Birmingham and Solihull Mental Health NHS Foundation Trust

Community-based mental health services of adults of working age

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Community-based mental health services of adults of working age

Requires Improvement 

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health services for people of Birmingham and Solihull, and to communities in the West Midlands and beyond.

Birmingham and Solihull Mental Health NHS Foundation Trust was established on 1 July 2008. Before becoming a foundation trust, the organisation was created on 1 April 2003 following the merger of the former North and South Birmingham Mental Health NHS Trusts.

The trust provides a range of inpatient, community and specialist mental health services for people from the age of 16 years upwards in Birmingham and for all ages in Solihull. However, the trust provides services to children younger than 16 in forensic child and adolescent mental health services and Solar services (an integrated service with trust staff, Barnardo's and Autism West Midlands staff working alongside each other). Other community mental health services for children and young people in Birmingham are provided by another NHS trust.

The trust provides services to 73,000 service users, with 700 inpatient beds across over 40 sites. The Trust has an annual income of £429 million and a workforce of around 4,000 staff.

We carried out this short notice announced focused inspection of community-based mental health services for adults of working age provided by this trust because we received information giving us concerns about the safety and quality of the services. We received information about serious incidents involving people who use the service. We inspected the Safe, Effective and Well Led key questions at this inspection.

Our rating of community mental health services for adults of working age went down. We rated them as requires improvement because:

- The service did not have enough staff to safely care for the people who used the service.
- Staff did not always assess and review risks for people who used the service and record these well.
- The medicine management systems were not managed well and meant that people may not receive their medicines in a timely way or the right medicines at the right time to treat their condition.
- Staff did not always know the lessons learned from incidents and these were not always communicated well.
- Staff did not always record what care a person needed and did not always record care and treatment given to people.
- Managers did not always monitor the effectiveness of the service and staff did not complete audits which could be used to improve the service.
- Leaders did not have information from audit processes to be able to run the service well.

Our findings

However:

- The environments were clean, well-maintained and fit for purpose.
- The service had robust lone working protocols, which staff followed.
- Staff had training in key skills and understood how to protect people from abuse.
- The service managed and controlled infection and prevention risks well.
- Staff worked well together for the benefit of people who used the service and advised them on how to lead healthier lives.
- Staff understood the service's vision and values, and how to apply them in their work.
- Staff felt respected, supported and valued. They were focused on the needs of people who used the service.

Following this inspection, due to concerns we found within the service, we issued the trust with a Section 29A Warning Notice requiring the trust to make significant improvements regarding governance systems to ensure patient risk and medicines are managed safely. The trust responded to this with action plans to show that action was being taken to reduce these risks and we are monitoring their progress with these.

What people who use the service say:

Most people told us the staff had been very helpful and kind. They said the service had been very good and they had received amazing support. However, some people said that staff on the telephone had not always been helpful and could sometimes be rude.

Three people said they did not have information as to who to contact if they were in crisis so would ring 999.

Two people said appointments were rushed and staff didn't really listen to them, they thought that staff cared but were very busy.

Some people said they waited 1 to 2 weeks to see a psychiatrist. People told us they did not always see the same psychiatrist, which was difficult and meant there was no continuity in their care. They felt that they had to repeat their symptoms and their story each time they saw a psychiatrist.

People said that when they try and phone it can be difficult to get through, but when they contacted the service by email, they usually got a quick response.

Only 14 of the 40 people we spoke with said they had information about their medicines.

People said that staff gave them advice about healthy eating, exercise and good sleep patterns, and suggested they avoided using alcohol and illicit drugs. However, only 8 of the 40 people we spoke with said they had a care plan that they were involved in.

Our findings

People told us they did not have information on how to make a complaint, however most people said they did not need to make a complaint.

Is the service safe?

Requires Improvement 

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. In all services we visited managers had completed environmental risk assessments which included ligature risk assessments. They took action to reduce risks and people using the service were always accompanied by staff in rooms.

All interview rooms had alarms and staff available to respond. Staff showed us where alarms were in interview rooms and showed us that these were regularly checked to make sure they were working. When staff did not have access to alarms, they used their lone working device to alert other staff if they needed assistance. All staff said that alarms were responded to if needed. In some offices there were security staff available to respond if needed.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. Staff had access to equipment to use for patients' physical health examinations that they used in the team offices or when visiting people at home.

We visited each location where community mental health services were based. All areas were clean, well maintained, well-furnished and fit for purpose. People who used the service told us when they visited the community mental health teams, the rooms were always clean and tidy.

Staff made sure cleaning records were up-to-date and the premises were clean. All services we visited were clean and cleaning records were up to date. We saw clean stickers in rooms to show they had been cleaned and were ready to use.

Staff followed infection control guidelines, including handwashing. In all services we visited there were hand washing facilities provided. We observed staff in clinics washing their hands and following infection control guidelines. The trust provided data about infection prevention and control training which showed that not all teams had received this. However, at time of inspection over 83% of staff had completed Infection Prevention and Control training level 1 except for Yewcroft CMHT where only 67% of staff had completed this. For level 2 training in Infection Prevention and Control over 85% of staff had completed this training except for Small Heath CMHT which was 77%, Warstock 71% of staff and at Lyndon CMHT only 57% of staff had completed this. However, the trust showed that monthly hand hygiene audits had been completed in the teams. All teams scored above 87% in these. The trust ensured that all staff were aware of the trust policy on fingernail requirements following these audits.

Staff made sure equipment was well maintained, clean and in working order. We saw that equipment was clean and checked to make sure it was working and safe to use.

Our findings

Safe staffing

The service did not have enough staff. Staff had received basic training to keep them safe from avoidable harm. The number of people on the caseload of medical staff was too high which prevented staff from giving each person the time they needed.

Nursing staff

The service did not have enough nursing and support staff. There were band 6 vacancies across the teams and the trust told us these posts had been difficult to recruit to. The trust was looking at different ways to recruit to these posts. They had plans to employ newly qualified nurses, at band 5, who had previously worked as student nurses in the teams. The plan was for them to receive mentoring and support to progress to band 6. In the interim where there were vacant band 6 posts, these were covered by locum agency staff or experienced nurses who had retired and returned. Staff told us they did not have time to always complete and update people's risk assessments and care plans and we found this during this inspection.

The service had decreasing vacancy rates for nurses at 6% which had decreased from 22% in January 2023. These vacancies were: 5 band 5/6 mental health nurse preceptorship roles; 2 band 5 depot clinic nurse; 2 band 6 clinic and physical health nurses; 7 band 6 community mental health nurses; 5 band 7 advanced nurse practitioners; 3 band 7 clinical leads.

The service used bank and agency nurses and nursing assistants. Data provided by the trust showed in July 2023 across this core service, that bank and agency staff were requested to cover 1144 shifts. A total of 93% of these shifts were filled with bank staff covered 949 shifts and agency staff covered 122 shifts. This had increased from June 2023 when bank and agency staff were requested to cover 1107 shifts and in May 2023, 1118, shifts. Some vacancies were filled by nurses who had retired and returned and had worked in the service before. This meant they knew many of the people who used the service and were experienced.

Managers made arrangements to cover staff sickness and absence. Managers limited their use of bank and agency staff and requested staff familiar with the service. This was covered by bank and agency staff and for long term sickness cover, the trust tried to use regular staff who knew the service and people who used it.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Some staff had retired and returned and knew the service well. Bank and agency staff told us they received an induction.

Managers supported staff who needed time off for ill health. Sickness levels were mostly higher than the trust target of 3.9%. Data provided by the trust showed at time of inspection the sickness levels for East Hub was 12%, for West Hub was 4% and North Hub was 1%. The South and Solihull teams' data was presented per team (Zinnia, Longbridge, Lyndon, Newington, Yewcroft and Warstock) the lowest was at Newington at 6% and the highest was Longbridge at 12%.

Managers used a recognised tool to calculate safe staffing levels. The number and grade of staff matched the provider's staffing plan. The trust told us that due to the national transformation plan for mental health services it had received money to fund some new posts. This had affected the number of staffing vacancies as it now had posts for support time recovery workers and mental health and wellbeing practitioners. However, some of these posts had been filled and others were being recruited to. The trust told us at time of inspection, there were 3 support time recovery posts, 2 senior support time recovery posts and 3 mental health and wellbeing practitioners vacant across this core service.

Our findings

Medical staff

The service did not have enough substantive medical staff. Across the service there were vacancies for psychiatrists and vacant posts were filled by locum staff.

Managers used locums when they needed additional support or to cover staff sickness or absence. However, locums were also needed to cover vacancies across the teams. People who used the service and staff said this often meant that they did not have continuity of care. People said that they often had a different psychiatrist at every appointment which meant they had to explain their symptoms each time. Permanent doctors said that often locums would stay for only 2 to 3 months which put additional pressure on them and their caseload. They said that as demand on the community services had increased, the number of doctors employed had not increased so their caseloads were high. They had raised this with the trust new medical director who they felt listened to their concerns.

Managers made sure all locum staff had a full induction and understood the service. Doctors told us that locums had an induction and were supported by permanent staff.

The service could get support from a psychiatrist quickly when they needed to. People who used the service and staff said they could access a duty psychiatrist if needed. People said they could access a psychiatrist when needed. However, some people said their psychiatrist often changed which meant there was not always continuity of care.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Training data provided by the trust showed that over 75% of staff had completed and were up to date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training including safeguarding children and adults, infection prevention and control, fire safety, emergency life support and intermediate life support, clinical risk assessment, dual diagnosis, electronic prescribing for nurses and prescribers, equality, diversity and human rights, food hygiene, health and safety, information governance, moving and handling, medicines code awareness, mental capacity act, mental health legislation, NHS conflict resolution, preventing radicalisation, suicide prevention and falls prevention.

Managers monitored mandatory training and alerted staff when they needed to update their training. All staff told us that they could access the system that told them when they needed to update their training and managers also alerted staff to this.

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well. They did not always respond promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of patient risk

Our findings

Staff completed risk assessments for each patient on admission to the service, using a recognised tool, but did not always review this regularly, including after any incident. In 5 of 7 records, we reviewed at Warstock Lane staff had not reviewed the person's risk assessment when risks were identified by staff in the person's progress notes.

Staff did not have access to up-to-date risk assessments as accurate risks were not reflected and risk management plans had not been updated. We reviewed 44 records of people who used the service across all the teams we visited. From these we found that staff had not regularly reviewed people's risk assessments. One person's records showed staff had reviewed their risk assessment in April 2023. However, the risks were related to 2019 when they were an inpatient. The risk management plan also referred to transfer from hospital to the community team which was outdated. Another person had not had their risk assessment reviewed since 1 August 2022 but had yearly reviews prior to this. There was no indication their risks had reduced so no longer needed reviewing. Another person's risk assessment had not been updated since March 2022 despite contact with the person in June, July, and August 2023. Another person's risk assessment was last dated 2019 although they had been seen by staff in May 2022 and March 2023. This meant that we were not assured that staff knew the current risks of people who use the service or their presentation so they may not know when a person's mental health is deteriorating.

Staff could not always recognise when to use crisis plans. Records reviewed showed that people's risk plans had not been reviewed or updated when their risks had escalated.

Management of patient risk

Staff did not always respond promptly to any sudden deterioration in a patient's health. One person's records we reviewed showed the person had a forensic history. Their records showed their mental health had been deteriorating since March 2023. Their risk assessment had not been updated during this time.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. There was a system in place to manage people who had been identified as waiting for a care coordinator. This included risk assessing the person as to the priority needed to be allocated, the person should continue to be on the psychiatrist's caseload and have access to the duty worker while waiting and be allocated a mental health practitioner. These practitioners were supervised by clinical or team managers who should escalate any concerns to the multidisciplinary team. Depending on the risk, a person could be allocated a senior registered practitioner such as occupational therapist or psychologist while awaiting a care coordinator.

Staff followed clear personal safety protocols, including for lone working. All staff were supplied with a device that they used to alert other staff and the central team if they needed support when out in the community. However, some staff said there was not always a connection in some areas to be able to log in the device where they were. They used sign in and out sheets and had mobile numbers to contact in an emergency if needed. Each team had a morning meeting where they were asked to check their device was working and were reminded of the need to sign in and out.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. Training data provided by the trust showed that eligible staff had been trained in safeguarding adults and children at appropriate levels for their role.

Our findings

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff received training on Equality and Diversity and demonstrated an understanding of how to protect people who used the service from harassment and discrimination.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. All staff spoken with were able to recognise abuse and how to report this. Staff worked with local probation services, domestic violence teams and substance misuse services where there were concerns about safeguarding of people who used the service and their children.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff knew how to make a safeguarding referral and told us they would ask the trust safeguarding team for advice when needed and this would be responded to.

Staff access to essential information

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up to date but were easily available to all staff providing care.

Patient notes were not always comprehensive. However, all staff could access them easily. We found care plans and risk assessments were not always reviewed and updated as needed or when the person's risks and needs had changed. We have commented on this in other sections of the report.

When patients transferred to a new team, there were no delays in staff accessing their records. However, these were not always updated, for example, we saw one person's risk assessment related to their risks when they were an inpatient in 2019.

Records were stored securely. All records of people who used the service were electronic and, on a password, protected system. We observed staff locking their computers when they moved away from their desks, so information was not visible to other staff or visitors walking around the office.

Medicines management

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff did not always follow systems and processes to prescribe and administer medicines safely. We found that the systems were not in place to audit and monitor uncollected prescriptions by people who used the service. At Small Heath and Riverside, we found medicines for 10 people stored in medicine cabinets that had not been collected. One of these was dated May 2022, two were dated October 2022 and one was December 2022. There was no process in place to identify which prescription the medicines were dispensed against and not collected. Staff spoken with did not know why these medicines had not been collected and said there were no audits to ensure that the medicines were safely managed. This meant that prescriptions or prescribed medicines not collected may no longer be clinically appropriate for the person, but they may still collect them. It also meant that non-compliance or failure to start on a treatment as recommended by the clinician had not been documented or accounted for during the person's treatment pathway. One

person at Northcroft had medicines prescribed and dispensed on 3 July 2023 by pharmacy twice and therefore there was a duplicate, which meant there was an uncollected supply in the medicine's cupboard. This meant that non-compliance of the person could be easily missed, and that the person could access a surplus of their prescribed medicine.

At Northcroft, prescriptions waiting to be collected were kept in a box at reception. Staff told us that when a prescription was ready to be collected, they telephoned the person, made an entry on their electronic record, and added this to a spreadsheet. When the person collected the prescription, the spreadsheet was updated from live to completed. For 3 people at Northcroft we found prescriptions dated January 2023 that had not been collected. Another person had an uncollected prescription dated 14 March 2023, for a medicine that needed to be titrated (slowly increased to find the right dose effective for the person). The person was subsequently issued a prescription for a higher dose the following month without any reference to how or if they had access to another prescription for the titrating dose. For another person at Northcroft there was a prescription which was undated and unsigned. The clinical lead at Northcroft said they had oversight of audits of uncollected prescriptions that were completed every 6 to 8 weeks. They said they would go through the prescription box and leave any prescriptions in there if they are still in date but destroyed prescriptions for benzodiazepines and zopiclone (a type of sedative medicine) and informed the patients consultant. However, we found that there were not entries on people's records where prescriptions were not collected to say this and when prescriptions had been destroyed, this was not recorded. We found prescriptions that were still in the box after they had expired and were no longer in date. This meant that people may not be receiving medicines that were clinically appropriate for them at that time.

Staff reviewed each patient's medicines regularly but did not always provide advice to people and their carers about their medicines. Only 14 of the 40 people we spoke with said they had information about their medicines. One person told us they received information about their medicines in a format which helped them to understand.

Staff completed medicines records accurately and kept them up to date. Records reviewed in depot clinics were accurately completed and the nurse recorded what side of the body and where they administered the injection to the person.

Staff did not always store and manage all medicines and prescribing documents safely. We found there was not a system to log the serial numbers of prescriptions. Some prescription pads were printed with the doctor's names and other unstamped pads were used if the doctor was running out. Staff told us they gave the doctors as many as they needed, but this was not recorded anywhere. At Northcroft we found a blank prescription in a doctor's office that was not locked which we gave to the hub manager. This meant people may misuse the prescriptions for medicines that were not clinically appropriate for them.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Records reviewed showed that when a person was moved between community mental health teams or from and to home treatment teams their medicine record was reviewed.

Staff did not always learn from safety alerts and incidents to improve practice. However, the lead pharmacist for the trust held monthly meetings with the advanced nurse practitioners. They advised them on recent studies in relation to the monitoring of clozapine and plasma levels. This information was shared across the trust in an email. Although some staff said they did not always have time to read their emails.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence (NICE) guidance. We observed staff asking people during their depot clinic appointment about their

physical health needs and checking their blood pressure and pulse rate. Where needed, staff advised people to go to their GP or contacted their psychiatrist to discuss the need to review their medicine. Where people were prescribed Clozapine (anti-psychotic medicine) their records showed they were seen, and their bloods checked at regular Clozapine clinics.

Track record on safety

The service had received 3 Regulation 28 reports from the coroner about the deaths of 3 people who used this service. This was one of the reasons for this inspection. These included concerns about medicine toxicity and the monitoring of Clozapine (anti-psychotic) medicine. The monitoring of Clozapine in the blood needs to be done to ensure the person is not at risk of harm to their physical health.

The findings of this inspection show that there were not robust systems in place to monitor when people had collected their medicines to ensure they were taking the correct dosage. The systems to monitor the collection of prescriptions were not robust which meant that some people may be taking medicines they were no longer prescribed or clinically appropriate to treat their condition.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents but lessons learned were not always shared with the whole team and the wider service. When things went wrong, staff apologised and gave people who used the service honest information and suitable support.

Staff knew what incidents to report and how to report them. All staff spoken with knew what incidents they needed to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us they reported near misses and raised concerns when needed to.

Staff understood the duty of candour. They were open and transparent and gave people who used the service and families a full explanation when things went wrong. Staff spoken with demonstrated they understood the duty of candour and the need to be honest and transparent with people who used the service and their families.

Managers debriefed and supported staff after any serious incident. Staff said they had a debrief following any incident that involved their team and were supported by their manager. Psychology staff were also involved in supporting staff following incidents.

Managers investigated incidents thoroughly. We saw that these incidents had been investigated and processes changed but not all staff were aware of these.

Staff did not all receive feedback from investigation of incidents, both internal and external to the service. Some staff spoken with were not aware of the deaths of 2 people who used the service where the coroner had reported one was due to Clozapine toxicity and the other there were not systems to ensure abnormal Clozapine blood results were escalated. Some staff were not aware of the learning or feedback from these investigations. Managers told us this was discussed at their meetings but not all staff were aware of this.

Our findings

There was evidence that changes had been made following the deaths investigated by the coroner. The coroner had issued 3 Regulation 28 report to the trust about the deaths of 3 people who used this service. These included concerns about medicine toxicity and the monitoring of Clozapine (anti-psychotic) medicine. The monitoring of Clozapine in the blood needs to be done to ensure the person is not at risk of harm to their physical health. We saw that systems had changed and when a Clozapine blood result was received and was a cause for concern, it was escalated to the multidisciplinary team to discuss, and they reviewed the persons Clozapine medicines.

Is the service effective?

Requires Improvement

Assessment of needs and planning of care

Staff assessed the mental health needs of all people who used the service. They did not always work with people and their families and carers to develop individual care plans or update these as needed. Care plans did not always reflect the assessed needs, were not always personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each person but did not always update this when people's needs changed. The mental health assessment was often done by doctors, but this information was not always used to develop the person's care plan. One person's records did not include a care plan which meant there was no guidance for staff as to how to provide care and treatment to the person. Their records showed that despite them expressing risks of suicidal ideation there was no plan for staff to follow this up. Another person's records showed their Care Programme Approach care plan was last updated 5 November 2021. Their progress notes showed the person had little insight into their mental health and was quite unwell. Their care plan or risk assessment had not been updated to reflect these changes. Some records showed that rating scales such as Health of the Nation Outcome Scales (HoNOS) were used to measure people's health and social functioning and plan their care and treatment.

Staff made sure that people had a full physical health assessment and knew about any physical health problems. Most records showed that staff had assessed people's physical health needs. When people came into clinics they had their blood pressure, pulse rate and temperature checked. People had electro cardiograms when needed in clinics and regularly had blood tests if they were prescribed Clozapine (anti-psychotic medicine). However, 2 people's records reviewed at Newington did not include a physical health assessment.

Staff did not always develop a comprehensive care plan for each patient that met their mental and physical health needs. One person's records did not include a care plan. Their last risk assessment was dated 1 July 2014. They had a review of their care and treatment on 17 May 2023, but their risk assessment had not been updated or the information put in a care plan. Therefore, staff would not know which care and treatment to provide for the person.

Staff did not always regularly review and update care plans when patients' needs changed. One person's records showed their Care Programme Approach care plan was last updated 21 January 2020. They had been seen in the Clozapine clinic on 12 May 2023, but no information had been added to their care plan from this. Therefore, this was not an accurate and contemporaneous record of their care and treatment. Another persons' records showed their Care Programme Approach care plan was last updated 6 January 2022, but their progress notes showed their medication had been changed on 15 May 2023. Staff had not updated their care plan to reflect this. Another person's records had a care plan dated 10 November 2022 and their last risk assessment was dated March 2021. Their progress notes showed their needs had changed but their care plan was not updated to reflect this.

Our findings

Care plans were not always personalised, holistic and recovery orientated. One person's records stated in their assessment summary dated 14 June 2023 that random drug testing should take place as part of the conditions of their discharge from hospital. However, this information was not included in their risk assessment or Care Programme Approach care plan. In the last year of the person's progress notes it was not documented that the drug testing had been done. Therefore, their records were not complete and did not record their care and treatment. However, another person's records showed that staff had liaised with other professionals to meet a person's physical health care needs and ensure they had access to an operation to meet these.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. However, staff did not always participate in local quality assurance audits.

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national guidance. The service was responding to the national agenda for transformation of community mental health services. This meant that Neighbourhood mental health teams were being formed aligned to primary care teams and GP practices. The trust employed support time recovery workers and mental health and wellbeing practitioners. These staff were to work with people who needed mental health support in the community but who did not need a care coordinator or the support of secondary mental health community services. Staff organised groups in the community to help prevent people becoming socially isolated so improving their mental health and wellbeing. These included Tai Chi, exercise groups, Mindfulness, yoga and meeting for picnics at local parks. Mental health and wellbeing practitioners supported people who were on psychology waiting lists by providing lower-level psychological interventions such as cognitive behavioural therapy and helped reduce waiting times.

Staff made sure people had support for their physical health needs, either from their GP or community services. There were physical health leads aligned to each community team. They led clinics and worked with the multidisciplinary team and the person's GP to support people's physical health.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. Support time recovery workers provided advice to people on healthy eating, smoking cessation, exercise and good sleep patterns.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes.

Staff did not always take part in local quality assurance audits. The trust told us that they recognised that Care Programme Approach audits had been completed inconsistently. This was due to capacity of team managers and clinical leads to complete these. The trust had appointed a Matron for the community mental health teams who commenced in post 5 weeks before this inspection. Prior to this there was no matron structure to support the oversight and monitoring of an audit schedule. The new matron's priority was quality assurance and auditing. The trust said clinical leads and team managers use the caseload clinical supervision template on a more regular basis to further review care plans with the wider team and the matron will have oversight of this.

Managers did not use results from audits to make improvements. Staff told us that medicine audits were not completed. We found that medicine management systems and processes were not robust, and improvements were needed.

Our findings

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. However, they did not always support staff with appraisals and supervision. Staff had opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of each patient. Each team had access to doctors, psychologists, nurses, occupational therapists, art psychotherapists and physical health nurses. Teams now also had access to support time recovery workers and mental health and wellbeing practitioners.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff told us and records showed that all staff including bank and agency staff had access to training.

Managers gave each new member of staff a full induction to the service before they started work. Staff spoken with told us they had an induction before they started work or in a new role.

Managers supported permanent staff to develop through yearly, constructive appraisals of their work. The trust told us that at time of inspection 79% of staff across this core service had received an appraisal. However, this varied across the teams as 100% of staff at Sutton CMHT had an appraisal whereas only 66% of staff at Warstock and 68% of staff at Longbridge and Newington had an appraisal.

Managers did not always support staff through regular, constructive clinical supervision of their work. The trust told us that across this core service 45% of staff had received clinical supervision. However, 80% of staff at Yewcroft CMHT had received this whilst no staff at Warstock had received this and only 16% at Lyndon had received this. The trust told us that across this core service 44% of staff had received management supervision. However, at Riverside and Sutton CMHT's 100% of staff had received this whilst at Yewcroft only 18% of staff and at Longbridge only 21% of staff had received this.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Teams held fortnightly business meetings which were attended either in person or by video link. Minutes of these were available for staff if they were unable to attend. Each team also held a daily 'huddle' where the day was planned, and any updated information shared. This was also in person or by video link.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff spoken with said they had access to specialist training and their manager always agreed opportunities for training if it would benefit the people who used the service.

Managers recognised poor performance, could identify the reasons, and dealt with these. Managers told us they knew how each staff member performed and acted where needed to improve staff performance.

Multidisciplinary and interagency teamwork

Our findings

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. However, pharmacists were not involved in multidisciplinary team meetings, their role in this core service was to supply medicines and provide information to people about the medicines they were prescribed.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. We observed a multidisciplinary team meeting at Northcroft and saw the team worked together well. They discussed individuals needs and who might be the best team member to work with the person. They allocated the action to a staff member and kept minutes so they could follow this up at the next meeting.

Staff had effective working relationships with other teams in the organisation. Some staff said they had difficulty with the expectations of local home treatment teams who would not always take on patients they assessed as being in crisis.

Staff had effective working relationships with external teams and organisations. Evidence from people's records showed that staff worked with local substance misuse teams, safeguarding teams, GP's and local hospitals.

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

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The trust told us at time of inspection that over 85% of staff in all community mental health teams had received this training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff accessed this through the trust intranet.

Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff were aware of who the administrator was and knew how to contact them.

Staff followed clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. The trust had policies and procedures and staff knew how to access these.

Patients had easy access to information about independent mental health advocacy. Records reviewed showed that staff gave patients information on advocacy and referred patients who lacked capacity.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Records showed that where a person was subject to a Community Treatment Order, staff had informed them of this and their rights.

For patients subject to a Community Treatment Order, staff completed all statutory records correctly. There were 114 people who used this core service subject to a Community Treatment Order at time of inspection.

Our findings

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed. Records showed that people had a review of their Section 117 aftercare services to ensure they were getting the support they needed in the community.

Staff did not always complete regular audits to make sure they applied the Mental Health Act correctly. Staff told us they did not always complete regular audits. A matron had recently been recruited whose priority was oversight of quality assurance and auditing.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The trust told us that in all but Lyndon CMHT where 83% of staff at time of inspection had completed this training, over 85% of staff in all other teams had completed this.

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

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Records showed that staff had given people support to make decisions for themselves by using information in a language or format that may make it easier for the person to understand.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Records reviewed showed that staff had assessed and recorded capacity to consent to each decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. One person's records showed that staff had liaised with other professionals when the person was assessed as not having capacity to decide about having surgery. The multidisciplinary team had attended the person's best interests meeting and had developed a multiagency plan of care for the person. The person had an Independent Mental Capacity Advocate to ensure their rights and opinions were considered.

Staff did not always complete audits on how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve. A matron had recently been recruited whose priority was oversight of quality assurance and auditing.

Is the service well-led?

Requires Improvement 

Leadership

Our findings

Not all leaders had the capacity to perform their roles, but they had the skills, knowledge and experience. Team managers had a good understanding of the services they managed and were visible in the service and approachable for people who used the service and staff. However, staff said that senior managers were not visible in the service.

Staff said the team managers and clinical leads were visible in the service and supported them in their roles. The trust had recently appointed a community matron (5 weeks before this inspection) whose priority was to have oversight of quality assurance and audits. There was only 1 matron across this core service which covered all community mental health services in Birmingham and Solihull provided by this trust. The matron said a previous business case for community matrons had been declined. Our findings from this inspection found that leaders needed more oversight to assure the trust that the service was safe and effective for people who used it.

Team managers said they were supported and had been given opportunities to develop and undertake leadership training.

Team managers had good working knowledge of their team but said they did not always have the time to perform their roles. We found that not all managers had time to supervise and appraise staff regularly.

Staff spoken with told us that as local teams they supported each other and there was good teamwork. They said their local team managers supported them well, but senior managers were not visible in the service.

Vision and strategy

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

The trust values were Compassionate, Inclusive and Committed. Staff spoken with were aware of these and how they applied to their day-to-day work.

Staff said they liked working for the trust and they were committed to their work. Staff spoke of the challenges of working in inner city areas but felt the trust was a good place to work.

The trust worked with local commissioners and was working to develop the national transformation strategy for community mental health services locally. This involved employing and training staff to work in local neighbourhood mental health hubs aligned with primary care services.

Culture

Staff felt respected, supported and valued. They said the trust provided opportunities for development and career progression. They could raise any concerns without fear.

At Warstock and Northcroft teams staff told us they had received trust awards and said this helped them as a team to feel valued. Staff said that staff wellbeing was prioritised by their manager, and they were encouraged to attend team meetings which they found supportive. Staff said they worked well as a local team.

Staff said they had opportunities to develop their career within the trust. Student nurses told us they had opportunities following qualification to progress within the service. Mental health and wellbeing practitioners said there were opportunities to progress within the psychology service and they were supported in their training.

Our findings

Staff felt able to raise concerns without fear of retribution. Staff said they would always raise concerns if they needed to and would not be afraid to do this.

Staff were aware of the Speak Up process and how to contact the Speak Up Guardian if they needed to. There were Speak Up champions in place across the trust and in local teams who they could contact when needed.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not always managed well.

We found that the governance processes and systems had failed to ensure the proper and safe management of medicines and had not identified the risks to people who use the service. We found that there was not a system to audit and monitor uncollected prescriptions by people who used the service. This meant that people may still collect prescriptions for medicines that were no longer clinically appropriate for them to treat their condition. Audits were not completed so we found medicines still stored in medicine cabinets and no audit trail as to why they had not been collected or when and why they had been left there.

We also found that the governance systems and processes have failed to identify that staff had not updated or reviewed people's risk assessments in a timely manner or when there had been a change in their risk. There was no evidence of auditing of people's records to identify this. The governance systems had also failed to ensure that accurate, complete, and contemporaneous records for each service user were kept for the care and treatment provided, and decisions made about their care and treatment.

We also found that the systems to monitor if staff were regularly supervised by their manager were insufficient. We found evidence that staff had not always responded to people who used the service whose health was deteriorating in a timely way. Staff did not always have time to learn from previous incidents to improve their practice. The lack of clinical audits to identify these issues meant that risk was not always managed well.

Following this inspection, we issued the trust with a Section 29A Warning Notice requiring them to make significant improvement in this area.

Management of risk, issues and performance

Teams did not always have time to access the information they needed to provide safe and effective care so they could use that information to good effect.

Findings of this inspection showed that audits were not always completed for medicine management systems, risk assessments and care plans. This meant that teams did not have the information they needed to ensure improvements could be made. We found that where audits were completed, for example, infection prevention and control, improvements had been made as managers knew where the risks were and what improvements were needed.

The trust told us of the items from this core service that were on their risk register as red (high) and amber (medium) risks. The increase in demand on the service was a high risk on the trust risk register. They told us what was being done to reduce this risk and staff told us about the use of caseload validation tool. This helped teams and clinicians identify the levels of acuity and needs of the patients on the large caseloads. The aim of this was to then stream the patients into

the appropriate clinical care pathways. This was aligned to the community mental health transformation work. Neighbourhood Mental Health Teams had been set up to support with triaging and diverting referrals of people from Primary Care services and supporting people who were appropriate to step down from the teams to primary care services.

The trust also told us of a medium risk on their risk register which was the change in care planning with a move from Care Programme Approach to a new tool. The trust were monitoring this.

Another medium risk was the number of vacant consultant posts across this core service. They had difficulty in recruiting permanent staff to these posts so were currently using a mix of locum and fixed term contract doctors. The trust said this led to a risk of lack of consistency in decision making and in the quality of care provided to service users due to the frequent changes. People who used the service told us they had experienced lack of continuity of their care because of changes to doctors.

A further medium risk was delays to psychological therapies and assessments. We found that the appointment of mental health and wellbeing practitioners as part of the transformation programme had helped to reduce this risk. In addition, at Northcroft we were told that psychology posts had been recruited to and these staff would be in post in September 2023.

Information management

Staff did not always collect and analyse data about outcomes and performance and were only just beginning to engage actively in local quality improvement activities.

Our findings from this inspection found that team managers did not have access to all audits of the work of the team to enable them to make improvements where needed.

Staff had access to the equipment and information technology needed to do their work. All staff had access to their own laptop and mobile phone for use at work.

Information governance systems included confidentiality of patient records. Staff were aware of the trust information governance systems and policies. We observed they always logged out of laptops and patient records when they moved away from their desk.

The trust had some data about outcomes and performance and the newly appointed matron was starting to use this to engage staff in local quality improvement activities. However, they had not yet completed their quality improvement training. They said each directorate had a quality improvement lead and they were working with them to discuss proposed projects which would firstly be on reducing waiting lists.

Engagement

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

Our findings

We found that managers were engaging in the transformation project and had obtained funding to employ support time recovery workers and mental health and wellbeing practitioners. These staff worked within the community mental health teams but were also part of the newly formed neighbourhood mental health teams aligned to primary care services.

People who used the service did not always know how to feedback their experience in a formal way. One person said they were recently asked for feedback on their tablet computer, but other people said the only way they could feedback was to staff during their appointment.

Staff from the patient experience team told us how they signposted people to other agencies in the area who could help them with housing, finance advice and to activities they may benefit from. They thought that the way staff listened to the concerns of people who used the service had improved.

Staff told us how they had worked with under–represented communities and people that had recently arrived in the UK. They used ways to reach out to communities promoting mental health awareness in mosques, temples, and churches. Staff told us how they had set up network group meetings with local faith and community leaders in Small Heath. They had delivered mental health awareness sessions to service users and carers. Staff knew the languages spoken in different areas of the city and ensured they had information provided in these languages so that people could understand the service.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. The trust told us that 18 staff in this core service had been trained in quality improvement since January 2023. The trust told us of current quality improvement initiatives which included managing people who do not attend appointments, standardising triage of referrals, improving risk assessments and improving care coordinators waiting lists.

The newly appointed matron was setting up a staff engagement forum which included learning lessons and sharing practice between teams.

Some staff told us how learning was shared across the teams following serious incidents via emails, team meetings and supervision. However, some staff told us they did not always have the time to read their emails, attend team meetings and data provided by the trust showed some staff did not have regular supervision. Some staff spoken with had not utilised the various methods to keep updated on key learning and messages so could not put this into practice.

Our findings

Areas for improvement

- The trust must ensure that governance systems and processes identify the risks to people using services. The trust must ensure that audits identify gaps in staffing vacancies, risk assessments, care plans, and learning from incidents. (Regulation 17 (2) (b) (c))

- The trust must ensure that people's risk assessments and care plans reflect their assessed risks and needs. (Regulation 17 (2) (b) (c))

- The trust must ensure that governance systems and processes ensure the proper and safe management of people's medicines. (Regulation 12 (2) (f))

- The trust must ensure they continue to recruit to vacant staff posts to reduce the risk to the safety of people who use the service. (Regulation 18 (1))

- The trust must ensure all staff have access to clinical and managerial supervision as appropriate for their role as per trust policy. (Regulation 18 (2) (a))

- The trust should ensure that people who use the service have an opportunity to feed back their views anonymously.(Regulation 17)

- The trust should consider the need for more matrons in the community mental health teams to help improve the governance processes.

Our inspection team

Four inspectors, a CQC pharmacist specialist, two nurse specialist advisors, two experts by experience and an operations manager carried out this inspection.

We visited all the locations where community mental health teams were based:

Zinnia Centre,

Longbridge

Small Heath

Osborn House

Lyndon

Newbridge

Northcroft

Warstock Lane

We spoke with 61 staff including nurses, support time recovery workers, doctors, psychologists, mental health and wellbeing practitioners, reviewed 44 care records of people who use the service, accompanied staff on visits to people at home, spoke with 40 people who use the service and their carers by telephone or face to face in clinics.

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
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment