Specialist community mental health services for children and young people.

Quality Report

Birmingham Women's and Children's NHS
Foundation Trust
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Inadequate
Are services well-led?	Inadequate

Summary of findings

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

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

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

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

Overall summary

We changed the overall rating from requires improvement to inadequate because:

- Following the inspection in May 2016, we told the provider of the actions they must take in order to improve the service. During this inspection, we identified that the trust had only completed three of the eight actions we had told them they must complete.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. During inspection, we identified a number of concerns in relation to infection control, medicines management practice, health and safety, risk assessment, care planning, safeguarding, patient record keeping, staffing, governance and leadership.
- Not all the environments were safe and clean. Staff did not always adhere to infection control principles, maintain clean environments or have systematic approach to deal with risks identified. Staff were not sure how to respond to an activated alarm call. Staff did not always adhere to the Control of Substances Hazardous to Health Regulations.
- Medicine management was poor at the urgent care team base, South and East hubs. Staff did not store or dispose of medicines correctly. Staff did not routinely undertake medicines audits.
- Not all patients had an up to date fully completed risk assessment or risk management plan. Where we saw risk assessments in place they were basic and lacked detailed information.
- Not all patients had a care plan. Where we saw care plans in place, they were not personalised, specific or detailed. Some care plans did not address young peoples' identified needs. Staff did not always record patients' views. A clinical audit of care plans had not led to improvements in care record documentation.
- Staff could not always access electronic care records in a timely manner. The lack of detail in electronic care records meant that even if staff could access records, the information was not always there. The high use of agency staff and turnover added to the unsafe hand over of care and inconsistent monitoring of patients. The lack of oversight from managers also meant that some patients were not reallocated care coordinators when staff left or passed between teams.
- Although staff had access to mandatory training, staff compliance rate in some modules were low. These included adult safeguarding level 2 and children's safeguarding level 3. National guidance from an intercollegiate document published by the Royal College of Paediatrics and Child Health set out minimum safeguarding children training requirements for NHS staff. All staff within a child and adolescent mental health service should be trained to level 2 minimum and all clinical staff who work directly with children and young people should be trained to a minimum level 3. Across the core service only 46.5 %of eligible staff had completed level 3 children's safeguarding.

Summary of findings

- Overall governance within the integrated community services lacked coordination amongst partners and there were clear issues with data collection, monitoring of waiting lists, and allocation of caseloads, staffs understanding of standard operational policies and estates management. Data shared by the trust was at times contradictory and not always broken down between hubs and teams. The trust themselves had identified issues with data collection amongst staff and systems.
- The core service had a overall staff vacancy rate of 27 %. The trust employed a high number of agency staff to cover the majority of vacancies but 44% of these vacancies had not been filled. This all impacted directly upon patient care resulting in poor patient handovers, cancellation of appointments, increasing waiting lists, patients waiting allocation of care coordinators, inconsistent care and low staff morale.

However:

- The trust provided a health-based place of safety for patients under the age of 18.
- The trust had updated the health-based place of safety policy in line with the revised Mental Health Act Code of Practice 2015.
- Patient care records we reviewed from the health-based place of safety showed that staff assessed and documented risks and management plans.
- Clinical staff we met were experienced and skilled and from a wide range of mental health disciplines.
- Staff were able to provide psychological therapies recommended by the National Institute for Health and Care Excellence.
- Staff had a good understanding of Gillick competence.

Summary of findings

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Inadequate

Birmingham Women's and Children's NHS Foundation Trust

Services we looked at

Specialist community mental health services for children and young people

Summary of this inspection

Our inspection team

The team that inspected the core services consisted of six CQC inspectors, one inspection manager, two specialist advisors and two experts by experience. The specialist advisors were a specialist child and adolescent nurse and a social worker. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them, for example as a carer.

Why we carried out this inspection

We undertook this inspection to find out whether the specialist community child and adolescent mental health service had made improvements since our last comprehensive inspection of the service on 17 -19 May 2016.

When we last inspected the service, we rated it as requires improvement overall. We rated the service as requires improvement for Safe, Effective, Responsive and Well-led. We rated it good for caring.

Following the comprehensive inspection, we told the community child and adolescent mental health service that it must take the following actions to improve;

The provider must:

• Ensure there are sufficient numbers of skilled and qualified staff to provide an effective service.

• Ensure that information needed to safely manage patient care is accessible and available for staff.

• Ensure that risk assessments are updated on a regular basis and using the risk screening tool.

• Ensure that care plans are completed consistently using the care planning documentation.

• Ensure that consent to treatment is obtained and recorded within patient care records.

• Ensure that staff at the place of safety accurately complete records relating to the duration of use of the section 136 suite.

• Ensure that the policy for the place of safety is updated to reference the 2015 Mental Health Act Code of Practice.

• Ensure that staff receive an annual appraisal and that management supervision is provided consistently for staff.

The trust was in breach of the following regulations;

Regulation 17 HSCA (RA) Regulations 2014 Good governance.

Regulation 18 HSCA (RA) Regulations 2014 Staffing.

Regulation 11 HSCA (RA) Regulations 2014 Need for consent.

We also told the trust that it should take the following actions to improve:

The provider should:

• Ensure that waiting areas are designed to take into account the needs of all people using their services.

• Ensure that cleaning records are maintained and that staff are able to access them.

• Ensure that equipment and facilities are available to support staff in carrying out their role.

How we carried out this inspection

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

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

Summary of this inspection

- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services,

During the inspection visit, the inspection team:

- visited four hubs, and looked at the quality of the environment and observed how staff were caring for patients
- visited the health-based place of safety
- visited the team base for the two urgent care teams and inspected how staff cared for patients
- spoke with six patients under the age of 18 who were using the service
- spoke with six carers of patients under the age of 18
- spoke with the managers or acting managers for each of teams
- spoke with 22 other staff members; including doctors, nurses and social workers, psychologists and other members of the multidisciplinary team
- spoke with six staff who were employed by another trust but worked across the integrated team age range of 0-25
- attended and observed one multi disciplinary meeting
- looked at 30 treatment records of patients under the age of 18
- carried out a specific check of the medicine management at all the hubs and urgent care base
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Specialist community mental health services for children and young people.

Birmingham Women's and Children's NHS Foundation Trust is the lead provider of Forward Thinking Birmingham. Forward Thinking Birmingham is the provider of mental health services for children, young people and young adults up to the age of 25 in Birmingham.

It is a partnership of five organisations that have come together to offer integrated community and inpatient care. There are five core partners:

Birmingham Women's and Children's NHS Foundation Trust –They offer in conjunction with Worcestershire Health and Care NHS Trust, community mental health services for children and young people. Birmingham Women's and Children's NHS Foundation Trust take the lead in providing the service for under 18 patients and Worcestershire Health and Care Trust take the lead for over 18 patients. Birmingham Women's and Children's takes the lead on the overall governance for the integrated service 0-25. They also provided child and adolescent (0-18 years) inpatient care.

Worcestershire Health and Care NHS Trust - They are the lead provider of the Early Intervention in Psychosis service for children and young people up to the age of 35.

Beacon UK – Provide and manage the access centre. The access centre processes all referrals to Forward Thinking Birmingham.

The Children's Society – Provide a drop in service for 0-25 year olds across Birmingham.

The Priory Group – Provides inpatient care for 18 – 25 year olds.

This inspection focused on the community services provided by Birmingham Women's and Children's NHS Foundation Trust. These were the North, South, East and West hubs, the urgent care teams (Crisis and home treatment) and the health-based place of safety. Birmingham Women's and Children's NHS Foundation Trust takes responsibility of providing the care and treatment to under 18s that use the service and take the lead for the overall governance of the integrated 0-25 service.

Summary of this inspection

During this inspection we focused on the under 18 service as provided by Birmingham Women's and Children's NHS Foundation Trust.

The hubs offered multidisciplinary mental health services to children and young people (0-25) with mental health difficulties and disorders. Assessment, care and treatment were available from four locations across Birmingham. The service also had citywide speciality teams who offered specific interventions for eating disorders and Neurodevelopmental conditions. The hubs had adopted the Choice and Partnership approach (CAPA). CAPA is a service transformation model that combines collaborative and participatory practice with patients. Patients who met the referral criteria are offered choice appointments. This is a face-to-face appointment aimed at identifying what the patient and /or carer want help with to reach a shared understanding of the problems. If treatment was indicated, patients were offered partnership appointments. In partnership appointments, staff offered specific therapeutic interventions. Further specialist partnership appointments were offered if patients and or carers needed specific interventions, for example family therapy.

The urgent care teams consisted of a crisis team and a separate Home Treatment team. The crisis and home treatment teams worked across the whole of Birmingham. The crisis team offered a 24 hour, seven day a week service. The crisis team supported children and young people who were experiencing an acute mental health crisis. The team also staffed the health-based place of safety.

The home treatment team offered support to patients following a mental health crisis, after an inpatient stay or as an alternative to inpatient admission. The home treatment staff worked with patients primarily between 8am- 8pm, seven days a week. After 8pm, the crisis team supported home treatment patients if needed.

What people who use the service say

Most patients and carers told us that staff were kind, respectful and professional. They were pleased with the care they were receiving and found it helpful. Patients said they felt listened to and understood and had been involved in planning their care.

Some patients and carers told us it was often difficult to get through to staff, as the telephone lines were always busy. Some patients and carers said waiting rooms were basic and did not offer privacy.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

- The clinic rooms at the East hub were unclean and staff did not adhere to good infection control principles. The fridge in the kitchen at the health-based place of safety was unclean and stored out of date food. Staff at the health-based place of safety did not carry out adequate checks to ensure emergency equipment was maintained in working order.
- Staff from the East and South hubs and urgent care teams did not demonstrate good medicines management practice. There was inadequate medicines monitoring and storage. There was no evidence that the trust calibrated the medicines fridges in order to ensure temperatures were recorded correctly. This was a risk to patient safety.
- The provider had not reviewed the environmental risk assessment they completed in 2016, despite the provider identifying concerns and recommending a review as the services developed.
- The provider had not produced protocols for staff to follow when responding to alarms.
- Patient risk assessments and management plans were incomplete or not completed, lacked detail and not always in date.
- Staff who worked at the health-based place of safety had not received training in physical intervention skills. They relied on staff from other wards to respond and intervene.
- There were shortfalls in the staffing establishment. The overall vacancy rate was 27% with a high staff turnover of 23% .The crisis team had a vacancy rate of 56%. Not all assessed patients had an allocated care coordinator.
- Not all eligible staff had completed training in adult safeguarding or childrens safeguarding level 3.
- We found evidence in care records that staff did not always follow up safeguarding concerns.
- We were not assured that management always fed back lessons learnt of feedback from incidents.
- The trust did not ensure that all staff were able to follow the lone working policy.
- We saw that a fire door was propped open at the East hub.
- Not all substances hazardous to health were correctly stored.
- The trust did not always ensure that cleaning schedules were followed.

Summary of this inspection

However:

- The trust provided a health-based place of safety exclusively for patients under the age of 18. Patient care records we reviewed from the health-based place of safety showed that staff assessed and documented risks and management plans.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Patients did not always have a full, documented assessment of their needs and care. Most care plans lacked detail and some were incomplete. Some were unclear and illegible. The majority of the care records we viewed were not person-centred, and very few of the records we viewed contained evidence of people's involvement in planning their own care.
- There were no robust systems in place to ensure staff handover of care was safe and timely. We saw instances in care records where patients' care coordinators had left the service and the staff had not handed over patients care to other staff.
- Mental Health Act training was not mandatory.
- Staff did not always accurately record that consent to treatment and competence to consent had been considered.
- Staff did not always record the time of patient discharge from the health-based place of safety.
- Staff did not always follow the standard operating policy for seven-day follow-ups and handover of care.

However:

- Clinical staff we met were experienced and skilled and from a wide range of mental health disciplines.
- Staff were able to provide psychological therapies recommended by the National Institute for Health and Care Excellence.
- Staff had a good understanding of Gillick competence.
- The trust had updated the health-based place of safety policy in line with the revised Mental Health Act Code of Practice 2015.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- We found patient-identifiable information left in a clinic room at the East community hub.

Summary of this inspection

- Care plans and patient care records did not reflect that people were always fully involved in the planning of their own care. Care records did not evidence that staff offered or gave patients a copy of their care plan.

However:

- Patients, families and or carers spoke positively about the staff and the interventions they received. They said staff had a good understanding of their needs.
- We observed staff discussing patients in a respectful and caring manner. We saw that staff had a positive approach to patients and were caring.

Are services responsive?

Inadequate

We rated responsive as inadequate because:

- In the 12 months prior to inspection, 266 patients had waited longer than 18 weeks to access initial assessment and treatment. Eight patients had waited longer than 52 weeks. There were internal waiting lists of patients waiting to be allocated a care coordinator and other therapies.
- The trust cancelled patients' appointments due to a lack of staff cover.
- Staff did not always follow the trust's policy for patients who did not attend appointments. We found evidence in care records where staff had not recorded follow up plans, what action they had taken or documented what action they planned to take.
- Not all staff were aware if the duty system was accessible to patients under the age of 18.
- Staff did not have always have access to play therapy equipment at the West Hub. Toys had been removed because managers said staff did not evidence they were kept clean.
- Some clinical rooms across the hubs had inadequate soundproofing.
- Two of the reception areas within hubs did not provide adequate privacy for patients talking to staff.

However:

- The trust reviewed and monitored complaints and all patients we spoke with said they knew how to make a complaint if needed.
- Patients had access to a variety of accessible information, such as leaflets about treatments, local services, patients' rights and how to complain.

Are services well-led?

Inadequate

We rated well led as inadequate because:

Summary of this inspection

- During our inspection, we identified that five of the eight actions required of the trust following the comprehensive CQC inspection May 2016 had not been fully completed. General overall governance within the integrated team lacked coordination amongst partners and there were clear issues with data collection, monitoring of waiting lists, allocation of caseloads, staffs understanding of standard operational policies and estates management.
- Staff morale was low. Most staff felt that the services had not improved since the last inspection and were concerned about poor patient documentation, waiting lists, inadequate working environments and difficulties with agile working practices.
- We found there was a lack of oversight in relation to the staff training. There was not an effective system in operation to ensure that all staff working with children under 18 years had the appropriate level of children's safeguarding training. We could see from the data supplied by the trust, that staff employed by a partner of Forward Thinking Birmingham to work within the hubs and urgent care, had not all been trained to that level. Data indicated for this staff group that the compliance rate was between 0 -17% for level 3 children's safeguarding.
- Staff we spoke to were unclear what the vision and values of the organisation were. Some staff were unsure of who they worked for i.e. Forward Thinking Birmingham, Birmingham Women's and Children's NHS Foundation trust or Worcestershire Health and Care NHS Trust.
- Staff did not always have access to equipment or space to support agile working.

However:

- Most staff told us they were aware of the whistle blowing procedures.
- Staff told us there were opportunities for leadership development.

Detailed findings from this inspection

Mental Health Act responsibilities

Staff we spoke with had a good understanding of the Mental Health Act and the Mental Health Act Code of Practice. They were aware of whom to contact for guidance. The health-based place of safety policy reflected the amendments made within the revised Mental Health Act Code of Practice 2015.

Staff completed section 135/136 monitoring forms and recorded the start time of each admission to the unit. Staff did not always record the end time.

At the time of the inspection Mental Health Act training was not mandatory; the trust said that it would be a part of mandatory training requirements from January 2018 onwards.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had access to the Mental Capacity Act policy on the intranet and were aware of whom to contact for guidance on it application. It was clear that staff we spoke to had a good understanding of Gillick competence and applied this when working with children under the age of 16 but staff did not always document this in care records. Staff had access to Mental Capacity Act training within the mandatory training and data showed that 89% of staff had completed this.

Specialist community mental health services for children and young people

Inadequate

Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
Responsive	Inadequate
Well-led	Inadequate

Are specialist community mental health services for children and young people safe?

Inadequate

Safe and clean environment

Community Hubs

- All the hubs, except the South hub, had a secure entrance. Receptionists monitored who was entering and exiting the buildings using an intercom system. All receptions had a signing in and out book for staff and visitors to use. We observed receptionists prompting visitors to sign in
- Staff at all hubs had access to alarms to summon additional support if needed. At the South and West hubs, rooms were fitted with an alarm call system. At the North and East hubs, staff had access to portable personal alarms. However, staff we spoke with at South hub were not sure how the alarm system worked. Staff did not have access to a local protocol for guidance on responding to alarms. Data provided by the trust showed they had undertaken an environmental risk assessment. However, it was not clear from the document when they had carried this out, as they had not dated it. The environmental risk assessment included health and safety risks by comparison to workplace regulations and security. Concerns highlighted were cleanliness, fall and aggression risks. One concern, identified at the South Hub, was the narrow corridors leading to both staff and clinical areas. Staff had identified that the narrow corridors within clinical areas could be challenging if an incident of aggression occurred in those areas. It highlighted that none of the community sites could demonstrate a standardised response to an activated alarm. Its action to improve this was to develop a response protocol. The trust had not done this and an incident had occurred in May 2017. The trust had also noted a potential risk in waiting areas with the service changing to 0 – 25 year old patients. It recommended staff reviewed the risk as the service developed. The service had been running since April 2016 and we saw no evidence that staff had reviewed this since then.
- All hubs had a clinic room and physical health monitoring equipment in order to carry out physical health observations. We saw equipment such as weighing scales, height measurers, blood pressure monitors and examination couch available. However, at the East and South hubs, staff did not have access to disposable blue paper roll for the examination couch. This should be used as part of infection control measures between patients. The provider was unable to evidence that the equipment staff used for physical health monitoring, across all hubs, had been calibrated and maintained in accordance with manufactures guidelines.
- Staff did not always adhere to infection control procedures. At the East hub, we saw two unclean clinic rooms that did not adhere to infection control principles. There were no records to demonstrate that staff had cleaned the rooms or equipment on a regular basis. We found a cleaning record in the room, which recorded that staff had last cleaned the room and examination couch, in November 2016. Staff did not use blue disposal paper on the couch between patient uses.

Instead, they had access to antibacterial wipes to clean the examination couch after each use. In the second clinic room, we found the environment and cleanliness very concerning. We saw open plastic containers used to store cotton wool, needles, tourniquets and other phlebotomy related equipment open on a clinical surface. Inside the containers, we found brick dust from recent building work. There were four full sharps disposal boxes, one of which had an open top, and were easily accessible to patients. There was dried blood on top of one sharps box; Staff had placed these in front of the hand washing sink, along with two large cardboard boxes containing clinic supplies. This meant staff would have had to lean over both the sharps boxes and cardboard boxes in order to wash their hands. The clinical waste bin had stains on the lid. The height and weighing scales had a thick layer of dust on the bases. The air vent in the room had dead insects protruding from it. The seats used in the room were both fabric, which meant staff could not clean them easily in order to adhere to infection control principles. On the day of inspection, we raised our concerns to managers. We re-inspected three days later and saw staff had placed a cleaning schedule in the clinic rooms. Staff had cleaned worktops and removed unclean blood vials and cotton wool. However, the skirting boards were still visibly dirty and the sharps box lid was still open and accessible to patients. We reviewed a cleaning audit competed by the provider on 9 June 2017. We were concerned to see they had highlighted some of the issues we had identified at the East hub with no action plan to address them.

- The cleaners' storeroom at the East hub was in a patient accessible area. During inspection, we saw the door to the room was unlocked and had keys left in it. The door was a fire door and staff had propped it open with a wet floor sign. The room contained cleaning equipment subject to Control of Substances Hazardous to Health Regulations (COSHH). COSHH is the law that requires employers to control substances that are hazardous to health in a safe way. Staff had not locked the cleaning fluids away. Staff had stacked boxes on top of each other, which were at risk of falling down. We reported this to the manager during the inspection. When we revisited three days later we saw staff had left the left keys in the door again and the room was unattended.
- The levels of cleanliness and maintenance within other areas of the hubs varied. We found the West hub was clean and well maintained. However, they had taken away therapeutic toys and books, as staff could not evidence they were kept clean. This meant clinicians used their own supplies. This in itself did not guarantee that staff kept the equipment clean. The waiting areas at the South and East hubs were untidy and furniture looked worn. At the East hub, we found toys in the waiting area were visibly unclean and there was no regular cleaning plan in place.
- Across all sites, there were adequate hand washing facilities, with hand washing instructions displayed above the sinks.
- Fire extinguishers were maintained and testing stickers visible and in date

Crisis and Home Treatment teams (Urgent care)

- The crisis and home treatment teams did not see patients at their team base.
- The staff environment at the team base was visibly clean and maintained.
- The team had access to a locked clinic room where patient and stock medicines were stored. Other clinical supplies such as hand gel sanitiser, first aid kits, needles and plasters were also stored there. The shift coordinator and duty worker held the keys to the room.
- Staff had access to hand washing facilities and posters were displayed to remind staff of infection control principles.
- Fire extinguishers and portable appliance testing stickers were visible and in date.

Health-based place of safety

- The health-based place of safety was situated on the first floor of the inpatient child and adolescent unit, at Parkview Hospital. Entrance to the unit was not secure. It led through a patient waiting area and a corridor, past staff offices with windows, and up a flight of stairs.
- There were ligature points (places patients intent on self-harm might tie something to strangle themselves) and blind spots (a place where a person cannot be seen) within the health-based place of safety. Staff we spoke to were aware of them. They reduced the risks these posed by using continuous patient observation and risk assessment.

Specialist community mental health services for children and young people

Inadequate

- Staff carried personal alarms to call for assistance if needed. Staff who worked in the health-based place of safety did not have training in management of aggression and violence. Staff told us if a patient needed physical restraint they would summon staff from the inpatient unit.
- Shower and toilet facilities did not have an alarm point, this meant patients could not summon assistance in an emergency.
- Staff had access to emergency life support equipment. However, we saw the defibrillator was last tested September 2015. The oxygen canister in the emergency grab bag was out of date by one month. We notified staff during of this during inspection. When we re- inspected three days later we staff had ordered a new defibrillator and the oxygen canister had been replaced and was in date.
- Fire extinguishers were accessible and in date.
- Furniture was wipe clean, strong, durable and well maintained.
- We inspected the place of safety kitchen. Staff used this kitchen to provide patient with food during their stay. We found out of date cheese in the fridge. The inside of the fridge was unclean; it had food stains on it. The freezer section was unusable, as it had frozen over. This would put people at risk of food poisoning.

Safe staffing

Community Hubs

- The provider had estimated the number of clinical staff needed during commissioning arrangements. Due to the unique service delivery, staff who worked within the hubs were either employed by Birmingham Women's and Children's NHS Foundation Trust or from Worcestershire Health and Care NHS Trust. All staff worked across the 0-25 age group as it was an integrated service. For the purposes of this report we have only reflected on staffing levels agreed to be provided by Birmingham Women's and Children's NHS Foundation Trust.
- The hubs each had a team of core staff that included psychiatrists, nurses, psychologists, occupational therapists, family therapist, psychotherapists and social workers. In addition, there were other staff who worked city wide to work with specific patient groups, for example, patients with eating disorders or neurodevelopmental conditions.
- Birmingham Women's and Children's NHS Foundation Staffing levels across all the hubs as were as follows:

  Whole time equivalent establishment (wte) : 173.5 wte

  Vacancies: 37.89 wte, that is a staffing vacancy rate of 22%

  Agency cover against vacancies: 21.5 wte

  Additional agency cover: 6 wte.
- Staff turnover (across hubs and urgent care) in the 12 months prior to inspection was 23 %.
- Staff sickness rates (across hubs and urgent care) in the twelve months prior to inspection were 3.4%.
- Staffing levels were on the Forward Thinking Birmingham risk register at the time of the inspection. Concerns highlighted were, the reduced ability to recruit into posts, staff retention and the cost of the high use of agency staff.
- All staff we spoke with expressed concern about staffing levels. They said it affected patients' continuity of care, assessment and treatment times.
- The provider employed locum/agency staff on block contracts to cover vacant posts. At the time of inspection, agency staff filled 56.26 % of the vacancies across both hubs and urgent care teams.. This meant some vacancies were left unstaffed.
- Data shared by the provider showed they had 202 clinically assessed patients on record with no recorded care coordinator. The provider told us the majority of these patients had received two contacts and where risks had been identified for patients; they were under the ongoing care of a duty worker or clinician. The provider told us they understood that a high number of these patients were under the care of a psychiatrist, but staff had not recorded themselves as a care coordinator. Other patients not allocated a care coordinator were those waiting for a specific treatment intervention. We were concerned that the trust could not provide us with accurate data.

Specialist community mental health services for children and young people

Inadequate

- The hubs with the highest number of unallocated patients were the South Hub with 80 unallocated patients. The data shared by the trust did not indicate if this was for under 18's only, therefore it may include unallocated patients above the age of 18.
- Staff told us the size of their caseloads varied. The trust told us the average caseload for each full time clinician would be 25 patients.
- At the time of inspection, managers were reviewing job plans with each member of staff. They were using a Choice and Partnership Approach tool to map caseloads to job descriptions and hours of work. This meant job descriptions would state how many assessments and therapeutic sessions staff would undertake each week. Managers told us they would complete this work by October 2017.
- There were no robust systems in place to ensure staff handover of care was safe and timely. We saw instances in care records for under 18 patients where patients' care coordinators had left the service and the staff had not handed over patients care to other staff. One example was a patient with complex needs who did not have an identified care coordinator, after their care co coordinator had left. The patient care records indicated the Birmingham Women's and Children's NHS Foundation Trust safeguarding lead contacted the service a month after the last recorded face to face contact, requesting who was holding responsibility for the patient as it was not clear in the records. Staff were unable to tell us who was following the patient up.
- Staff said they could usually access a psychiatrist when required. However, at the time of inspection the East hub told us they only had one locum psychiatrist in post. The second locum was on leave and staff were unsure whether the locum would be returning.
- Data shared by the trust indicated staff compliance rates for mandatory training varied across the hubs. The Forward Thinking Birmingham dashboard showed that mandatory training was rated amber. This indicated the average rate was below the providers target of 95% but above 80%. Health and safety, Information governance and Adult Safeguarding figures were below 80%. Adult safeguarding being the lowest at 53%. Equality training and Prevent were the only modules showing above the 95% target. Infection control and conflict resolution was 92%. The provider confirmed all agency staff were 100% compliant with mandatory training delivered by the agency they worked for.

Crisis and Home Treatment team (urgent care)

- The two teams had different staffing requirements. The provider had estimated the number and grade of clinical staff per shift using a matrix based on the teams' caseload. We found that the rotas reflected the staffing numbers calculated and needed. Generally, the crisis team had four nurses for a day shift and three nurses for the night shift. The home treatment team generally had eight nursing staff per shift.
- Data shared by the provider did not separate between the crisis and home treatment team. Staffing was as follows:

  Whole time equivalent establishment (wte) : 30.9 wte

  Vacancies: 17.5 wte. That is a staffing vacancy rate of 56%
  Agency cover against vacancies: 9.76 wte
  Additional agency cover: 5 wte
- Managers told us they booked an additional nine agency staff each week on a regular basis to give the team additional support.
- Staff turnover (across hubs and urgent care) in the 12 months prior to inspection was 23 %.
- Staff sickness rates (across hubs and urgent care)in the twelve months prior to inspection were 3.4%. This is lower than the national NHS average of 4.2%
- At the time of the inspection, the caseload for the crisis team was 25 patients and the home treatment team had 108 patients.
- During the day, the crisis team had one locum consultant psychiatrist. The home treatment team had two locum consultant psychiatrists and one substantive consultant psychiatrist. The substantive psychiatrist covered two areas. We were told they had no administrative support and they completed administrative tasks themselves. This meant they had less time on direct patient care. Out of hours staff contacted a psychiatrist from the on call rota for support.

Specialist community mental health services for children and young people

Inadequate

- Mandatory training rates supplied by the provider were not broken down into teams. Rates for the Forward Thinking Birmingham partnership were as above.

Health-based place of safety

- Staff from the crisis team staffed the health-based place of safety when needed. Each shift, a qualified staff member was allocated the role of health base place of safety coordinator. The coordinator liaised with the police, doctors and the local authority to ensure a mental health act assessment was undertaken.
- Staff reported occasional difficulties accessing psychiatrists. They also told us it was sometimes difficult accessing approved mental health professionals to attend the Mental Health Act assessments. The provider had highlighted this as a concern on the risk register.

Assessing and managing risk to patients and staff

Community Hubs

- Staff told us they completed risk assessments with patients at their first appointment. Risk assessments were tick boxes with space for staff to write a supporting narrative. For example, how a person self-harmed, or what a particular trigger was.
- During inspection, we reviewed a random sample of 19 electronic care records from across all hubs. Records showed nine patients had risk assessments. However, eight of these were incomplete, two of which, staff had handwritten and were illegible. Staff had not updated six of the risk assessments, despite clinical entries recording changes in the patient's presentation and risk. The risk assessments lacked detail, staff had not ticked all sections or where they had there was no narrative to explain why. We saw two risk assessments that different teams had completed for the same patient, on the same day, one by the community team and the other by the crisis team. One had identified concerns, the other had not, not even the concerns identified in the earlier risk assessment. Another risk assessment we reviewed had been ticked 'don't know' for all questions, including gender. Staff had not always recorded risks to or from patients. Staff did not always follow up on risks identified in triage or choice assessments. Three staff from we spoke with from Birmingham Women's and Children's NHS Foundation Trust told us they had concerns about how risk assessments were recorded. They said they always completed a risk assessment, but said the teams were not good at recording their findings and this felt unsafe. Three staff from Birmingham Women's and Children's NHS Foundation Trust told us that risk assessments were not always accessible as they had not been uploaded onto the electronic recording system. We were told that information missing from care records might have been completed and may be awaiting scanning onto the care record. We were told that the backlog of scanning was completed off site and included information from as far back as October 2016. This included choice assessments and referrals onwards.
- The records we reviewed had no evidence that staff were developing crisis plans or advanced decision statements with patients.
- Staff said they advised patients to contact their keyworkers or the duty system if they experienced deterioration in health. Staff referred patients to the 0-18 Crisis and Home Treatment team if they assessed the patient needed extra support.
- Staff advised patients awaiting assessments or on a waiting list to contact the service if their mental health was deteriorating.
- Staff had access to safeguarding training for adults and children at levels 1 and 2/3. National guidance from an intercollegiate document published by the Royal College of Paediatrics and Child Health set out minimum safeguarding children training requirements for NHS staff. All staff within a child and adolescent mental health service should be trained to level 2 minimum and all clinical staff who work directly with children and young people should be trained to minimum level 3. The trust shared data of compliance rates for safeguarding children levels 2 and 3, for all staff eligible. As at August 2017, 79.4% of eligible staff who worked directly for Birmingham Women's and Children's NHS Foundation Trust had completed safeguarding children level 3.
- Staff knew who the safeguarding lead was. Data shared by the provider showed staff had contacted the trust safeguarding team for advice 95 times during May and June 2017. The safeguarding team had delivered six

safeguarding sessions to the teams and given specific safeguarding supervision twice. Staff had attended two safeguarding multi-agency meetings. Forward thinking Birmingham had made 33 safeguarding referrals to the local authority in May and June 2017. The data was specific to the whole of Forward Thinking Birmingham and it was not clear which team or partner it related to.

- We were concerned to find staff had not always documented safeguarding concerns adequately or followed through with a referral to the local authority. We found evidence in three electronic care records, that staff had not always updated safeguarding information under the safeguarding tab, or had not followed through with a referral to the local authority when a safeguarding need had been identified. We made mangers aware of these cases during inspection.
- The trust had a lone working policy. Staff we spoke with told us the strategies they used to work safely within the community. For example, working in pairs or alerting other staff of their whereabouts. The duty worker monitored the in/ out board to ensure staff returned on time.
- During inspection we reviewed the storage, transport and dispensing of medicines across all the hubs. All hubs had lockable rooms in which to store medication. We were not assured staff were storing medicines correctly at the East and South hubs. Medicines need to be stored at the correct temperature to ensure it works effectively when taken. Some medicine deteriorates when kept at incorrect temperatures. Staff did not always record the temperature of the medicine fridge and clinic room. It is good practice for staff to record the temperatures using an external thermometer to the fridge. The medicines fridge at the East hub did not have an external thermometer.
- At the East hub, staff had not recorded the fridge temperature on 26 days and the room temperature on 30 days (out of a possible 79 days) between 1st April and 26th July 2017. We found no records of staff taking action following the missed dates. The temperatures should be taken daily.
- At the South Hub, the medicines fridge had both an external thermometer and internal thermometer. Staff told us they measured the temperature using the internal thermometer. We noted there was a four degrees difference in the temperature registered on each thermometer. We raised this with staff who were not aware of the differences or which one was accurate. Pharmacy staff told us they would not expect any staff to be recording the temperature from the internal thermometer if there was an external thermometer. Therefore staff were recorded the temperatures incorrectly. Furthermore, it was not clear which thermometer was accurate. Thermometers should have an annual calibration to ensure they are in working order. Staff were not aware if this had happened and there were no stickers on equipment to indicate this had been done.
- Nursing and medical staff across the hubs, except at the South hub, had access to patient prescription charts to ensure they administered medicine correctly. We asked to see the prescription charts at South hub and staff were unable to find all of them, as they were not kept in the clinic room. This was concerning as medicine may have needed to be administered. Staff should not administer medicines without checking the prescription charts
- Staff at the East hub told us nurses carried out weekly checks of the medicine stocks. Theses checks were not recorded anywhere. Medicine audits should be documented in order to provide assurance they have been completed and to prevent medicine errors.
- In the room used to store medication at East hub, we found three full medication disposal containers. In between two of the containers, we saw an unattached note informing staff sharps had been disposed of incorrectly within one of the three medicine disposal containers. The note did not indicate which one. This could have caused avoidable harm to staff.
- We saw evidence across all hubs that staff monitored controlled drugs according to national guidelines and two staff checked and signed stocks.

Crisis and Home Treatment team (urgent care)

- Each shift had an allocated assessment coordinator. They were responsible for gathering all known possible known risks about each referral and to check the patient's previous history on any care records available before assessment was undertaken.

Specialist community mental health services for children and young people

Inadequate

- We reviewed four care records. All had an up to date risk assessment and a management plan in place. However, three of the four had basic information only. For example, staff had ticked boxes, but had documented very little personalised information about the patient ie specific triggers or protective factors.
- Staffs were able to respond to deterioration in patients' health if alerted. They offered patients increased telephone support or home visits.
- Sixty per cent of eligible Birmingham Women's and Children's NHS Foundation Trust staff in the crisis and home treatment teams had completed level 3 child safeguarding training. National guidance from an intercollegiate document published by the Royal College of Paediatrics and Child Health set out minimum safeguarding children training requirements for NHS staff. All staff within a child and adolescent mental health service should be trained to level 2 minimum and all clinical staff who work directly with children and young people should be trained to minimum level 3.
- Staff told us the provider would not supply any agency staff with an individual

  Mobile phone to support lone working. Agency staff had access to one team mobile. However, this had been lost and not replaced. Agency staff used their own phones. The provider did not ensure t the agency staff had a personal mobile to use.
- Some staff told us that it was often difficult to get in touch with the team base for assistance when out in the community. This was because the phones were often engaged.
- Staff had access to a clinic room where stock and patient medicines were stored, along with other clinical equipment. We carried a check to review good medicines management practice. We found medicine in the medicines cupboard, which was not in its original packaging. There was out of date medicine in both the general medicine cupboard and the controlled drug cupboard. In the medicines fridge there was unidentifiable medicine and two un-named medicine pens for diabetes. Staff were unable to tell us why the medicine was there and who it was for. There were no medicine disposal bins. On a return inspection three days later, we saw staff had disposed of all the out of date medicine, except the medicine from the controlled drugs cupboard. We saw medicine disposal bins were also in place.
- We saw two staff signed medicine in and out of the clinic room. Staff had access to patient prescription charts to ensure they dispensed the correct medicine.
- Staff told us they used the external thermometer on the fridge to take the temperature of the clinical room. We saw staff had not recorded the room or fridge temperatures on eight dates in the month prior to inspection.

Health-based place of safety

- Staff completed an initial contact form to gather information about a patient's potential admission to the health-based place of safety. Information gathered included name, address, date of birth and gender, the Mental Health Act status of the patient, whether or not they were medically fit, presentation and risks, safeguarding issues and estimated time of arrival.
- We reviewed the care records for seven patients assessed at the health-based place of safety**.** All had a risk assessment. Staff wrote management plans in clinical entries. They showed evidence of working collaboratively with the police in managing risks.
- Staff documented the observation levels of patient and any ongoing monitoring.
- Staff were not trained in the management of aggression and violence. If a patient required restraint assistance would be summoned from the inpatients ward via an alarm call. Staff were trained in de-escalation techniques and spoke about how they would use these to manage potential aggression and violence.

Track record on safety

Community Hubs

- Between 1st January 2017 and June 2017 there had been one serious incident. requiring investigation that related to an under 18 year old patient.

Crisis and Home Treatment team (urgent care)

- Between 1st January 2017 and June 2017 there had been one serious incidents requiring investigation that related to the hubs.

Specialist community mental health services for children and young people

Inadequate

Health-based place of safety

- No serious incidents requiring investigation had been reported.

Reporting incidents and learning from when things go wrong

Community Hubs

- All staff we spoke to knew what to report and how to report incidents using the providers electronic reporting system. However, several staff said they did not always get feedback from incidents reported.
- Some staff employed by Birmingham Women's and Children's NHS Foundation Trust from the North Hub told us they probably underreported. Two of these staff said they were scared to report incidents as a colleague had been reprimanded following an incident report.
- Managers told us they shared any lessons learnt from serious incidents and investigations with staff through business meetings, memos and emails. We saw evidence of this on noticeboards and minutes from meetings.
- We reviewed the July 2017 governance report that showed numbers of incidents reported across all of Forward Thinking Birmingham from the previous 12 months. The highest number of incidents within the community hubs related to the environment and errors with documentation.
- Staff were not able to recall any evidence of change following incidents.
- Staff told us following incidents they would support each other informally.

Crisis and Home Treatment team (urgent care) and Health-based place of safety

- Staff from the crisis team covers the Health-based place of safety so information below is relevant to both.
- All staff we spoke to knew what to report and how to report incidents using the providers electronic reporting system. However, several staff said they did not always get feedback from the incident report. The Health-based place of safety coordinator had the responsibility to complete any incident forms relating to that unit.
- Mangers told us any lessons learnt from serious incidents and investigations shared with staff through business meetings, memos and emails. It was a standing agenda item at the team meeting. However, staff told us there was limited time to discuss issues in meetings.
- Staff from the urgent care teams reported 110 incidents during the 12 months prior to inspection. A large proportion of the incidents were due to communication failure within or external to the team. For example, staff not informing community teams of discharge, failure to contact patients, staff and patients not being able to get through to the teams via phone and missing or incomplete patient documentation. It was not clear from the data provided by the trust which incidents were specific to the under 18 service provision.
- All staff we spoke to knew what to report and how to report incidents using the providers electronic reporting system. However, several staff said they did not always get feedback from the incident report.
- We found no evidence that formal debriefs occurred after incidents. Staff told us they supported each other informally.

Are specialist community mental health services for children and young people effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Community hubs

- Staff used the Choice and Partnership approach (CAPA). This is a nationally recognised child and adolescent mental health service model complete with assessment and care planning tools. All clinical staff completed the initial choice appointment with the patient. During the choice appointments, a plan of care was agreed and if appropriate partnership appointments offered to begin treatment. Specific interventions had waiting lists and not all patients were allocated a permanent care coordinator straightaway due to difficulties with staff capacity.

Specialist community mental health services for children and young people

Inadequate

- During inspection we reviewed 19 electronic care records. These were chosen randomly. We reviewed the records with staff present to ensure we could find the information we needed and did not miss any. Of the 19 electronic care records we reviewed six had care plans. One care plan was out of date. Two had been written in the clinical entries tab and not under the care plan tab. Two had been scanned on to the record and the handwriting was illegible. One had been written to the patient within a letter. Out of the six care plans, three were holistic, personalised, recovery orientated and measurable. One had identified the patients' personal goals. The remaining three care plans were basic, lacked personal information and were not recovery orientated.
- We reviewed the care records clinical entries. We had significant concerns regarding records in all the hubs. Staff told us information missing from care records might have been completed and may be awaiting scanning onto the care record. We were told the backlog of scanning was completed off site and included information from as far back as October 2016. This included choice assessments (with indication of risk areas) and referrals onwards to other agencies. We were told letters could be generated through care notes and there would not necessarily be a delay on these appearing in records. We confirmed with staff that this meant that if correspondence had been completed through this particular method, it would be in care records and not awaiting scanning therefore we should have seen it; we did not.
- Staff were able to access information from the electronic system. Staff could view patient records from all services within the trust.

Crisis and Home treatment teams

- On inspection, staff were unable to tell us if they completed crisis assessments in a timely manner. Staff told us they often receive too many referrals to complete during the day shift. When this happened, staff left the referrals for the night shift.
- The crisis team and home treatment teams accepted trusted assessments from local agencies, for example the street triage team, local mental health clinicians from accident and emergency. A trusted assessment aims to prevent duplication of patient assessment within a short space of time and therefore minimises potential distress to patients.
- Staff told us the four-hour waiting times are hard to adhere to due to the staffing and the amount of referrals received. Staff said they often contact patients to do an assessment over the phone in order to prioritise visits.
- The crisis team provided a 72-hour care plan. Within this time, they identified a care pathway or discharge plan with the patient.
- We reviewed two crisis care plans. Interventions focused on managing the presenting crisis, safety, and discharge from crisis services. Plans were personalised, holistic and focused on goals. It was not evident from the documentation that patients had been given a copy of the care plans. Staff said they always agreed a plan of care with patients, family and or carers.
- We reviewed four home treatment patient electronic care records. They all had an up to date care plan. Three of the four care plans were personalised, holistic and had identified a range of problems and needs. One focused on goals and outcomes. It was not clear from records if staff had given patients a copy of their care plan.
- Staff were able to access information from the electronic system. Staff could view patient records from all services within the trust. This helped staff to provide safe and consistent care.

Health-based place of safety

- Staff updated the electronic patient record of patients assessed at the health-based place of safety. This included a management plan and an entry in the patient's progress record. We reviewed seven patient records and found details of comprehensive assessments undertaken by an appropriately qualified doctor.
- Staff at the health-based places of safety did not formulate care plans. However, they completed a management plan for the time the patient remained at the unit.

Specialist community mental health services for children and young people

Inadequate

- Staff were able to access information from the electronic system. Staff could view patient records from all services within the trust. This helped staff to provide safe and consistent care.

Best practice in treatment and care

Community hubs

- Forward Thinking Birmingham was part of the newly formed Birmingham Women's and Children's NHS Foundation Trust national guidance and alert triage group that reported on National Institute of Health and Care Excellence guidance. Managers said this would ensure staff had access to all new guidance relevant to mental health services.
- During this inspection we did not gather evidence regarding staff adherence to National Institute of Health and Care Excellence when prescribing medication.
- Staff offered a number of psychological therapies recommended by the National Institute for Health and Care Excellence (NICE) and as part of Children and Young peoples Improving access to Psychological therapies programme. These included; cognitive behavioural therapy, play therapy, attachment based parenting and family therapy.
- We saw evidence in care records that staff supported patients within schools and colleges.
- We saw very little recorded evidence in care records that staff considered physical health care needs. Patients on medicine did not always have a record of staff carrying physical health observations. We saw one entry in care records to indicate that medication had been increased but no letter to inform GP of change. Three of the 19 care records we reviewed showed documented evidence of physical health monitoring. All hubs had monthly phlebotomy clinics. Doctors and nursing staff told us they monitored physical health where needed and would liaise with the patients GP. We saw evidence that staff monitored patients on clozapine. This medicine has strict monitoring requirements to ensure adverse side effects are monitored and managed.
- Staff told us they used a standardised outcome measures and rating scales. These included the strengths and difficulties questionnaire, the revised children's anxiety and depression scale (RCADS) and the children's global assessment scale. Care records we reviewed showed they were uses inconsistently.
- Staff we spoke with said they were not involved in any clinical audit. Managers shared a care record audit they had completed in December 2016. The audit identified a high proportion of records lacked a risk assessment, care plan, that they required improvement in terms of making them person centred and measurable. Actions planned from this audit included the development of standard of record keeping for records, staff training and further audits. Staff we spoke to at the hubs told us they were not aware of this audit or any subsequent actions.

Crisis and Home treatment teams and health-based place of safety

- We saw evidence of staff using National Institute of Health and Care Excellence (NICE) guidance relevant to their practice for prescribing medication. This included guidance on the management of personality disorders and psychosis.
- The crisis and home treatment teams did not offer psychological therapies. If staff identified this need, staff would recommend within the patient's referral to the community team.
- The crisis and home treatment teams aimed to support patients in their own homes. Staff used a variety on interventions to support the patients through their crisis period. These included working on coping strategies, anxiety and stress management, solution focused interventions and medication monitoring, review and guidance.
- Staff assessments considered patients physical healthcare needs and they only accepted patients who had been assessed as medically fit, following an admission to accident and emergency.
- On inspection, we did not see outcome measures in care records we reviewed. Staff told us they used health of the nation outcome scales.
- Staff did carry out audit within the crisis and home treatment teams.

- Staff told us the health-based place of safety had completed an audit to identify length of patient admissions and completeness of patient section 135/ 136 Mental Health Act monitoring forms.

Skilled staff to deliver care

Community hubs

- Clinical staff we met were skilled and experienced in working within child and adolescent mental health services.
- All hubs had a range of mental health disciplines including occupational therapist, nurses, doctors, clinical psychologists and social workers. Staff said the teams would benefit from support workers to assist patients with recovery-orientated activities. The citywide learning disability team told us they did not have access to occupational therapy or speech and language therapists.
- All staff received a trust induction welcome and induction pack. This included temporary contractors, agency and bank staff. All permanent new staff completed a two-day induction training, which included mandatory training and orientation to the Forward Thinking Birmingham partnership.
- Staff told us that they received supervision and we reviewed documents confirming this.
- Staff had access to regular team meetings.
- Staff could also access group supervision from family therapists.
- Data shared by the provider showed 82.8 % of staff across the Forward thinking Birmingham Partnership had completed an appraisal.

Crisis and Home treatment teams and Health-based place of safety

- The crisis and home treatment teams consisted of doctors, nurses, support workers and administrative staff. The team did not have any other mental health disciplines.
- A senior nurse staffed the health-based place of safety when needed. Additional staffing was available on request.
- Staff we met on inspection were experienced and qualified.
- The provider shared evidence that confirmed all agency staff had received an induction.
- Staff had access to regular urgent care meetings. Team leaders recorded minutes and shared these with the team by email.
- Staff told us they received supervision and records confirmed this.
- Data shared by the provider showed 82.8 % of staff across the Forward thinking Birmingham Partnership had completed an appraisal.
- Staff on the urgent care teams received additional training to work on the health-based place of safety unit. This training covered the use of the Police and Criminal Evidence Act, Mental Health Act and Code of Practice, Jones Mental Health Act Manual, use of 135/136 legislation, relevant Children's Act legislation and the procedures for health-based place of safety. Data shared showed of the eligible 38 staff, 18 had completed the additional training. The remaining staff had dates for the training in place.

Multi-disciplinary and inter-agency team work

Community hubs

- Staff across all hubs attended regular multidisciplinary meetings. We observed one during inspection. Staff were respectful to each other and when talking about patients. However, we did not see discussions from these meetings documented in patients electronic care records. One manager acknowledged in discussion they often held information about patients that they could pass on verbally, but they did not always have time to write it down.
- Staff told us of incidents of ineffective handover between inpatient, crisis and home treatment and the community teams. For example, teams not being informed of the need for a seven-day follow up, teams giving incomplete handovers of patient care delays, incomplete discharge plans. We saw records open to individual hubs where there had been no patient activity for over six months. Many records had no explanation as to why there was no staff contact in that period and no evidence of the patient having been

referred on to another agency. In addition, in these instances no evidence of staff consistently following the did not attend policy. Where staff had handed patients over to other staff/ teams, staff had not recorded receipt of referral or transfer details and the patients record had not been closed to the service. This meant it looked as though the patient was still in service with the hubs when they may not have been. Staff we spoke with about this did not know if the patient had successfully transferred.

- Some of the records we reviewed indicated the patient did not have a care co-ordinator. There had been multiple changes of clinician throughout some patients care records due to staff leaving the service. In two records, we saw email correspondence recorded as the last note in the patient record. In both instances the emails were from one clinician to another trying to establish who is responsible for the patients care. In both instances, the email was sent over one month before inspection and in both instances the patients involved were female and under 16 years old with safeguarding concerns identified. In both records, we saw staff had not recorded a reply and this was the last note on file.
- We found another care record that showed a hospital team had referred a child to the hub following a crisis at the end of June 2017. A doctor had started the patient anti-psychotic medicine and the risk assessment completed by the referrer indicated the patient had risks to self. There was no evidence in the care record at the hub of any contact made to the patient by the hub staff. We discussed this with the manager who confirmed it was not documented that the patient had been seen by the team and was unsure if contact had been made. We escalated all our concerns regarding records on the day of inspection.

Crisis and Home treatment teams and health-based place of safety

- Staff had access to multidisciplinary meetings. On the morning of our inspection, the meeting had been cancelled, as the doctor was not available. Staff told us this happened regularly but were unable to tell us exactly how often.
- Crisis staff had a multidisciplinary meeting every Monday, Wednesday and Friday with all clinicians. This was because the team only reviewed patients for 72 hours.
- The Home Treatment Team had handovers daily with all clinicians. If clinicians are unable to attend handover, they could call in to the meeting using the phone. All visits were allocated on an evening for the next working day.
- Staff handovers were used to discuss caseloads and allocation of tasks. Staff documented and discussed key patient information. For example, location, diagnosis/ risk planned contacts. The manager of the night shift handed over every morning to the day staff and manager.
- Staff reported good working links with the police and other emergency services.

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

Community hubs

- A Mental Health Act policy was in place to provide guidance to staff on the application and use of the Mental Health Act and the Code of Practice.
- Staff we spoke to had an understanding of the Mental Health Act and the Mental Health Act Code of Practice.
- At the time of inspection Mental Health Act training was not mandatory. However, the provider confirmed that it would be introduced as mandatory training in January 2018. The provider had a training schedule to support this process.

Crisis and Home treatment teams and health-based place of safety

- Staff knew how to access support from Mental Health Act administrators.
- The last CQC inspection May 2016 had found that the health-based place of safety policy had not been updated in line with the revised Code of Practice 2015. During this inspection, we saw that provider had amended the policy correctly and in it was in line with the 2015 guidance.
- At the time of inspection Mental Health Act training was not mandatory. However, the trust confirmed it would

Specialist community mental health services for children and young people

Inadequate

be mandatory training in January 2018. The provider had a training schedule to support this process. However, the providers health-based place of safety policy stated staff working on the unit required additional training which covered use of the Police and Criminal Evidence Act 1984, Mental Health Act Code of Practice, Jones Mental Health Act Manual, use of 135/136 legislation, relevant Children's Act legislation and the procedures for health-based place of safety. Data shared showed of the eligible 38 staff, 18 had completed the additional training. The remaining staff had dates for the training in place.

- Clinical staff at the health-based place of safety completed a Section 135/136 place of safety monitoring form that accompanied detained patients.
- Staff at the health-based place of safety was responsible for recording legal matters and the outcome of assessments. Staff uploaded completed forms to patient's electronic records.
- Staff told us they recorded the start and end of each section 136 admission. Documents showed there had been 19 patient admissions to the unit since January 2017. Staff had recorded all admission start times, but four records did not have a recorded time of discharge.
- Staff used a checklist to ensure patients were explained their rights, the process of the assessment. They also gave the patient information on the process to follow if they wanted to complain to the hospital managers or CQC.
- Patient care records we reviewed showed staff involved carers and families, where appropriate in Mental Health Act assessments.

Good practice in applying the Mental Capacity Act

Community hubs

- The Mental Capacity Act only applies to young people 16 years old and over. For young people under 16 years old, Gillick competence is used to determine if the young person is able to consent to their treatment.
- Staff had documented in 6 out of the 19 care records we reviewed to show they had considered consent when explaining treatment options and decision-making. However, when speaking with staff it was clear they had knowledge of capacity to consent and Gillick competence and applied this during care and treatment.
- Staff we spoke with told us they could access the Mental Capacity Act policy on the intranet.
- Staff we spoke with were not aware of any arrangements in place to monitor the adherence to the Mental Capacity Act within the trust.
- Training data as at June 2017 showed 89% of staff had completed training in the Mental Capacity Act and 92.6% had received training in Deprivation of liberty safeguards.

Crisis and Home Treatment teams and health-based place of safety

- Of the four care records reviewed for the urgent care teams, none had recorded that staff had considered Gillick competence or consent.
- Training data as at July 2017 showed 30.3% of staff had completed training in the Mental Capacity Act and Deprivation of liberty safeguards.
- Staff we spoke with told us they could access the Mental Capacity Act policy on the intranet.
- Staff we spoke with were not aware of any arrangements in place to monitor the adherence to the Mental Capacity Act within the trust.

Are specialist community mental health services for children and young people caring?

Requires improvement

Kindness, dignity, respect and support

Community Hubs

- During inspection, we observed three patient appointments. Staff were caring, respectful and showed expertise during their interactions with patients. They

demonstrated good listening skills and adjusted their use of language when needed. For example, we observed staff phrase questions in different ways so a child could understand.

- We observed staff discussing patients with respect at clinical review meetings.
- Patients and carers we spoke with told us staff were kind and caring. They felt supported and listened to.
- The Trust completed a review of complaints received about the community hubs between December 2016 and May 2017. The complaints were categorised as concerns, formal complaints and professional concerns. Of the 92 complaints, 10 were about staff having a unprofessional attitude towards the patient or carers. For example, staff being insensitive or rude. For the period of December 2016 and May 2017 there had been 6 formal complaints relating to the care of under 18 year olds.
- Staff did not always maintain confidentiality. We found patient identifiable information left on a worktop in the clinic room at the East hub. Staff told us of numerous administrative errors where letters or emails containing patient information were sent to incorrect addresses. We heard administrative staff talking about confidential information in front of visitors in the waiting area at the West hub.
- Staff did not always document how patients were involved in their care plans.

Crisis and Home Treatment and Health-based Place of Safety

- During inspection we did not observe staff contact with patients, family or carers. However, we heard staff speak about patients with care, respect and in a professional manner.
- Staff we spoke to had a good understanding of their patient's needs, emotionally and practically.
- We observed staff maintaining confidentiality, for example sharing information on a need to know basis only. All patient documentation was stored electronically or locked away.
- Staff took patients to the health-based place of safety through a waiting area and passed by staff offices, which had windows. We were concerned that a patient's dignity and confidentiality could be compromised as they walked through these areas.

The involvement of people in the care they receive

Community Hubs

- Patients we spoke with during inspection told us they had been included in planning their care. However, staff did not consistently evidence this in care records.
- Staff told us they offer support to families and carers where needed. We saw evidence of this is clinical entries within care records.
- We reviewed data from the friends and families questionnaire for April 2017. Out of 45 completed forms, 30 had positive feedback. Most of the negative feedback was about parking arrangements and the appearance of waiting rooms. The trust also sought feedback from social media sites.
- All hubs had leaflets available informing patients, families and or carers of local advocacy services.
- We saw people were able to give feedback on the care they received in various ways. This was through either family and friends questionnaires or the patient and liaison service.

Crisis and Home Treatment and Health-based Place of Safety

- Care records we reviewed did not indicate if staff offered or gave patients a copy of their care plan.
- Staff we spoke said they were familiar with advocacy services and knew where to obtain information for patients.
- Staff said they involved carers and family but did not give any examples.
- We saw patient feedback forms in the health-based place of Safety.
- Staff told us patients could request family members or carers attend to support them at the health-based place of safety.

Specialist community mental health services for children and young people

Inadequate

- Staff told us they engaged with the patient and encouraged them to participate in the assessment and management process.
- Staff we spoke said they were familiar with advocacy services and knew where to obtain information for patients.

Are specialist community mental health services for children and young people responsive to people's needs?

(for example, to feedback?)

Inadequate

Access and discharge

Community Hubs

- Managers told us they were not sure how many referrals the hubs received each week as this was managed by another partner within Forward Thinking Birmingham.
- Staff told us the access centre staff book in initial assessments appointments for the hubs through staff calendars. They were concerned that the access team occasionally booked patients into hubs not within their geographical location. Staff said this contributed to patients not attending their appointments. Staff did not feel the access team looked at clinician skills to see which clinician would be best suited to complete the initial assessment.
- Patients have the right to access treatment within maximum waiting times. The NHS constitution sets out that patients should wait no longer than 18 weeks from referral to treatment. As at 28 July 2017, the total number of patients who had waited longer than 18 weeks to access treatment was 266. The hub with highest number of patients waiting more than 18 weeks was the East hub with 98, followed by the South hub with 83. There were eight patients who had been waiting more than 52 weeks.
- Data shared showed there were 176 patients waiting for the next appointment to begin therapeutic work. We did not have data to reflect how long they had been waiting.
- The hubs had a duty system in place. Some staff told us this was for patients above the age of 18 only and there was not a duty system in place for under 18's. Others told us it was for all age groups. We reviewed the standard operating procedure for the duty worker provided by Forward Thinking Birmingham. It stated that staff (band 5 or above) should take part in a duty rota to take responsibility for the entire hub for any clinical or operational issues. It did not state the role was for over 18's only. We were concerned that staff were not clear about the role of the duty worker.
- Staff told us they would actively follow up patients who did not engage. However, we saw in six patient care records, where staff had recorded that the patient had not attended their appointment but had not documented what action was to be taken. Staff had not documented any attempt to follow up. On one electronic care record, we read about a patient who had self-harmed on two occasions, staff had not recorded any attempts to contact this patient when they did not attend an appointment following these incidents.

Crisis and Home Treatment teams

- Emergency assessments were accepted by the Crisis team 24 hours a day, seven days a week, from a wide range of professionals including, GP'S, mental health professionals, Police, RAID, Health-based place of safety, Psychiatric decision unit and street triage teams. They also accepted self-referral from known patients.
- The Home Treatment team provided a service between 8am and 8pm, seven days a week. The Crisis team provided an urgent service to patients after 8pm if needed.
- The Crisis team offered emergency same day assessment to those at risk of immediate and significant harm to self and or /others. They acted as gatekeepers to inpatient admissions ad supported early discharge from inpatient units. They did not have waiting lists.
- The Crisis team had a key performance target of providing a four hour response to patients following referral. On inspection, staff told us, it was a struggle to meet this target. They often contacted patients to do a risk assessment over the phone in terms of prioritising visits.
- Staff had clear guidelines to follow if they were unable to make contact with patients.

Specialist community mental health services for children and young people

Inadequate

- The Home Treatment team accepted referrals from the Crisis team and other staff from within Forward Thinking Birmingham. They had no waiting list.
- Both the urgent care teams had clear patient entry and exit criteria for staff to follow. The teams were able to respond to patients promptly when contacted by phone. Although there had been a number of complaints from patients stating they had difficulty getting through to the team on the phone.
- Staff said they were flexible with patient appointments where possible.

Health-based Place of Safety

- The Health-based Place of Safety was available for use 24 hours a day, seven days a week.
- The unit had capacity for one patient under the age of 18. If a second patient required a health-based place of safety, police sought alternative options.

The facilities promote recovery, comfort, dignity and confidentiality

Community Hubs

- All of the hubs apart from the South hub had sufficient rooms to support treatment and care. Staff at the South and East Hub voiced concerns about the general environment. They did not have enough interview rooms and often undertook appointments in the clinic room. This was not a suitable environment, as it was a clinical room where physical examination equipment and medicine was stored.
- The providers had placed the environment of both the South and East hubs on the risk register. We reviewed the risk register and it stated the accommodation for the community teams at the East and South Hubs were unfit for purpose.
- All staff told us the agile working policy did not work. They said there was not enough computers and desk space to work. The trust had provided staff with tablets in order to work remotely. However, staff said this only worked if care record information had been preloaded and there were connectivity issues. Staff reported they were sometimes unable to complete clinical entries due to lack of access to computers. One member of staff told us it was common for staff to have to wait an hour or more to access a computer. Staff at the East hub told us the Wi-Fi did not work properly which meant using the tablets to upload work was difficult.
- The rooms in the North and South hubs were hot and some did not have windows. The Forward Thinking Birmingham quality report had identified in June 2017, 10 out of 42 incidents reported related to high temperatures with in rooms. Nine of these were related to the South Hub.
- Staff at the West hub told us the service no longer provided play equipment for therapy sessions. Management told us, this was because they could not evidence the equipment was kept clean. This had led to staff bringing three own supplies.
- We heard conversations from within clinic rooms in the South and North hubs as the rooms were not adequately soundproofed. The reception areas at both the South and West hubs did not provide patients with adequate privacy when talking with the receptionists. One patient we spoke with said they had heard a receptionist giving patient details aloud over the phone.
- Patient waiting areas were tidy. The North hub had toys and crayons available to children and child seating. The others had minimal facilities for children and adolescents.
- We saw leaflets in waiting rooms appropriate to the needs of people who used the service. For example, information about advocacy, how to complain and compliment and psycho educational material. Staff told us leaflets were available in different languages if needed.

Crisis and Home Treatment

- Staff from the Crisis and Home Treatment teams primarily worked within patients' homes or other community facilities.
- There were adequate rooms at the team base for staff to have supervision and meetings.

Health-based Place of Safety

- The unit provided the necessary rooms and equipment for assessing patients detained under Section 135/136 of the Mental Health Act.

Specialist community mental health services for children and young people

Inadequate

- Staff had access to a kitchen to provide patients with refreshments and food.
- The furniture was clean, comfortable and durable.
- There was a camp bed available if the patient wished to sleep.
- Patients had access to a shower.

Meeting the needs of all people who use the service

Community Hubs

- The North hub was not compliant with the Disability Discrimination Act as it was only accessible by the stairs. Staff told us they arranged to see patients who could not access the stairs at a local hospital. However, this information was not included in its appointment letters, therefore patients were not always aware of the issue. All other hubs had disabled access and adapted toilet facilities.
- Staff said they were able to access interpreters easily if needed.

Crisis and Home Treatment (urgent care)

- Staff knew how to access interpreters and or signers.
- Staff said they were able to access interpreters easily if needed.

Health-based Place of Safety

- Although access to the unit was by the stairs, there was a lift available.
- Info leaflets about local resources, advocacy, and patient's rights were available.
- The suite did not have access to spare clothing if patients needed these.
- There was no clock on the unit. This meant patients were unable to know the time without asking staff. A patient that is distressed may not feel comfortable asking staff.

Listening to and learning from concerns and complaints

Community Hubs

- Data shared by the Trust showed they reviewed and monitored complaints. The trust had completed a review of complaints in May 2017 to identify themes and take actions to improve where needed. Between December 2016 and May 2017 the total number of formal complaints relating to the hubs was 11. They had also received 15 professional concerns and 28 informal complaints received through the patient advice and liaison service. It identified that the South Hub had received the most complaints. An additional five formal complaints were made in June 2017. At the time of inspection 16 formal complaints remained open for ongoing investigation. Complaints ranged in nature from not receiving an appointment letter, lack of staff availability, care and treatment not being delivered in a timely manner and poor communication.
- All patients' we spoke with knew the process to make a complaint.
- Staff said they sometimes received feedback about complaints by email or within team meetings.

Crisis and Home Treatment teams (urgent care) and health-based place of safety

- Data shared by the provider showed the urgent care teams received two formal complaints, six professional concerns and four complaints through the patient and liaison service. Themes identified included communication delays, for example, patients not being able to get through to the service by phone and delayed handover between urgent care and community hubs.
- The data shared by the provider did not show any complaints about the Health-based Place of Safety

Are specialist community mental health services for children and young people well-led?

Inadequate

Vision and values

Community Hubs, Crisis and Home Treatment teams and health-based place of safety.

- Birmingham Women's and Children's NHS Foundation Trust officially launched in February 2017 following the integration of Birmingham Women's Hospital together with Birmingham Children's Hospital. At the time of

inspection the trust was working on a set of values based on four common goals: safe, high quality care today, continually looking to improve and be even better, working in partnership with others and leading the way across health care. They are the lead provider of Forward Thinking Birmingham. Forward Thinking Birmingham aims to provide a seamless mental health service for 0-25 year olds across Birmingham. However, staff employed by Birmingham Women's and Children's NHS Foundation Trust told us it felt disjointed and they did not feel it offered a seamless service.

- Some staff from we spoke with from Birmingham Women's and Children's NHS Foundation Trust were not clear about the vision and values of the service.

Good governance

Community Hubs, Crisis and Home Treatment teams and health-based place of safety.

- The trust had a dedicated Forward Thinking Birmingham quality and governance lead, a compliance lead and governance facilitator who provided monthly quality and governance reports for Forward Thinking Birmingham. The reports were aligned with the five CQC domains of safe, effective, caring, responsive and well led. Governance reports produced for the community services did not always differentiate between the age of the patients, they reported on the governance of each hub has an integrated teams i.e. a 0 -25 service. This means some data shared by the trust may be representative of the over 18 aspect of the service. It was not always clear if it reflected only the under 18's.
- Mandatory training data provided by the trust was unclear. Data showed training rates for all staff members within the integrated team. At times it was categorised under which trust the staff worked for, other times it was categorised together. This meant that there was no clear system for monitoring training compliance. We found Mental Health Act training was not part of the mandatory training schedule for staff despite the service being a mental health service. Staff who worked within health-based place of safety were not trained in management of violence and aggression. This was concerning as staff working in this type of setting are likely to experience violence and aggression at some point during the course of their work from an unwell patient group and should be equipped with skills to manage situations appropriately. The inspection demonstrated that staff from partnership agencies work as part of the staff team who carry out the regulated activities in relation to children 0-18 years, which is the service provided by Birmingham Women's and Children's NHS Foundation Trust. It is the responsibility of Birmingham Women's and Children's NHS Foundation Trust to ensure staff providing care for their service are trained adequately, as they take the governance lead. We found there was a lack of oversight in relation to the staff training. There was not an effective system in operation to ensure that all staff working with children under 18 years had the appropriate level of children's safeguarding training. We could see from the data supplied by the trust, that staff employed by a partner of Forward Thinking Birmingham to work within the hubs and urgent care, had not all been trained to that level. Data indicated for this staff group that the compliance rate was between 0 -17% for level 3 children's safeguarding.
- Clinical supervision structures were in place and 81% of staff across the community services had completed an appraisal. Data shared did not differentiate between staff from the two trusts who provide the service.
- There was little evidence of clinical audit across the core service. Staff told us they did not have time.
- There was limited evidence to suggest staff had opportunities to learn from incidents, complaints and service user feedback. For example, Staff we spoke with were unaware that managers had completed a caseload audit in December 2016.
- The provider used key performance indicators to measure the effectiveness of the service. For example, referral to treatment times, sickness rates, mandatory training rates, 7-day follow-ups. However, inconsistent data collection did not assure us they gave an accurate judgement of overall performance and quality.
- Staff told us they were not always able to maximise their direct care activities. Staff reported ongoing issues with agile working and accessing computers, which prevented them documenting in care records in a timely manner. Psychiatrists in urgent care teams competed their own administrative tasks and therefore had less time for patient contact.

Specialist community mental health services for children and young people

Inadequate

- Hub managers felt they had sufficient authority and administrative support. However due to vacancies they often covered more than one hub which meant they could not always adequately manage one hub. They also told us it was difficult monitor how well their hub was performing against its key target areas, as the dashboard did not breakdown data to specific hubs.
- Staff were unsure if they could submit items to the risk register. Hub managers and team leaders were aware they could. At the time of inspection there were 33 identified risks, 22 were relevant to the community services inspected. Managers had rated five of these risks as moderate risks. All had a review date.
- We had concerns about the organisational governance overall. There was a lack of clarity amongst staff regarding the standard operating procedures for seven day follow ups and the duty system. The trust did not appear to have full oversight of the waiting list due to incompatible software and the trust electronic recording system. Governance systems had not alerted managers to all of the concerns we found during inspection. Where the trust had highlighted concerns there was little evidence of action being taken. Following the inspection in May 2016, we told the provider of the actions they must take in order to improve the service. During this inspection, we identified that the trust had only completed three of the eight actions we had told them they must complete. During inspection, we identified a number of concerns in relation to infection control, medicines management practice, health and safety, risk assessment, care planning, safeguarding, patient record keeping, staffing, governance and leadership. There did not appear to be an overall process in place to address and improve issues we had identified. Data shared by the trust was at times contradictory and not always broken down between hubs and teams. The trust themselves had identified issues with data collection amongst staff and systems.

Leadership, morale and staff engagement

Community Hubs, Crisis and Home Treatment teams and health-based place of safety.

- Each hub had a designated hub manager. At the time of inspection, there was one vacancy, which meant one hub manager was covering two hubs. Each hub also had a team lead. There were also team leads for the citywide services as well as the urgent care teams.
- Sickness rates were reported monthly in the Forward Thinking Birmingham quality and Governance report. The June 2017 report showed sickness rates were 3.59% for Birmingham Women's and Children's NHS Foundation Trust hospital staff.
- Most staff were aware of whistle blowing procedures and the role of the CQC in supporting staff who wish to raise concerns. However, two told us they were not aware of the whistle blowing policy and two indicated they would not feel comfortable raising a concern.
- Not all Birmingham Women's and Children's staff we interviewed during the inspection felt confident in being able to raise concerns with their local managers without fear of victimisation. Two told us they were not aware of the whistle blowing policy and two indicated they would not feel comfortable raising a concern.
- Staff morale was very low across the whole of the community services. Staff said they were demoralised by others leaving and not joining, worried that they don't have time to adequately mange care record documentation, concerned that something might happen, and feel they will get the blame from the management. Staff also expressed dissatisfaction with the agile working arrangements, the premises from which they worked and lack of feedback from higher-level management.
- Staff told us there were opportunities for leadership development.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
The provider MUST:

- The trust must ensure that have a procedure in place so all staff are aware of how to respond to an activated alarm (personal or built in) at all hubs.
- The trust must ensure that all staff are able to follow the lone working policy and all steps are taken to ensure that the processes are in place for them to do so.
- The trust must ensure that all staff adhere to the infection control policy and have the equipment available to do so.
- The trust must ensure that equipment used to monitor physical health are clean, and cleaned regularly, is calibrated and maintained in accordance with manufacturers guidelines and a record of when this was done is kept.
- The trust must ensure that all substances hazardous to health are kept securely locked away.
- The trust must ensure that fire doors are not propped open.
- The trust must ensure that staff follow the standard operating procedures for seven-day follow-ups and understand who is responsible for care and treatment when it is shared across teams.
- The trust must ensure that medicines are stored, dispensed and disposed of safely. The trust must ensure that staff undertake medicines audit regularly and complete actions from audits.
- The trust must ensure that facilities for storing patient food are cleaned and maintained in accordance with food safety and hygiene standards.
- The trust must ensure that patients' privacy, dignity and confidentiality are maintained at all times. All patient identifiable information must be stored in line with Caldecott principles.
- The trust must ensure that all staff are trained to the required levels in safeguarding adults and children and ensure staff follow up on all safeguarding concerns.
- The trust must ensure that care records are clear, legible, and contemporaneous and reflect all contacts with or about patients.
- The trust must ensure that staff follow the correct procedures when patients do not attend their appointments.
- The trust must ensure that staff have access to information needed to manage patient care is accessible and available for staff. This includes improving agile working practices and complete and contemporaneous care records.
- The trust must ensure that that staff document consent to treatment within patient care records.
- The trust must ensure that there are sufficient numbers of skilled and qualified staff to provide an effective service.
- The trust must ensure that patients have a risk assessment and management plan in place that is complete and updated on a regular basis.
- The trust must ensure that staff complete care plans using the care planning documentation, that care plans are person centred and reflect changes in patients' wellbeing and behaviours.
- The trust must ensure that staff who work in the health base place of safety are trained in physical intervention to manage challenging behaviours safely and in a timely manner.
- The trust must ensure that governance processes are robust and systematic in order to identify and manage risks, monitor performance and provide a safe service for patients and staff.
- The trust must ensure that they review the environmental risk assessments of all hubs and action all concerns identified in the previous assessment.

Outstanding practice and areas for improvement

- The trust must ensure that toys in waiting areas and those used for therapeutic means are cleaned and maintained and a record of cleaning kept.
- The trust must ensure that all areas are clean, there is a regular cleaning schedule in place, and its adherence monitored.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure that their plans to make Mental Health Act training mandatory are completed.
- The trust should ensure that all lessons learnt are communicated to all staff.
- The trust should ensure that staff are clear about which age group of patients can access the duty worker.
- The trust should ensure that all staff have access to play therapy equipment needed for clinical work.
- The trust should take precautions to ensure interview rooms used to meet with patients are sound proof.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • Care plans were not up-to-date or personalised, and did not reflect progress towards recovery. They did not indicate if the patients were involved in planning their care. This was a breach of regulation 9 (3)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Not all patients had risk assessment and risk management plans in place. Risk assessments were not kept up-to-date. • The trust did not have a procedure in place for staff to follow when an alarm call was activated. • The trust did not ensure that all staff were able to follow the lone working policy and did not take steps are taken to ensure the processes were in place for them to do so. • The trust did not ensure staff followed the standard operating procedures for seven day follow ups and understand who is responsible for care and treatment when it is shared across and within teams.

This section is primarily information for the provider

Requirement notices

- Staff did not always adhere to infection control standards.
- Staff did always follow the correct procedures when patients do not attend their appointments
- The trust did not ensure medicines were stored, dispensed and disposed of safely.
- The trust did not ensure equipment used to monitor physical health was clean, and cleaned regularly, was calibrated and maintained in accordance with manufacturers guidelines and a record of when this was done kept.
- The provider did not ensure the kitchen area in the health-based place of safety complied with national infection control standards.

This was a breach of regulation 12 (2) (a)(b)(d) (e)(g)(h)(I)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The trust did not ensure staff maintained an accurate, complete and contemporaneous record in respect of each service user. Care plans and risk assessments were incomplete. Not all records were legible, clear and contemporaneous. Not all patient information was stored in line with Caldecott principles. • The trust did not follow up on actions identified in environmental risk assessments and audits.

This section is primarily information for the provider

Requirement notices

- The trust did not ensure that staff always had access to information needed to manage patient care.

- The trust did not ensure that its governance processes were robust and systematic in order to identify and manage risks, monitor performance and provide a safe service to patients and staff.
- The trust did not have effective oversight to ensure that all staff who worked within the hubs and urgent care, with under 18's, were trained to the appropriate levels in children's safeguarding.

This was a breach of regulation 17 (1) (2)

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing

- Not all staff were up-to-date with their mandatory training. Not all eligible staff were trained to levels 2 and 3 in safeguarding children.
- Vacancy rates across the core service were high. This was on the trust risk register at the time of our inspection.
- The trust did not ensure that staff who worked in the health base place of safety were trained in undertaking physical interventions to manage challenging behaviours safely and in a timely manner.

This was a breach of regulation 18 (1) (2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	• The provider did not ensure that that staff documented consent to treatment within patient care records. This was a breach of regulation 11 (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The trust did not ensure that they reviewed the environmental risk assessments of all hubs and action all concerns identified in the previous assessment. • The trust did not ensure toys in waiting areas and those used for therapeutic means were cleaned and maintained and a record of cleaning kept. • The trust did not ensure that all areas were clean. • The provider did not ensure substances hazardous to health were stored in line with current legislation and guidance. • The trust did ensure that staff always complied with Fire regulations. This was a breach of Regulation 15 (1)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

- Staff did not always follow up on safeguarding concerns.
- Not all staff were trained to the required standards for Safeguarding children and adults.

This was a breach of regulation 13(1)(2)