

Birmingham and Solihull Mental Health NHS
Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXT	Northcroft	Northcroft North Assertive Outreach Team	B23 6AL
RXT	Orsborn House	Aston and Nechells West Assertive Outreach Team	B19 1BP
RXT	Northcroft	Sutton Community Mental Health Team	B23 6DJ
RXT	Orsborn House	Handsworth and Ladywood Community Mental Health Team	B19 1BP
RXT	Warstock Lane Resource Centre	Warstock Community Mental Health Team	B14 1BP

Summary of findings

RXT	Lyndon Resource Centre	Lyndon Community Mental Health Team	B92 8PW
RXT	Small Heath Health Centre	Small Heath/O' Donnell Community Mental Health Team	B10 0PG
RXT	Small Heath Health Centre	Riverside Community Mental Health Team	B10 0PG
RXT	Longbridge Health Centre	Longbridge Community Mental Health Team	B45 9PL

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community based mental health services for adults of working age as good because:

- All locations where patients were seen and treated had access to emergency equipment.
- All buildings were clean and well maintained.
- There was adequate hand washing facilities and we observed staff following infection control practices.
- Patients and carers were happy with the way that staff worked and the services that were offered to them.
- Patients felt that their needs were met and that the services belonged to their community.
- Staff felt supported by senior managers and told us that they were able to share their concerns with the chief executive officer for the trust.

Summary of findings

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

Are services safe?

Good



We rated safe as good because:

- All locations where patients were seen had access to emergency equipment.
- All buildings were clean, tidy and well maintained.
- All records reviewed had a completed risk assessment.
- We saw staff respond to identified changes in a patients presentation.
- We saw services had systems in place to respond to patients and carers queries.
- Patients could access nursing staff and psychiatrists urgently if required.
- Staff were familiar with the lone working policy and had systems in place to support each other safely in the community.
- Staff have received and were up to date with mandatory training.

However:

- The fridge at Orsborn House was not working properly and recorded consistently high temperatures.
- Care programme approach coordinator's caseloads ranged in size from 10.5 to 81.9 patients , these included those who ran depot clinics and groups .Those who only carried care work had a limit of 35 on their caseload.

Are services effective?

Good



We effective as good because:

- The teams consisted of a range of multi-skilled and disciplined staff including psychiatrists, nurses, psychologists, occupational therapists, art therapists, support workers and administrative staff.
- The teams ran dedicated physical healthcare and clozapine clinics that patients could access for blood tests and regular in-house monitoring of antipsychotic medication.
- Staff had access to a range of clinical, peer and management supervision.
- All medication records we looked at evidenced that staff followed National Institute of Care Excellence (NICE) guidance when prescribing and reviewing medication.
- Staff completed recognised rating scales to measure the effectiveness of the clinical treatments and interventions that were being offered to patients.
- Staff participated actively in clinical audits.

Summary of findings

Are services caring?

We rated caring as good because:

- All interactions we observed between patients and staff were supportive, caring, respectful and polite.
- Staff had a comprehensive knowledge of patients lives and their needs.
- Staff involved and offered support to family members.
- Patients were actively encouraged to feedback on the service and supported to complain if they needed to.

However:

- Not all care plans could evidence that they were written collaboratively with the patients.

Good



Are services responsive to people's needs?

We rated responsive as good because:

- Teams were able to prioritise urgent referrals and review waiting lists.
- All teams operated a duty worker system.
- Teams took a pro-active response to building relationships with patients who were reluctant or unable to engage in treatment.
- Teams did safe and well checks on patients they were concerned about.

However:

- Posters and information on the information boards at Orsborn House was written in English when English is not the first spoken or read language of most of the patients.

Good



Are services well-led?

We rated well-led as good because:

- Staff reported trusting and supportive relationships with team leaders and local management.
- Staff reported that the chief executive officer was easy to talk to and had been to visit their service.
- Staff participated in clinical audits and research.
- Staff we spoke with said that they believed in the values of the trust and the trust's commitment to the patients who used the services.

Good



Summary of findings

Information about the service

There were 27 community services across Birmingham and Solihull that provide assessment, specialist support, treatment and care planning for patients aged between 17 and 65 years with functional mental health conditions such as depression and psychotic mental illness. We inspected nine of these locations.

The trust state that they provide high quality care through:

- Comprehensive and co-ordinated community mental health teams and effective treatments based on the best available evidence
- A service which is safe for everyone
- Equality of access and experience for all actual and potential service users.

They promote recovery and inclusion for service users using acute mental health services through:

- Care oriented to strengths and abilities while attending to difficulties and disabilities
- Helping service users remain connected with their local communities

- Providing purposeful, stimulating and appropriate mental and physical activities.

They promote positive services through:

- Integrated care pathway services where all the component services are co-ordinated
- Having in place robust evaluation and governance systems
- Supporting continued service improvement.

Criteria exclusions for this service:

- ADHD
- Mild / minor mental health issues
- Primary diagnosis of learning disabilities
- Alcohol and substance misuse without additional complex mental health issues
- Illnesses of an organic nature
- Moderate mental health issues that can be dealt with at a primary care level
- Older people with complex mental, physical and social needs.

Our inspection team

Chair: Mick Tutt, Non-executive director, Solent NHS Trust.

Head Of Hospital Inspections: James Mullins, Head of Hospital Inspections, CQC.

The team that inspected the core service comprised of two CQC inspectors, two nurses, one consultant psychiatrist and one social worker.

Why we carried out this inspection

Birmingham and Solihull Mental Health NHS Foundation Trust was last inspected in May 2014 and received an overall rating of Good.

There were no MUST actions for this core service.

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 findings

• Is it well-led?

During the inspection visit, the inspection team:

- visited nine of the services and looked at the quality of the environment and observed how staff were caring for patients
- spoke with 24 patients who were using the services
- spoke with the managers for each of the nine services
- spoke with 49 other staff members; including doctors, nurses, psychotherapists, occupational therapists, art therapists and social workers
- spoke with two carers
- attended and observed a multi-disciplinary meeting, a referrals meeting, a planning meeting and a clinic
- attended and observed five home visits
- looked at 47 care records
- looked at 11 medication records
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 29 patients and two carers who used the services.

People who used the services were extremely complimentary about the teams and the way that staff treated them. They said that staff were knowledgeable, respectful and kind and they felt that the services 'belonged' to them and the local community. One patient

said that they no longer felt stigmatised as a black person using mental health services. They told us that the staff and the service made them feel that they were receiving treatment and this was the first time this had ever happened to them in their life and they felt proud to be a patient there.

Areas for improvement

Action the provider SHOULD take to improve Actions that the provider should take:

The trust should ensure that fridge temperatures are regularly checked.

The trust should ensure that care plans can evidence that they were written collaboratively with patients.

Posters and information on information boards should be written in languages that are spoken by the local communities.

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Birmingham and Solihull Mental Health NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Northcroft North Assertive Outreach Team	Northcroft
Aston and Nechells West Assertive Outreach Team	Orsborn House
Sutton Community Mental Health Team	Northcroft
Handsworth and Ladywood Community Mental Health Team	Orsborn House
Warstock Community Mental Health Team	Warstock Lane Resource Centre
Lyndon Community Mental Health Team	Lyndon Resource Centre
Small Heath/O'Donnell Community Mental Health Team	Small Heath Health Centre
Riverside Community Mental Health Team	Small Heath Health Centre
Longbridge Community Mental Health Team	Longbridge Health Centre

Detailed findings

Mental Health Act responsibilities

The trust provided Mental Health Act (MHA) training for community staff. Out of the nine teams we visited only Small Heath/O'Donnell CMHT fell below the trust target of 90% at 78% for this training. Four teams achieved 100% compliance.

Staff we spoke with were able to demonstrate a satisfactory understanding of the MHA, the Code of Practice, the guiding principles and community treatment orders.

Staff told us that they knew how to access administrative support and legal advice on the implementation of the MHA, however staff that we spoke with were not aware of any regular audits undertaken locally to ensure that the MHA was being applied correctly to patient care.

Staff that we spoke with displayed a comprehensive knowledge of the role of the independent mental health advocate (IMHA). Teams displayed advocacy information in waiting areas and in clinic rooms from which patients could access information on IMHA services when required.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust provided Mental Capacity Act (MCA) training for community staff. Out of the nine teams we visited only Lyndon CMHT fell below the trust target of 90% at 83% for this training. Six teams achieved 100% compliance.

All of the staff we spoke with had a clear understanding of the MCA, the trust provided a policy on the MCA. Staff were aware of the policy and knew how to access it if they needed to.

Are services safe?

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

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

Our findings

Safe and clean environment

- There were alarm systems in place at all of the sites where patients attended. Some sites had alarm trigger points within interview rooms, while at others, staff carried personal pin-point alarms.
- Clinic rooms were well equipped and had the necessary equipment to carry out physical examinations. Appropriate in date stock such as clozapine was kept on site if required. At Orsborn House, the medicines fridge temperature was persistently over five degrees and was reading at six point four degrees celcius at the time of our inspection. There was not any stock kept in the fridge. The team manager said that they would order a new, smaller one immediately as they did not hold a lot of medicine stock on site.
- All communal and office areas, corridors and rooms were visibly clean and maintained with new furniture and décor at some of the locations. At Orsborn House, the reception area was too small for the numbers of patients using the building and there had been incidents between patients in the reception area in the past so funding had been allocated to provide a bigger reception area and work was almost complete on this.
- Cleaning records were up to date and we observed that the environments in all of the services was regularly cleaned. Patients commented on how clean, friendly and welcoming the building was at Northcroft North Assertive Outreach Team and Sutton Community Mental Health Team (a shared site).
- There was adequate handwashing facilities, with handwashing instructions displayed above the sinks and we observed staff following infection control practices.
- Equipment at all services was well maintained, cleaned and clean stickers were visible and in date.

Safe staffing

- Staffing levels across teams were reviewed by team managers and varied according to the services provided and the size of the locality covered. The core services were unable to provide this data as March's

establishment/vacancy position was not yet available. The Finance Team was in the middle of completing 'year end' and they envisaged that March 2017 establishment position would not be ready until w/c 10 April. However, staffing establishments as at November 2016 for each team were as follows:

1. Northcroft North Assertive Outreach Team: substantive staff 14.8 down from 16.9 in October 2016. Whole time equivalent (WTE) vacancies: 1.4 or 0.7% down from -0.5 to -3.3% in December 2015. Staff sickness rate: 1.5%, sickness rate across the year: 0% to 2.7%.
2. Aston and Nechells West Assertive Outreach Team (AOT): substantive staff 14.6 down from 15.6 in October 2016. WTE vacancies: 2.6 or 21.9% down from 0.3 or 1.8% in December 2015. Staff sickness rate: 0.2%, sickness rate across the year: 0% to 9%.
3. Sutton Community Mental Health Team (CMHT): substantive staff 16.9 down from 21 in December 2015. WTE vacancies: 3.9 or -4.2 to 23.2% across the year. Staff sickness rate: 0.8%, sickness rate across the year: 0% to 11.3%.
4. Handsworth and Ladywood Community Mental Health Team: substantive staff 20.1 down from 21.1 in December 2015. WTE vacancies: 1.4 or 6.6% down from -4.9% to 15.6% across the year. Staff sickness rate: 1.7%, sickness rate across the year: 0% to 7.9%.
5. Warstock Community Mental Health Team: substantive staff 18.1 down from 20.6 in December 2015. WTE vacancies: -0.3 or -1.8% ranging from -12.5% to 11.1% across the year. Staff sickness rate: 4.1%, sickness rate across the year: 0% to 8.9%.
6. Lyndon Community Mental Health Team: substantive staff 14.6 no change in number from the previous year. WTE vacancies: 2 or 7.8% ranging from 7.8% to 21.1% across the year. Staff sickness rate: 1.1%, sickness rate across the year: 0% to 6.7%.
7. Small Heath/O' Donnell Community Mental Health Team: substantive staff 13.4 down from 16.4 in December 2015. WTE vacancies: 5.6 or 24.1% ranging from 15% to 24.1% across the year. Staff sickness rate: 17.4%, staff sickness rate across the year: 3.1% to 21.6%.

Are services safe?

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

8. Riverside Community Mental Health Team: substantive staff : 17 down from 21.9 in December 2015. WTE vacancies: 3.1 or 23.2% ranging from 8.1% to 23.2 across the year. Staff sickness rate: 6.1%, staff sickness rate across the year: 0% to 11.9%.
 9. Longbridge Community Mental Health Team: substantive staff 22.1 down from 24.9 in December 2015. WTE vacancies: 0.1 or 0.2% ranging from -3.5% to 14.2% across the year. Staff sickness rate: 4.5%, staff sickness rate across the year: 0.7% to 7.8%.
- The team with the highest level of sickness in November 2016 was in Small Heath/O' Donnell CMHT and this was also the team with the highest level of sickness in any month. Sutton CMHT had the highest level of staff turnover rate between 1 December 2015 and 30 November 2016 with 21.5%.
 - The average caseload per care co-ordinator per team:
 1. Aston and Nechells West Assertive Outreach Team: 11.7
 2. Northcroft North Assertive Outreach Team: 10.5
 3. CMHT Ladywood & Handsworth: 37.2
 4. CMHT Longbridge: 48.4
 5. CMHT Lyndon: 66.7
 6. CMHT Riverside: 54.9
 7. CMHT Sutton: 59.2
 8. CMHT Warstock Lane: 59.4
 9. CMHT Small Heath/O'Donnell: 81.9
 - Caseloads varied from team to team and caseloads were managed and reviewed regularly by managers during caseload management supervision. Those numbers include those who ran depot clinics and groups. Those who only carried care work had a limit of 35 on their caseload Trust policy states that each full-time care coordinator will manage a caseload the size of which will be determined by their team manager and dependant on complexity. The trust's operational framework for integrated community mental health services states that this should be no less than 35 service users. However, the Department of Health's Mental Health Policy Guidelines - Community Mental Health Teams (2002) recommends that full time care coordinators carry a maximum of 35 patients on the Care programme Approach. The trust also recommend a maximum caseload of 35 for full time staff. Care coordinators should aim to spend approximately 50% of their time in direct face to face clinical activity and should aim to have between 3-5 face to face contacts per day.
 - Staff reviewed and assessed referrals daily and prioritised cases based on the risk of individual patients. Staff also monitored the number of referrals daily and patients were reviewed and continually assessed whilst on the waiting list. If a patients needs changed or worsened whilst they were on the waiting list then they were seen either by the Crisis Team or Home Treatment Team as required. In some services, there was a waiting list to access psychological therapies. The reason given for this was the reduction in the numbers of posts of psychologists in the trust.
 - Patient appointments were not cancelled at any of the services that we visited without being offered the opportunity to either see the Duty Worker or another member of staff if appropriate. At Longbridge CMHT, we observed a patient being offered a same day appointment to see the Consultant Psychiatrist by the Duty Worker.
 - There was low use of bank or agency staff at all of the sites we visited. The majority of the services used either part-time or retired staff to fill vacancies to ensure consistency and safety with patient care.
 - There was rapid access to see a psychiatrist when required. At Longbridge CMHT, we observed a patient being offered a same day appointment to see the Consultant Psychiatrist by the Duty Worker.
 - Staff received and were up to date with mandatory training. The training compliance for services was 93% as at January 2017 against the trust target of 85%.

Assessing and managing risk to patients and staff

- All 47 care records that we looked at had up to date risk assessments in them. These were updated after any identified incidents or changes to risk and if not, they were reviewed a minimum of twice yearly. All of the risk assessments were completed comprehensively with detailed information.
- Crisis plans were developed from the risk assessments and these were done with the patient. Staff used other services such as the crisis team to offer support outside of working hours to the patients. We did not see any

Are services safe?

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

evidence of advance decisions in patient's files yet four patients we spoke with told us they had advance decisions in place as part of their care treatment package.

- Staff responded promptly to a sudden deterioration in peoples' health and gave us examples of this.
- All teams monitored waiting lists and referrals to detect increases in levels of risk. Staff were able to explain how they did this and what steps they took to manage increases in levels of risk such as referring patients to the home treatment or crisis team.
- Staff we spoke with showed a good understanding of when and how to make a safeguarding referral. Staff accessed local safeguarding policies online and knew who the local safeguarding leads were and how to contact them. In some services, social workers shared the building and offices and staff said that this improved and made inter-agency working easier and more accessible.
- Teams typically worked from 9am to 5pm although staff offered appointments outside of these hours that were flexible to the needs of patients. We saw evidence that lone working practices had been adapted to reflect these changes in working. The trust had personal safety and lone working procedures in place. Procedures varied but we saw that all locations had systems to record and monitor the movements of staff in the community. Some had developed systems to reflect the needs of staff and patient's. For example, some locations operated a 'Buddy System' so that staff could safely facilitate appointments after 5pm or staff attended in pairs.
- Staff undertook additional safe working practices to mitigate risk. Staff worked in pairs or asked other staff to be around the area if patients were unknown or had known risks. We observed staff discussing home visiting risks and taking appropriate steps to mitigate these at Northcroft North Assertive Outreach Team.
- Staff adhered to medicines management principles for the storage and transport of medicines. We saw that staff stored medication correctly and used lockable cases to transport medicines in the community. Cases contained the necessary equipment to safely store and administer medicines.

Track record on safety

- There were 20 serious incidents relating to the nine services we inspected during the period from November 2015 to October 2016. The highest number of incidents was in the category of 'apparent/actual/suspected self-inflicted harm meeting SI criteria' with 19 incidents. The team manager at Longbridge gave us an example of a change to practice after an incident had occurred.

Reporting incidents and learning from when things go wrong

- All staff knew what to report and could give an example of incidents that they had reported. They said that if they were unsure of what to report, they would check with the team manager for clarification. Incidents were recorded on the electronic recording system.
- Staff told us they were open and transparent with patients when something went wrong. Most incidents and complaints were dealt with in line with the trust policy, however, at Longbridge CMHT, staff told us that the team manager dealt with complaints and incidents immediately and she confirmed that she endeavoured to do this.
- Staff told us that they received feedback from investigation of incidents both internal and external to the service in a variety of ways such as during attendance and participation at multidisciplinary team meetings (MDT), supervisions and team meetings. This was also followed up by email.
- The team manager at Longbridge CMHT gave us a specific example of a change to working practice having been made as a result of recent feedback regarding an incident. They now did safe and well checks on patients that had not made contact with the service or patients who they were concerned about.
- All staff received a debrief and support following serious incidents. This was done in a variety of ways; either in groups or one to one if required. If further support was needed, this was done through counselling at occupational health. Staff stated that similar support was offered to patients if required.

Are services effective?

Good 

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

Our findings

Assessment of needs and planning of care

- We looked at 47 care records of patients across the nine sites. All care records contained a comprehensive assessment. We saw evidence that the assessment process was ongoing and was continually updated.
- All of the care records that we looked at contained a care plan. The quality varied from worker to worker within each team from standardised care plans to being personalised, holistic and recovery oriented. Most care records reviewed had evidence of personalised, holistic and recovery focussed care plans although some were written in a way which did not evidence collaborative working with patients. However all patients we spoke with stated that they were consulted and their treatment was done in conjunction with staff.
- All community staff had laptops so they were able to access and update records in the community. Staff stored information electronically and showed us that care records were easy to access and to input information onto. Bank and agency staff also had access to the electronic care records system.

Best practice in treatment and care

- All 11 medication records we looked at evidenced that staff followed National Institute for Care Excellence (NICE) guidance when prescribing and reviewing medication such as Psychosis and schizophrenia in adults (QS80).
- All services offered psychological therapies recommended by National Institute for Care Excellence and these included cognitive behavioural therapy and family therapy.
- Services had previously shared an employment, housing and support worker but due to funding issues this was no longer available and staff were taking on the support around this. Some services had previously been able to access citizens advice bureau workers as they had satellite clinics running in them but due to local authority funding cuts to the citizens advice bureau, these were no longer available.
- All services considered and addressed physical healthcare needs. They ran dedicated physical healthcare and clozapine clinics that patients could access for blood tests and regular in-house monitoring of antipsychotic medication. The physical healthcare

assessments were very comprehensive and detailed and covered all healthcare needs ranging from diet and lifestyle to smoking and substance misuse. All services showed effective partnership working with local drug and alcohol services. If necessary, patients were referred to external healthcare services such as diabetes clinics, for co-working, additional support or monitoring.

- Staff completed recognised rating scales to measure the effectiveness of the clinical treatments and interventions that were being offered to patients; this included the health of the nations outcomes scales (HoNOS).

Skilled staff to deliver care

- All services had a wide range of skilled staff to carry out assessments, deliver treatment and a range of therapeutic interventions to patients. This included doctors, psychologists, nurses, social workers, occupational therapists, art therapists and all had the required qualifications and experience to carry out their roles.
- All staff attended and participated in the trust corporate induction and local induction varied from service to service.
- All staff we spoke with had access to clinical, peer and management supervision at least every six weeks. All staff were encouraged to attend regular team meetings and if unable to, they received the minutes by email.
- As at the end of November 2016, the overall appraisal rates for non-medical staff within this core service was 84%. Northcroft North Assertive Outreach Team had the highest compliance rate with 100% appraisals compared with Sutton CMHT who had the lowest with 74%.
- Staff told us that they were encouraged and supported to attend specialist training for their role such as advanced nurse practitioner training or phlebotomy training.
- Poor staff performance was addressed promptly and effectively and all team managers were able to demonstrate when and how to escalate concerns within the trust and obtain support from human resources or occupational health.

Multi-disciplinary and inter-agency team work

- All services held regular multidisciplinary team (MDT) and staff meetings and staff were actively encouraged to

Are services effective?

Good 

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

attend these. Minutes of these meetings were then sent out to all staff. Services also held regular allocation meetings and we observed a daily planning meeting at Northcroft Assertive Outreach Team.

- Staff reported having good communication links with other teams within the trust, including inpatient services, crisis services and other specialist services. All teams had access to the electronic recording system, which ensured that they had access to relevant information regarding patient care. Staff also used secure emails to share patient information within and across teams.
- Staff reported good working links with a range of external health and social care providers. We saw that staff from services including social care, substance misuse and local authority safeguarding teams attended MDT meetings.

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

- Staff we spoke with knew who the Mental Health Act (MHA) administrators were and were able to access support as required.
- As at January 2017, the teams had the following compliance rate with Mental Health Act training; Warstock CMHT 100%; Lyndon CMHT 100%; Aston and Nechells CMHT; 100%; Handsworth and Ladywood CMHT 93%; Longbridge CMHT 92%; Riverside CMHT 92%; Sutton CMHT 92%; Northcroft North AOT 91% and Small Heath/ O' Donnell CMHT 78%. Only Small Heath/ O' Donnell CMHT was below the trust target of 90% for this training.
- Staff we spoke with had a good understanding of the Mental Health Act (MHA), the code of practice and the guiding principles and could give us clear examples of these. Two services regularly audited their community treatment orders (CTO's) and we saw Longbridge's community treatment orders regular audit that was undertaken by the advanced nurse practitioner.
- Consent to treatment and capacity requirements were adhered to and copies of consent to treatment forms were attached to medication charts on the medical records that we looked at. However, at Longbridge CMHT, out of the 10 patient records we looked at, none

had capacity requirements included on the electronic recording system. We spoke to a member of staff who said that they were completed but they were behind on their scanning and they had not been uploaded onto the electronic system at the time of the inspection.

- We saw evidence in clients records that their rights under the MHA/CTO were explained to them at the start of treatment and routinely after.
- CTO paperwork we looked at was filled in correctly and stored appropriately. We saw evidence of CTO audits.
- Patients had access to the independent mental health advocate (IMHA) services and some patients we spoke with had used these services. Staff we spoke with were clear on how to access and facilitate engagement with the IMHA to ensure patients had consistency of care and support. Teams displayed advocacy information in waiting areas from which patients could access an IMHA where needed.

Good practice in applying the Mental Capacity Act

- As at January 2017, the teams had the following compliance rate with Mental Capacity Act Training; Longbridge CMHT 100%, Sutton CMHT 100%, Northcroft North AOT 100% Handsworth and Ladywood CMHT 100%, Aston And Nechells CMHT 100%, Riverside CMHT 93%, Warstock CMHT 92%, Small Heath/O' Donnell CMHT 91% and Lyndon CMHT 83%. Only Lyndon CMHT was below the 90% trust target for compliance for this training.
- Staff we spoke with were trained in and had a good understanding of the Mental Capacity Act 2005 and the five guiding principles. Some staff had the principles printed on a card that they kept. Staff we spoke with could explain the presumption of mental capacity and acting in a patient's best interests where the patient lacks capacity.
- The trust has a policy on Mental Capacity Act which staff we spoke with were aware of and could refer to.
- Staff reported that they would record the capacity assessment in a patient's ongoing care record and discuss the event at the MDT.
- Staff that we spoke with were not aware of any arrangements in place to monitor the adherence to the Mental Capacity Act within the trust.

Are services caring?

Good 

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

Our findings

Kindness, dignity, respect and support

- We observed staff during home visits, assessments, and clinic appointments. Staff demonstrated care, consideration, respect and expertise during their interactions with patients and carers. We saw that staff provided both emotional and practical support. We also saw additional evidence of staff's positive attitudes and behaviours during their professional conduct in the office when patients were not present.
- Patients we spoke with described staff as caring, respectful and honest. They reported that they felt confident that staff and services were able to offer them the right support and treatment, that staff listened to them and took their fears and concerns on board. They said that they felt that the service was for them and their community. One patient said that whenever they saw the chief executive officer of the trust, he always stopped and spoke to them. They felt confident that he took what they said about the services on board and cared about what the patients thought.
- Staff demonstrated a high level of understanding of the needs of patients. We saw staff involve patients friends and relatives in their care and treatment.
- We saw evidence that patient confidentiality was maintained by staff conduct and by staff using the trust approved electronic recording system, storing records and information in line with trust policy and procedures.

The involvement of people in the care they receive

- Patients told us that staff listened to them and involved them in their care. However, there was a lack of written evidence in care plans to corroborate this.
- There was appropriate involvement of, and provision of support to families and carers. Patients told us that staff took their families opinions into account and one patient told us in detail how the trust supported their daughter as their carer and tried to meet her needs. Northcroft Assertive Outreach Team had a service user and carer support group that went on holidays and organised social nights out to offer support to each other and reduce social isolation. They also had an allotments group that gave food to the local community and a decorating service set up by ex-patients and supported by staff that decorated other patients homes that were in need.
- Patients had access to advocacy services and we saw leaflets displayed about these.
- Patients told us that they were able to get involved in decisions about their service and at Longbridge CMHT patients were involved in the recruitment of staff.
- The trust provided comments boxes in waiting areas to capture the feedback of people using community services. Staff told us that patients could leave feedback on the trust's website that included a 'Friends and Family Test'. The chief executive officer had visited the carers group and took on board the comments that they made about services.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

- All referrals were allocated for assessment within 24 hours of receipt of the referral by the Single Point Of Access (SPOA) triage.
- All routine referrals were assessed within 1-4 weeks. The assessment team decided on the timescale to see the patient, based on referral and Single Point Of Access information.
- All referrals were received by Single Point Of Access (SPOA) triage within 24 hours for CMHT. Care coordinators are allocated to those who required support under the Care Programme Approach (CPA). Once identified as requiring CPA, patients were allocated a care coordinator at that time. The clinical recording system required that both happen at the same time to ensure that there were not any patients waiting to start treatment.
- Assessments were dependent on the requirements of the patients and what triage decided, and the waiting time could be between 1-7 days. Duty workers could assess patients within 1-7 days, Advanced Nurse Practitioners within 2 weeks, the medical appointment waiting list was currently 12 weeks.
- There was no waiting time for treatment to start. If a patient needed a follow up two weeks after being assessed they were offered an appointment two weeks after assessment. This was on a needs led basis.
- All teams had a duty worker who responded promptly and efficiently when patients and carers phoned in. We observed patients being offered same day appointments if required.
- The services provided a clear criteria for inclusion; assessment, specialist support, treatment and care planning for service users aged between 17 and 65 years with functional mental health conditions such as depression and psychotic mental illness. They also provided a clear criteria for exclusion which included the following; ADHD; mild / minor mental health issues; primary diagnosis of learning disabilities; alcohol and substance misuse without additional complex mental health issues; illnesses of an organic nature; moderate mental health issues that can be dealt with at a primary care level and older people with complex mental, physical and social needs.

- We saw the teams take active, proactive approaches to engaging with people who found it difficult or were reluctant to engage with mental health services. These included conducting assessments at home, visiting with other professionals if required and visiting when supportive family members or carers were there.
- We saw the teams taking a pro-active approach to re-engaging with people who did not attend appointments by visiting them at home or engaging the patient's GP or other professionals involved in their care. Safe and well checks were also conducted weekly by duty staff for patients who had not responded to either telephone calls or letters.
- We saw that appointments were offered with a level of flexibility to suit the patients needs. Examples included visiting one patient when their mother could be there to support them or visiting a patient in the evening before they went to work a night shift.
- Appointments were only cancelled when absolutely necessary. Patients were given an explanation and offered an appointment either with a duty worker or other member of staff.
- We saw that clinic appointments ran on time and patients were kept informed when they did not.

The facilities promote recovery, comfort, dignity and confidentiality

- The locations we visited had a range of rooms and equipment to support the treatment and care of patients. This included waiting areas and interview, meeting and clinic rooms. They varied from site to site in terms of décor and availability.
- Interview rooms also varied from site to site in terms of size and décor and there was adequate sound proofing so conversations were confidential.
- We saw that information leaflets were available in all waiting areas. We saw information about carers and family handbooks, patient and carers experience, advocacy services, activity groups, help-line numbers, substance misuse, self help and physical health information.

Meeting the needs of all people who use the service

- All services were accessible to people with disabilities, including wheelchair users. Toilet facilities were also available and accessible for wheelchair users.
- We did not see any leaflets or information notices available in languages spoken by people who use the

Are services responsive to people's needs?

Good 

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services. However, staff reported that they could obtain information in languages other than English on request or in response to individual needs. At Orsborn House, the majority of the patients using the service did not speak English as their first language, however, the posters and information leaflets on display were all written in English.

- Services said that they could access interpreters or signers when required for patients and could give us examples of when they had done so.

Listening to and learning from concerns and complaints

- Total complaints received for 12 month period beginning of April 2016 – end of March 2017; Northcroft North Assertive Outreach Team 0; Aston and Nechells West Assertive Outreach Team 0; Sutton CMHT 3; Handsworth and Ladywood CMHT 4; Longbridge CMHT 2; Warstock CMHT 5; Lyndon CMHT 8; Small Heath CMHT 5 and Riverside CMHT 5.
- Total number of those complaints received beginning of April 2016 – end of March 2017 that were upheld; Northcroft North Assertive Outreach Team n/a; Aston and Nechells West Assertive Outreach Team n/a; Sutton CMHT 0 upheld (2 partial upheld); Handsworth and Ladywood CMHT 0 upheld (3 partial upheld); Longbridge CMHT 0 upheld (2 partial upheld); Warstock CMHT 0 upheld (3 partial upheld; 1 open); Lyndon CMHT 0 upheld (5 partial upheld); Small Heath CMHT 0 upheld (3 partial upheld; 1 open) and Riverside CMHT 2 upheld (1 partial upheld; 1 open).
- Total number complaints referred to Ombudsman in last 12 months beginning of April 2016 – end of March 2017: Northcroft North Assertive Outreach Team 0; Aston and Nechells West Assertive Outreach Team 0; Sutton CMHT 0; Handsworth and Ladywood CMHT 1; Longbridge CMHT 0; Warstock CMHT 0; Lyndon CMHT 2; Small Heath CMHT 0 and Riverside CMHT 0.
- Total number complaints upheld by Ombudsman in last 12 months: Northcroft North Assertive Outreach Team 0; Aston and Nechells West Assertive Outreach Team 0; Sutton CMHT 0; Handsworth and Ladywood CMHT 0 (1 remains open with PHSO); Longbridge CMHT 0; Warstock CMHT 0; Lyndon CMHT 0 (1 partially upheld; 1 not upheld by PHSO); Small Heath CMHT 0 and Riverside CMHT 0.
- Services had information leaflets about patient and carers experience available at waiting areas and around the locations that we visited. This included information on how to raise a concern or complaint. Patients we spoke with said they knew how to complain and one patient said the trust had acted on her complaint and took her seriously. Most complaints were resolved at a local level but if patients required additional support they could access the patient advice and liaison service (PALS).
- Staff we spoke with were aware of the complaints process and we saw posters displayed informing patients of this. They reported that they would first try to resolve complaints informally before escalating them to PALS (the patient advice and liaison service).
- There were processes in place to inform staff of outcomes and learning from complaints. We saw agenda items and discussions from the minutes of team meetings. Team managers also reported that they raised this in supervision or emails with staff.

Are services well-led?

Good 

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

Our findings

Vision and values

Birmingham and Solihull Mental Health Foundation NHS Trust has the following four values:

1. Honesty and openness: We will keep each other well informed through regular communication. We will have honest conversations and explain our decisions.
 2. Compassion: We will bring compassion to all our dealings with service users and carers and expect it in our colleagues.
 3. Dignity and respect: We will respect all those whom we deal with at work, especially our service users and staff and take action to address those who do not.
 4. Commitment: We commit to help our colleagues provide the best care services that we can. We will do what we say we will.
- Staff we spoke with said that they believed in the values of the trust and the commitment to the patients who used the services and tried to embed this in the work that they did.
 - All staff were aware of who the senior managers were and could email the chief executive officer and ask him questions anonymously if they wanted to. All staff we spoke with said that the chief executive was accessible and that he had visited their service or focus groups.

Good governance

- Staff received mandatory training.
- Staff could access a range of clinical, peer and management supervisory practices.
- All services had administrative staff and this enabled nursing staff to maximise shift time on direct care activities.
- Staff knew what incidents to report and how to report them. Systems were in place to enable staff to learn from incidents, complaints or service user feedback.
- Staff had undertaken four clinical audits at this core service and this meant that staff did consistently measure the quality of the care provided. The audits the use of sodium valproate, schizophrenia re-audit, care programme approach, quality care planning and

community team medicines code. There was evidence of shared learning and agreed action plans as outcomes from the findings of the audits. However audits had not significantly improved the quality of care plans.

- Safeguarding, mental health act and mental capacity act procedures were followed and staff could give us examples of how to do this.
- Teams assertively monitored key performance indicators including care programme approach reviews, risk indicators and waiting list times.
- Team managers reported the ability to work with autonomy and authority locally and received good support from both their managers and administrative staff.
- Staff had the ability to submit items to the trust register. However, at the time of the inspection, there were no items on the risk register that were specific to this core service.

Leadership, morale and staff engagement

- Sickness and absence rates varied in the teams visited. Team managers dealt with this locally and made referrals to the occupational health department where required.
- No staff at any teams reported any bullying or harassment cases.
- Staff we spoke with knew how to use the whistle blowing process and were aware of the whistle blowing policy within the trust.
- Staff we spoke with stated that they were able to raise concerns without the fear of victimisation and reported supportive managers who created an environment of trust.
- Morale was high in most teams that we visited even though varying numbers of staff had been cut. Some staff were worried about future cuts to budgets and the impact that this may have on future service provision.
- Staff reported opportunities for leadership development through meetings, supervisory practices and mentorship.
- Staff consistently reported strong and supportive local management. Staff reported that they functioned well in respect of team working and mutual support.
- Staff across teams demonstrated that they were open and transparent and provided an apology and full explanation to patients if things went wrong.

Are services well-led?

Good 

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

- Staff had the opportunity to feedback on services and input into service development and this was evidenced in the flexibility of each service to adapt to its local population's needs.
- Staff participated actively in research programmes from the trust, and this core service undertook four clinical audits to monitor and evaluate the effectiveness of treatments. The audits were: the use of sodium valproate, schizophrenia re-audit, care programme approach, quality care planning and community team medicines code.

Commitment to quality improvement and innovation