits were fed into the trust's management teams. The team managers monitored caseloads and capacity through supervising staff on a monthly basis. The trust had established induction and supervision for new staff.

Our findings

Trust Headquarters Community Mental Health Teams

Assessment and delivery of care and treatment

We looked at records and saw that care plans were outcome based and reflected progress in achieving aims. Progress notes were comprehensive and linked to the care plan in place. Records we were shown were person centred and demonstrated people's involvement. People told us they were aware of their care plans and they had been involved in their reviews.

We saw evidence of comprehensive assessments by medical and nursing staff on initial contact and they had covered all aspects of care as part of a holistic assessment.

Teams offered a good range of evidence based psychological therapies. Patients told us that they had benefitted from psychological therapies and understood the treatment contract about engaging in psychological therapy.

Staff were able to discuss issues around consent and capacity and how to undertake or organise an assessment for people as necessary. Mental Capacity Act and Deprivation of Liberty Safeguards are part of the mandatory training program.

Outcomes for people using services

The trust had systems and processes in place for monitoring and recording outcomes for people. For example, regular care programme approach (CPA) reviews and person reported outcome measures (PROMS).

Staff, equipment and facilities

The teams we visited had daily handover meetings, weekly clinical meetings for case discussion and also a monthly team meeting for more team related issues, which included information sharing and caseload management support. Staff told us that they were supplied with the essential equipment to enable them to carry out their role effectively.

Multidisciplinary working

Requests for social worker input for patients in the Birmingham teams have to be made via the local authority as social work staff are no longer integrated into community mental health services. Some team managers were social workers so there was a resource for staff to obtain advice and guidance. In the Solihull teams staff reported positive engagement and working with social work colleagues and said they were a necessary part of the team and supported the team's duty system.

Information on patients subject to the Care Programme Approach was shared on the electronic system which both health and social work staff can access. Documents were scanned into the social services database to share information about risk management and care plans.

Staff told us in all the teams we visited that capacity to meet demand was challenging but there was good team support form more senior nurses and their manager. Staff were aware of the service improvement plan and the updates on the trust's intranet about the development and implementation of this. Staff could not say how this would impact upon them but did not raise any concerns about the plan.

In all teams we visited staff described positive relationships with other community services. Multi-disciplinary teams

Are services effective?

Good

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

were made up of, or had input from, occupational therapists, nurses, social workers and medical staff. A good relationship was reported between CMHT, inpatient and the crisis teams.

Mental Health Act (MHA)

We saw information about the MHA was available in areas that people accessed and which was available in different languages with an interpreter service also available.

Records we looked at for people under a Community Treatment Order (CTO) were comprehensive with evidence of people's involvement and multi-disciplinary review.

Trust Headquarters early intervention service, early detection and intervention team, youth clinical support team and leaving care community team

Assessment and delivery of care and treatment

Records we were shown contained outcome based care plans. We saw that care plans were developed with people's involvement. In records we saw comprehensive assessment of need which was completed over an initial period of up to three months in order to gather important information about peoples' health, welfare and lifestyle.

A good range of evidence based psychological therapies were available to people using the service. The service involved people before writing to their GP about treatment. The service also took psychology trainees on placement who supported the team and develop their skills. The team was developing, subject to research, an assessment of risk mental health states.

Staff were able to discuss issues around consent and capacity and how to undertake or organise an assessment for people as necessary. Mental Capacity Act and Deprivation of Liberty Safeguards are part of mandatory training program.

Youth clinical support team and leaving care community team staff believed they provided an effective service. The leaving care team was funded on a year by year basis and said they felt 'highly regarded' by the local authority. Both teams had good links with other services.

Outcomes for people using services

A range of evidence based tools and education materials were used with people to establish understanding about their illness.

The trust had systems and processes in place for monitoring and recording outcomes for people. For example, regular care programme approach (CPA) reviews and person reported outcome measures (PROMS).

The leaving care team had caseloads of up to thirty people at any one time and were able to provide a therapeutic emotional support service for 16-18 year old people working alongside the youth clinical support team. The team consisted of two practitioners and focused on looked after children and children's homes. The service provided a flexible, fluid sign post service and supported young people to make the transition to adult services.

The clinical support team worked with young people aged 16-18 and had a consultant psychiatrist in the team. The team could access inpatient beds for young women but for young men the service had to link to children's and adolescent inpatient beds out of the area. This had been raised with NHS England and placed on the trust's risk register. Services could be accessed at Birmingham Children's Hospital through commissioning arrangements with that trust.

Staff, equipment and facilities

Clinical meetings took place weekly and covered a range of issues including caseload issues, complex cases and discharge planning. Staff told us that they were supplied with the essential equipment to enable them to carry out their role effectively.

Multidisciplinary working

We saw that the approach to assessing and coordinating care ensured that people's needs were understood. The early intervention service staff worked with people for up to three years as per national guidance, however staff reported 'blockages ' in the system as other teams were not taking referrals in a timely way, which meant people remained longer on the teams workload. Requests for social worker input for people had to be made via a contact centre with the local authority as social work staff were not integrated into the team, which had been put on the team's risk register. Information on patients subject to the Care Programme Approach was shared on the electronic system which both health and social work staff could access. Documents were scanned into the social services database in order to share information. The multi-disciplinary team was made up of nurses, support workers, occupational therapists psychiatrists and a psychologist.

Are services effective?

Good

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

The youth clinical support team raise the concern about the Attention Deficit Hyperactivity Disorder (ADHD) clinic that had over 500 people on the caseload. There was a consultant psychiatrist and two community mental health nurses that managed the clinic. The concern raised was there are no shared care arrangements with GPs so all prescriptions were written by hand as there was no printer in the service. This meant that there was no time to appropriately review the numbers of people aged 16-25 that used this service and offer psychological interventions, but had become a prescribing medication only clinic.

Mental Health Act (MHA)

Staff told us that they had access to social workers and advanced mental health practitioners within the wider trust to provide guidance on the Mental Health Act to support compliance.

Good

Are services caring?

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

Summary of findings

The services provided were caring. People told us that they were treated with dignity and respect. We found that staff were skilled and knowledgeable, and that the language they used was compassionate, clear and simple. People who used the services had access to appropriate literature and information. Staff also provided support for social and domestic issues where there were gaps in community resources.

Our findings

Trust Headquarters Community Mental Health Teams

Kindness, dignity and respect

We spoke with ten people using services and one carer. People were very complimentary about the care and treatment they received. They told us they felt listened to and included in each stage of the care they received. We observed an assessment between a nurse and person using the service which covered areas of their health, wellbeing and lifestyle. The person was engaged with the nurse who explained all their questions in detail so the patient understood the assessment process.

We observed several interactions between staff and people. The language used was understanding, clear and simple without the use of jargon. We saw staff were compassionate, warm, friendly, positive and engaging with people. Privacy and dignity was maintained with people offered a private quiet room in which to wait if preferred. Staff were professional and patient focussed.

In the assessment we saw and the examples of records reviewed; we saw people's cultural needs were included.

People using services involvement

We met people who used the services attending outpatient clinics or assessment meetings. At the assessment meetings we observed the aims of the service were clearly explained and person asked about their anticipated outcomes.

People we spoke with understood their medication, its use and described side effects demonstrating clear education provided around this. Outpatient clinics also contained patient information leaflets about the range of medications used.

Staff were clear about how to secure advocacy services for people. Information available about the service included how to access advocacy services. Appropriate literature and information was seen that people were routinely provided with throughout their treatment. These were available as necessary in a variety of accessible formats.

Emotional support for care and treatment

We met and spoke with ten people and a carer and received positive comments about the service provided. Staff we met with told us that people's carers were involved in their assessment and care planning. In all the care plans we sampled there was evidence that carers were involved where possible.

The teams had a duty system in place which offered people the option of speaking to the duty officer, their identified worker or visiting the office to speak to the duty officer or identified worker. We also saw that non-medical prescribers based in teams were available to support people to visit their GPs and discuss issues about prescribing medication.

Trust Headquarters early intervention service, early detection and intervention team, youth clinical support team and leaving care community team

Kindness, dignity and respect

Staff spoke passionately and positively about their work. The three records reviewed demonstrated that people were involved in their care and their views about their health, welfare and lifestyle were acknowledged and respected. Those trust feedback surveys seen demonstrated that people felt that they were being treated with kindness and respect.

People using services involvement

Appropriate literature and information was seen that people were routinely provided with throughout their treatment. These were available as necessary in a variety of accessible formats. The trust's website provided people with accessible information about the service available to them and the range of needs the service supported.

Good

Are services caring?

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

Emotional support for care and treatment

The three records we saw demonstrated that staff positively engaged family, friends and carers who supported people using their service. The 'staying well plan' seen included information about how family, friends and carers supported people as part of their recovery and in relapse prevention.

Are services responsive to people's needs?

Good

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

Summary of findings

We saw that there were waiting lists and these were small and well managed. Services had been developed in consultation with local people. In most cases, people accessed services at the team base. People also knew how to access help out-of-hours. During our visit, we observed teams working well together and we saw examples of good working relationships. We found evidence of trust-wide learning from complaints and incidents.

People needing urgent assessment were directed to use the bed management team who acted as a triage and access to crisis services.

During our visit, we observed teams working well together and we saw many examples of good working relationships. The teams talked to the crisis team about people that they were particularly concerned about, and made sure that information was available if the crisis team was contacted by them.

Our findings

Trust Headquarters Community Mental Health Teams

Planning and delivering services

The teams operated a duty system 9am to 5pm. We sat in on two team meetings and observed a handover at the beginning of the day and observed work being prioritised according to risk.

Referrals are taken from the single point of access team or a GP can refer to the duty officer if known to the service.

The home treatment teams were able to provide telephone support and in a crisis assess people if the bed management team arranged this. Community mental health teams could alert the home treatment and bed management teams of any pending crisis. This meant that appropriate systems to share information with other services were established.

Staff informed us that people needing an inpatient bed had to access this through the bed management team. The bed management team operates twenty four hours a day, seven days a week, and accesses inpatient beds in and outside of the trust.

Once the service improvement plan is introduced the community mental health teams will reduce in number. Staff told us they will work more in the local community and provide satellite clinics. We saw the trust had undertaken public consultation about the development of the service improvement plan for community mental health teams.

We saw that people were seen in their homes, community bases and clinics. Staff confirmed that home visit with additional support would take place if risk assessed as being required. This meant the services were responsive and flexible to the issues relating to and impacting upon the person's well-being.

Right care at the right time

Appointments waiting times were not always consistent with the times identified by the single point of access team. Some appointment times were out of the one to seven day timescales. Duty officers were able to contact people and assess further their need to be assessed and appointments offered on the outcome of the contact. The appointment times were prioritised by the team managers and respective consultant psychiatrist. We did not see evidence that care and treatment was cancelled. The teams we visited were not carrying many vacancies. Staff sickness issues were mitigated using cross cover from other neighbouring teams.

In Solihull we saw how one team had utilised the duty system to speed up the assessment of people and be able to take work form the community mental health nurses. This meant the duty officer could see people who had issues about their health or medication, follow up telephone calls and advise GPs. This short term arrangement had allowed the team to focus on its core business and had not increased caseloads as a result.

A non-medical prescriber assessment role was being developed as part of the service improvement plan. We spoke with three of the non-medical prescribing staff. We

Are services responsive to people's needs?

Good

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

saw two treatment plans for people being supported by these staff. Staff told us this role was to be functioning from June 2014 and there would be at least one non-medical prescriber in each team.

Care pathway

Staff told us that all members of the team were valued and respected regardless of discipline or level of seniority. We were able to observe teams working in collaboration and saw examples of positive working relationships. Transfer of care between teams and people living out of the area were said to be slow for some people due to the capacity of the teams people were being transferred to. Staff gave us several examples of how they kept these people on their caseload until the transfer had been completed. This meant that people still received the support to continue with their care and treatment.

Staff were clear about the lines of accountability and who to escalate any concerns to. Staff were able to describe the other services involved in people's care pathways and how the community mental health teams fitted into this.

The teams were involved with people prior to their discharge from inpatient wards and requiring CMHT follow up. Staff form teams linked into inpatient and other teams multi-disciplinary and discharge planning meetings. This meant people's transition back into the community was not unnecessarily delayed.

Within teams initial triage was undertaken with people being referred either by phone or face to face to agree upon the immediate plan of care and level of contact. This had a degree of flexibility and was subject to change in consultation with people.

Learning from concerns and complaints

Staff were aware of the trust's complaints policy. Complaints were received directly and passed to the team manager or from the Patient Advocacy Liaison service (PALS). We saw a number of posters in reception areas used by people regarding how to make a complaint. Information leaflets about each service included this information also.

A waiting room we saw had information available and forms to complete alongside a post box to place completed forms in. People we spoke to felt sure of how to take forward any issues they had. Investigations of complaints were by the service manager where appropriate.

Evidence of trust wide learning from complaints and incidents was demonstrated through the team manager sharing with staff and trust wide through updates via the trust email system. This information was also included and discussed at the monthly team meetings.

Trust Headquarters early intervention service, early detection and intervention team, youth clinical support team and leaving care community team

Planning and delivering services

Staff told us that they prioritised work according to risk and identified need. We saw that the majority of people were seen in the community bases and people's homes. We saw that the provider had employed both male and female staff from different ethnic backgrounds. This ensured that staff were able to support people with their gender, cultural and personal preferences. Information was accessible on the trust's website which offered information about the purpose of the service and how to be referred into it. Referrals to this team aware not through the single point of access team. Referrals could also be picked up following acute crisis or during inpatient admission.

Right care at the right time

No waiting lists were in operation. Cases were prioritised and discussed by the multi-disciplinary team (MDT) with contact made by letter with details of how to access services as an interim measure. No examples were shared of treatment being cancelled or delayed due to capacity issues.

People on the caseload and those with booked initial appointments were provided with the numbers to call if they needed an urgent response outside of working hours. EIS/EDIT staff liaised with the crisis service regarding people who may present out of hours or at weekends due to deterioration in their mental health.

Care pathway

Staff told us they felt worked coherently within the various teams and that all members were valued and respected regardless of discipline or level of seniority. We spoke with staff that were able to give a clear overview of the care pathways within the team and this involved collaborative working. Transfer of care between teams and shared care within teams was overall effectively managed. This enabled smooth transition between teams for the patient as part of their ongoing recovery.

Are services responsive to people's needs?

Good

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

People referred by inpatient staff as ready for discharge would be seen whilst still an inpatient to begin to build a rapport and relationship to optimise engagement in community. Relationships with other teams in the trust were described as good.

Learning from concerns and complaints

Staff were aware of the trust's complaints policy. Complaints were received directly and passed to the team manager or from the Patient Advocacy Liaison service (PALS). Staff told us they were confident on how to advise people with a concerns, complaint or compliment. We saw a number of posters in reception and waiting areas used by people regarding how to make a complaint. Information leaflets about the service included this information also.

Evidence of trust wide learning from complaints and incidents was demonstrated through the team manager sharing with staff and globally through updates via the trust email system. This information was included and discussed monthly team meetings.

Are services well-led?

Good

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

Summary of findings

Staff were dedicated and felt well supported by their managers. Some staff told us that they were able to go to consultation meetings about the service improvement plan. These events, and the examples of team and management meetings that we saw, demonstrated to us that staff were consulted about the trust's future plans. The trust's intranet was also updated as the plans changed.

At a local level, we saw that audits of records were completed for the Care Programme Approach (CPA). Staff said that managers could monitor and review these electronically. In addition, staff training was up-to-date and monitored regularly.

A trust-wide risk register was in place to monitor and identify risks to the trust, staff and people using the services. Staff were regularly supervised and knew how to access advocacy services for people.

People using the service were regularly asked for their comments and opinions about the service.

Our findings

Trust Headquarters Community Mental Health Teams

Vision and strategy

Most of the staff we spoke with told us they felt well supported by their managers. They spoke positively about their role and demonstrated their dedication to providing quality patient care. They told us that senior managers and the board engaged them, provided information and consulted with them in a variety of formats. Key messages about the trust were communicated to all managers at monthly senior management meetings and shared with the team. We ran a number of focus groups as part of inspection and spoke to a number of staff groups.

We saw the service integration programme (SIP) consultation key themes report summary. The consultation took place from October to November 2013 for a period of six weeks. Staff confirmed that teams had, or were offered, the opportunity to have an initial briefing from executive team members to all senior leads and managers within the trust to enable them to give briefings within their areas of service. Local briefings were then given by associate directors.

Briefings or updates were provided at all key internal and external meetings which took place within the consultation period as appropriate. Every adult CMHT consultant and team manager was offered a session with the medical director or his deputy or a clinical director together with the SIP model project manager. This was a 'Listening into Action' style session allowing concerns to be raised and responded to and an opportunity to put forward any alternative suggestions.

Responsible governance

Staff told us that they felt well supported by their line manager. Staff told us that they received clinical, managerial and group supervisions as required. Staff attended monthly team meetings. The trust vision was cascaded through 'Connect' and the chief executive's weekly brief emails and shared in team meetings. Staff told us monthly business meeting were good for feedback in regard to audits undertaken.

A trust wide risk register was in place and managers told us this was an effective tool for capturing ongoing concerns. Staff told us that they were aware of the trust's whistleblowing policy and that they felt able to report incidents and raise concerns and that they would be listened to.

Monthly monitoring of records were submitted to the governance team by managers. They receive bi monthly reports to monitor their performance. Audits of records we saw were in-depth in regard to the outcomes for people contained in care plans and progress notes. Staff attendance on training was monitored by their line manager. We saw evidence of high attendance rates for staff attending training. A training matrix was seen and this was updated and shared with staff.

Leadership and culture

We saw a supportive culture within teams. Staff had a broad understanding of the current and future needs of the organisation and a good understanding of the service improvement plan. We saw that staff were passionate about their work and showed a genuine compassion for people. They told us that the chief executive had visited

Are services well-led?

Good

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

their teams and engaged with staff at all levels. We found that the executive team visited teams and sat in on staff and multi-disciplinary meetings. Staff talked positively about the chief executive.

People who used the service said they were aware of who the CEO was and they were asked for feedback about the services they received involved in.

Engagement

People were asked about their views of the service via satisfaction surveys which related specifically to the team that cared for them. These asked them to rate the quality of the staff that supported them. These were provided to people via 'real time' surveys on the intranet available at the sites teams were based. Teams also provided people with surveys about the service they received and we saw evidence of the results of surveys in outpatients waiting areas and reception areas. There was a high satisfaction rate from people using the service. This meant the trust actively sought people's opinion and participation in improving service delivery. The trust provided us with information about the consultation over the service improvement plan. Feedback was received from individual staff members, over 200 people that use services, carers and CMHT teams.

Staff were aware how to access advocacy services for people and leaflets given to people about the team also contained information about relevant local advocacy contacts. Staff were aware of the whistleblowing policy and that they would feel confident to report and refer concerns if it was needed. The whistleblowing policy was available on the trusts intranet site.

Performance improvement

Staff understood their aims and objectives in regard to performance and learning. They valued the supervision they received and that it was "supportive". We saw that service developments were being monitored for risks, efficacy and with consideration of local needs. We found that monthly team meetings focussed on team objectives and direction particularly through the implementation of new ways of working. For example with the introduction of the service improvement plan one team was piloting the use of assistive technology to support staff to work remotely.

Trust Headquarters early intervention service, early detection and intervention team, youth clinical support team and leaving care community team

Vision and strategy

Staff reported to us that morale in teams was high. Key messages about the trust were communicated to managers at monthly senior management meetings. They felt well supported by their managers. They confirmed that senior managers and the board members engaged with them, provided information and consulted with them in a variety of formats.

Responsible governance

Staff received a variety of regular supervision, for example clinical, line management and professional. They told us these were well organised and meaningful. Team meetings were on a monthly basis and were used for sharing relevant information. The trust vision was cascaded through 'Connect' and the chief executive's weekly brief emails and shared in team meetings. Staff confirmed monthly business meeting were good for feedback in regard to audits undertaken.

Staff confirmed that they had an understanding of governance issues and aware of how 'listening into action' events had increased their awareness of the governance role and how they contributed to this.

Staff told us that they were aware of the trust's whistleblowing policy and that they felt able to report incidents and raise concerns and that they would be listened to. Staff reported that management were supportive and acted upon any concerns raised. Sickness and absence was monitored and we saw information from the trust that long term sickness absence was much lower than other trust service areas. Staff attendance on training was monitored by managers. A training grid was seen and this was updated and put up for staff to see. Mandatory training for the teams was 93% and on an upward trend and above the trust average.

Leadership and culture

We saw a supportive culture within teams with staff displaying a positive regard for each other. Staff had a broad understanding of the current and future needs and goals for the organisation. We saw a sense of collective team responsibility with good levels of supervision, support and clinical discussion in place.

Are services well-led?

Good

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

Engagement

Staff were aware of the whistleblowing policy. They told us that they had not needed to use it as they could speak open and honestly. A copy of the policy was available on the trust's intranet site. The team actively sought people's feedback by asking people to complete satisfaction surveys every three months. The team the information related to was identifiable and the forms were returned directly to the trust. This meant that people were able to be open and honest whilst remaining anonymous if they choose too. The questions asked people to rate the quality of the staff that supported them.

Staff were aware how to access advocacy services for people and leaflets given to people about the team also contained information about relevant local advocacy contacts.

Performance improvement

We saw that the trust invested time and resources into supporting staff. Staff we met with understood their aims and objectives in regard to improvement and learning, through regular formal supervision. They valued the supervision they received. We saw that monthly team meeting focussed on maintaining a high quality of service delivery and improving ways of working.

Team performance was monitored through key performance indicators and we saw that the teams were meeting the national targets where applicable.

Evidence was seen that demonstrated to us that the trust was trying to reduce the stigma and identify the performance of services and teams to address barriers and improve the take up of services where appropriate.

The youth clinical support team and leaving care community team showed us the 0-25 age range service specification they were currently involved in developing with Birmingham South and Central Clinical Commissioning Group.