Requires improvement

Birmingham Children's Hospital NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Birmingham Children's Hospital NHS Foundation Trust
Steelhouse Lane
Birmingham
B4 6NH
Tel: 0121 333 9999
Website:www.bch.nhs.uk/

Date of inspection visit: 17th-19th May 2016
Date of publication: 21/02/2017

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RQ301	Birmingham Children's Hospital NHS Foundation Trust	North community hub	B721QA
RQ301	Birmingham Children's Hospital NHS Foundation Trust	South community hub	B296JB
RQ301	Birmingham Children's Hospital NHS Foundation Trust	West Community hub	B191HS
RQ301	Birmingham Children's Hospital NHS Foundation Trust	Home Treatment Team	B138QE

Summary of findings

RQ301	Birmingham Children's Hospital NHS Foundation Trust	Crisis Team	B138QE

This report describes our judgement of the quality of care provided within this core service by Birmingham Children's Hospital 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 Children's Hospital NHS Foundation Trust and these are brought together to inform our overall judgement of Birmingham Children's Hospital 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	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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

Contents

Summary of findings

Overall summary

We rated the community mental health services for children and young people as requires improvement because:

- There were shortfalls in the staffing establishment. At the time of our inspection, the community mental health services for children and young people had an overall vacancy rate of 26% and a staff turnover rate of 22%. This was on the trust risk register at the time of our inspection.
- There were large waiting lists for young people requiring treatment for attention deficit hyperactivity disorder and who had been transferred to the care of Forward Thinking Birmingham as part of the reconfiguration of services. At the time of our inspection there were 441 young people awaiting their first appointment with services and staff raised concerns this number was increasing.
- Young people were not transferred from the home treatment team to the care of the community hubs at the point they were ready. This was due to a lack of capacity and staff in the community hubs. This was on the trust risk register at the time of our inspection.
- The learning disabilities service was not meeting trust key performance indicator targets for children and young people seen within 18 weeks from the point of referral
- Staff within Birmingham Children's Hospital reported that they did not always feel they had been consulted with effectively during the roll out of the new approach to providing mental health services for young people: "Forward Thinking Birmingham".
- Risk assessments were not always up to date. Reviews of risk were noted in clinical entries but the screening tool had not always been reviewed or updated.
- The signatures of young people and their families and carers were not always found in care planning documentation. This meant that consent to treatment was not always accurately recorded.
- The policy for the place of safety at Parkview Hospital did not reference the new and updated 2015 Mental Health Act Code of Practice. Staff at the place of safety had not made accurate records of the start and finish times of the use of the section 136 suite
- Morale was variable across the community teams and team meetings were not taking place consistently. Learning from lessons was not always evident and staff reported they were working less collaboratively following the reconfiguration of services.
- A combination of paper and electronic records meant that information was not always available or accessible for staff. The trust were in the process of introducing a new electronic care records system.
- Staff reported that they did not always receive regular managerial supervision. Appraisal levels were low within the community teams.

Summary of findings

However:

- Forward Thinking Birmingham (FTB) is a mental health partnership established to provide care to children, young people and young adults up to age 25. Integrating the expertise of Birmingham Children's Hospital's (BCH) 0-16s mental health provision with Worcestershire Health and Care NHS Trust, the Priory Group, Beacon UK and The Children's Society, Forward Thinking Birmingham aims to provide a single point of access for GPs, schools, local authorities, children, young people, young adults and families to access the right support at the right time. The partnership, which is led by BCH, went live on 1 April 2016.

- Families and carers we spoke with said that staff had a good understanding of the individual needs of the young people they worked with.
- Staff worked proactively with young people and their families to engage them in their care. Rates for non attendance at appointments were low.
- The trust were part of the national schools link pilot project. The link project focussed on early intervention for young people at primary or secondary schools.
- There was evidence of good multi agency working. Staff at the health based place of safety had also developed links with the local street triage team.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because

- There were shortfalls in the staffing establishment. At the time of our inspection, the community mental health services for children and young people had an overall vacancy rate of 26%.
- Staff turnover was high at 22%. This was more than twice the trust target of 9%.
- Risk assessments were not always up to date. Reviews of risk were noted in clinical entries but the screening tool had not always been revisited.
- Cleaning records were not available for two of the community hubs we visited. Staff were unsure how cleaning schedules were monitored or audited..

However:

- The average compliance rate with mandatory training for the community hubs was 84%. This was above the national target for training for the National Health Service.
- All staff knew how to report incidents, and were able to give us examples of lessons learned and changes to practice as a result.
- The trust had a lone working policy in place. The crisis and home treatment teams had been provided with lone worker devices for use in an emergency.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- A combination of paper and electronic records meant that information was not always available or accessible for staff. The trust were in the process of introducing a new electronic care records system.
- Completion of care plans was inconsistent. We found that staff either used a care planning document or outlined plans within clinical notes.
- The policy for the place of safety at Parkview Hospital did not reference the new and updated 2015 Mental Health Act Code of Practice.
- Staff at the place of safety had not made accurate records of the start and finish times of the use of the section 136 suite.

Summary of findings

- The signatures of young people and their families and carers were not always found in care planning documentation. This meant that consent to treatment was not always accurately recorded.
- There had been no recent training for staff regarding the understanding of Gillick competence when working with children and young people.
- Staff reported that they did not always receive regular managerial supervision.
- Appraisal levels were low within the community teams.
- Multi-disciplinary team meetings did not take place on a regular basis at the community hubs.

However:

- Care was based on nationally recognised guidelines and standards.
- There was evidence of good multi agency working. Staff at the health based place of safety had also developed links with the local street triage team.
- Staff had involved families and carers in Mental Health Act assessments. There was also evidence of the use of advocacy services.

Are services caring?

Good

We rated caring as good because:

- Families and carers of children and young people reported that staff treated them with respect and involved them in patients' care.
- The trust had developed a range of initiatives to involve children and young people in decisions about the planning of services.
- Young people had access to volunteering opportunities and the trust involved them in the recruitment of new staff.
- Families and carers we spoke with said that staff had a good understanding of the individual needs of the young people they worked with.
- The trust offered young people the opportunity to become involved in research and the development of training videos for staff.
- Staff provided information to families on the treatment options available and explained the possible outcomes of each one.

Summary of findings

However:

- All care plans did not have evidence of being signed by either the young person, or their family and carers.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- There were large waiting lists for young people requiring treatment for attention deficit hyperactivity disorder and who had been transferred to the care of Forward Thinking Birmingham as part of the reconfiguration of services. At the time of our inspection there was a waiting list of 441. Staff were processing between two and four referrals and receiving eight new referrals per week and as a result the waiting lists for treatment continued to increase.
- The learning disabilities team were seeing 57% of patients within 18 weeks from referral. This was below the trust target of 90%.
- Staff did not transfer young people from the home treatment team to the care of the community hubs at the point they were ready. This was due to a lack of capacity and staff in the community hubs. This was on the trust risk register at the time of our inspection.
- Most staff we spoke with at the community teams raised concerns that there were now waiting lists for young people to receive initial choice appointments. Concerns were also raised that internal waiting lists for young people were growing and were not being monitored effectively.
- Staff did not have access to sufficient facilities or equipment at the community hubs. Reported incidents had increased as a result of a lack of infrastructure for staff.
- Interview rooms at the North community hub were not sound proofed and voices could be heard, this meant that confidentiality could be compromised.
- Waiting areas did not have suitable provision for children or adolescents. Toys for the use of young people had been removed at two of the community hubs

However:

- The average waiting time from referral to triage was 24 hours due to a new referral hub.
- Data provided by the trust showed that 89% of young people were seen within 18 weeks of their initial referral into services.

Summary of findings

- Staff worked proactively with young people and their families to engage them in their care. Rates for non attendance at appointments were low.
- The trust were part of the national schools link pilot project. The link project focussed on early intervention for young people at primary or secondary schools.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Morale was variable across the community teams. Staffing vacancies and turnover were above the trust targets. Staff raised concerns that there were insufficient qualified and experienced staff to effectively deliver the service.
- Staff reported that they did not always feel they had been consulted with effectively during the implementation of Forward Thinking Birmingham.
- Supervision did not routinely take place and appraisal rates were low. Mandatory training rates were below trust targets.
- Team meetings did not consistently happen, and staff reported that individual professions were working in silo's and not collaboratively.
- Learning from incidents appeared to be happening inconsistently within the community teams.

However:

- The trust had a raising concerns policy and staff that we spoke with said that they felt able to use the whistle blowing process if required.
- Staff were able to submit items to the trust risk register and we saw that a number of recent concerns identified were reflected in the risk summary for the period January to April 2016.

Summary of findings

Information about the service

During this inspection we visited the community hub's and the crisis and home treatment team provided by Birmingham Children's Hospital as part of Forward Thinking Birmingham.

Forward Thinking Birmingham is an integrated community and inpatient mental health service for 0-25 year olds. It had been in place since April 2016 and running live for approximately six weeks at the time of our inspection. The new service comprises five core partners; Birmingham Children's Hospital, Worcestershire Health and Care NHS Trust, Beacon UK, The Children's Society and The Priory Group.

The services provided by the partners are:

Birmingham Children's Hospital – clinical care and support for patients aged 0-18

Worcester Health and Care NHS Trust– clinical care and support for patients aged 18-25, Early Intervention services for 16-35 year olds

Beacon UK – management of Forward Thinking Birmingham's Access Centre

The Children's Society – Forward Thinking Birmingham's city centre drop-in service

The Priory Group – inpatient beds for 18-25 year olds

During this inspection we looked at only the services provided by Birmingham Children's Hospital. This included the services for 0-18 year olds provided at community hubs and the Crisis and Home treatment Teams based at Parkview Hospital.

Our inspection team

Our inspection team was led by:

Chair: Dr Michael Anderson

Team Leader: Tim Cooper; Head of Hospital Inspection (acute hospitals) CQC

Inspection Manager: Donna Sammons

The inspection team for the community child and adolescent mental health services comprised four CQC inspectors, a psychiatrist, a social worker, a psychologist and a Mental Health Act reviewer

The team would like to thank all those who met and spoke to inspectors during the inspection. They were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust. They had prepared for our visit by gathering relevant information and requesting availability of staff and service users to meet or speak with us.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

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 three community hubs, the crisis team and the home treatment team at Parkview Hospital. We looked at the quality of the environments, and observed how staff supported children and young people
- spoke with five young people who were using the service and ten carers
- spoke with the managers of the five teams visited
- spoke with the associate service director and the head of nursing
- spoke with twenty eight staff members; including psychiatrists, nurses, clinical psychologists, occupational therapists, nurse prescribers, substance misuse workers and the Mental Health Act manager
- attended and observed a review meeting between a psychiatrist and a young person and their family, attended a home visit in the community with the home treatment team, observed a handover meeting with the home treatment team and a partnership appointment with a young person and their family at a community hub
- looked at 24 care records of young people
- 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

- People we spoke with said they found staff to be approachable and friendly. We were told that staff explained the goals for planned interventions clearly and worked well with other agencies, including schools.
- Families and carers that we spoke with said that the care they received from the service was good, one family member said the service went above and beyond what was expected of them.

Good practice

- Staff at the place of safety completed screening tools for young people at risk of sexual abuse. This demonstrated concern for arrangements for young people leaving the place of safety who had not been detained.
- Staff at the trust had developed a range of initiatives to involve young people in the planning and delivery of their care, A young persons advisory group was in place and young people were invited to take part in the recruitment process for new staff.

Areas for improvement

Action the provider MUST take to improve

The provider must:

- Ensure there are sufficient numbers of skilled and qualified staff to provide an effective service.
- Ensure that information needed to safely manage patient care is accessible and available for staff.
- Ensure that risk assessments are updated on a regular basis and using the risk screening tool.
- Ensure that care plans are completed consistently using the care planning documentation.
- Ensure that consent to treatment is obtained and recorded within patient care records.
- Ensure that staff at the place of safety accurately complete records relating to the duration of use of the section 136 suite.
- Ensure that the policy for the place of safety is updated to reference the 2015 Mental Health Act Code of Practice.
- Ensure that staff receive an annual appraisal and that management supervision is provided consistently for staff.

Summary of findings

Action the provider SHOULD take to improve

The provider should:

- Ensure that waiting areas are designed to take into account the needs of all people using their services.
- Ensure that cleaning records are maintained and that staff are able to access them.
- Ensure that equipment and facilities are available to support staff in carrying out their role.

Birmingham Children's Hospital NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location

Mental Health Act responsibilities

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

- The trust provided details for staff attendance at Mental Health Act training. However, this included all of the child and adolescent mental health services, including the inpatient services and was not service specific for the community teams. Figures provided by the trust indicated that 76% of qualified nursing staff had completed training. The trust had recently provided Mental Health Act training for staff working in the community as part of Forward Thinking Birmingham and future dates were planned. It was unclear how attendance at Mental Health Act training would be monitored in future for community teams.
- There were no children or young people detained at the place of safety at the time of our inspection. However, we reviewed five care records of the 18 admissions to the place of safety in the twelve months prior to our visit.
- Staff we spoke with said that it was possible for Mental Health Act assessments for children and young people to be carried out by professionals with child and adolescent mental health expertise, although this may cause delays.
- The place of safety policy had been updated in September 2015. However, all Mental Health Act Code of Practice references were to the 2008 edition, rather than the revised code which came into effect in April 2015.
- The Mental Health Act manager provided administrative support and legal advice on the implementation of the Mental Health Act and its code of practice . The Mental

Health Act manager and support team delivered training for staff at the crisis team, assisted with arranging Mental Health Act assessments and arranged detention for young people under the Mental Health Act if appropriate.

- The section 136 Mental Health Act monitoring forms were generally well completed, including outcomes of assessments and police involvement. However, staff could not tell us about any audits of section 136 data. This was not in line with Mental Health Act Code of Practice guidance.
- Staff had not made accurate records of the start and end times of the use of section 136 in any of the five records we looked at. In two cases, start and end times were identical. In another, the patient was recorded as having been at the place of safety for six days.
- Records showed that staff had involved families and carers in Mental Health Act assessments. Staff made them aware of the role of advocacy services and advocates had attended these assessments to support the families and young people.

Mental Capacity Act and Deprivation of Liberty Safeguards

Good practice in applying the Mental Capacity Act

- The trust did not deliver Mental Capacity Act training as part of it's statutory and mandatory training package. The trust told us that training in the Mental Capacity Act and Deprivation of Liberty Safeguards had been provided to senior managers and would be cascaded to the their staff. Figures for how effective this had been were not available at the time of our inspection.
- The Mental Capacity Act would apply only to children and young people over the age of 16. There was no record that any young person had, or had required, a best interest's assessment.
- Evidence of consent was variable within clinical notes. In one set of notes we saw that the staff member had clarified with the young person and gained their consent to share information with relevant professionals. However, in another set of notes we could find no evidence that consent had been explored with the young person.
- There had been no specific recent training for staff regarding Gillick competence. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
- Staff reported that guidance on the use of the Mental Capacity Act was available from the Mental Health Act manager and team based at Parkview Hospital.

Requires improvement

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

- The South and West community hubs all had interview rooms fitted with alarms. However, some staff at the South community hub reported that due to the alarms system being newly in place, they were unsure how to operate them. Interview room alarms were not fitted at the North community hub. Staff reported that this was due to the building being rented by the trust and the current landlord would not allow alarms to be fitted. Staff that we spoke with said that personal alarms were on order, but had not yet arrived. This meant that there could be delays in staff receiving assistance and support in emergency situations. Staff working at the place of safety based at Parkview hospital carried personal alarms.
- The place of safety for young people was situated on the first floor at Parkview hospital. A lift was available for use if required and the staircase was wide enough to accommodate two staff escorting a patient, in restraint holds if required. A fold out bed was available for use if needed which could provide potential ligature points. This was mitigated by the use of observations and the presence of staff. Sofa's with wipe clean coverings were also in place.
- The team at the South community hub had raised concerns about the suitability of waiting rooms being used for both very young people, and young adults as the service had changed to a 0-25yrs model. These concerns had been placed on the trust risk register and highlighted as a potential safeguarding concern. The trust had mitigated the risk by asking that children and young people be supervised at all times whilst at the community hubs.
- There was a well equipped clinic room at each community hub. This contained equipment for physical health monitoring checks of young people using the service including height weight and blood pressure. Evidence was available to show that all equipment was maintained in line with manufacturers recommendations. A resuscitation bag was held at the place of safety and staff carried out nightly checks of its contents and documented this in the log. Defibrillators were available on all sites that we visited and records showed that regular checks of this were undertaken.
- Cleaning records were available for equipment within the clinic rooms. The equipment appeared visibly clean and a review of the cleaning logs showed that they were completed in accordance with identified schedules. Equipment had stickers in place to show that they had been safety tested within the last twelve months.
- Areas that we visited appeared visibly clean and well maintained. The place of safety was included in the Parkview ligature audit and cleaning schedule. However, staff that we spoke with at the North and South community hubs were unable to provide any details on the cleaning schedules, how they were monitored and who was responsible for them. Staff at the North community hub told us that cleaning was provided by an outside contractor but were unsure who this was or how the cleaning schedule was audited. We did not see signage relating to infection control principles,such as handwashing techniques at the North or South community hubs.

Safe staffing

- Data provided by Birmingham Children's Hospital from May 2016 showed that their child and adolescent community mental health services had a total of 189.5 whole time equivalent staff in post at the time of our inspection. There were 49 vacant posts and a vacancy rate of 26%.
- Vacancies in the crisis team were 73% as of May 2016. Staffing levels within this service had been placed on the trust's risk register as a concern.
- There were two place of safety co-ordinators based on the children's inpatient ward at Parkview Hospital. They responded to cover the place of safety as and when required. At the time of our inspection there were no young people using the place of safety. Staff that we spoke with said that qualified nurses had been trained to respond and cover the place of safety in the absence of the designated coordinators and this arrangement worked well.
- The child and adolescent community mental health services were on the trust's risk register at the time of

our inspection. Concerns identified were the ability to recruit to posts for Forward Thinking Birmingham, the recruitment gap being larger than expected and the transfer of staff from other organisations being less than expected.

- The crisis team was on the risk register at the time of our inspection due to a lack of staff within the urgent care pathway. The crisis team were using temporary staff to fill the gaps but there were concerns these staff may be less experienced at working with young people under the age of 16. Controls put in place to manage this included agency staff being block booked to embed themselves within the team and recruitment for vacant posts.
- Staffing levels were raised as a concern by staff across all community hubs that we visited. Staff reported that due to redundancies, staff leaving and a lack of recruitment they felt under resourced as a service. Managers said that organising staffing had been a challenge following the formation of Forward Thinking Birmingham. The staffing structure and the line management structure for all staff had not been finalised at the time of the inspection.
- Sickness rates across the community hubs from April 2015 to March 2016 were 3%, This was equal to the trust target. However, staff turnover during the same period was 22%, this was more than twice the trust target of 9%.
- Staff told us that there was no nationally recognised tool used for the staffing of the community hub teams. Staffing levels for the new Forward Thinking Birmingham service for 0-25 year olds had been based on an analysis of the clinical activity for the previous service providers. Managers said that data they had received to enable them to plan services had not been reliable and this had impacted on their ability to effectively plan staffing requirements. Home treatment team staff said that they usually had a case load of between 6 and 15 patients, they did not have a cap on their individual caseload but monitored it daily.
- A crisis team was in place and offered support to young people under the care of the community teams, for a maximum of 72 hours.
- Out of hours access to a psychiatrist was provided through a three tier on call duty rota. The first tier on call was provided by foundation year and core trainee medical staff, the second tier was provided by specialty registrars and the third tier was provided by consultant psychiatrists. The on call duty protocol was updated in July 2015. Medical staff providing the first tier of the on call rota were required to be within a 20 minute response time to Parkview hospital. At the time of our inspection, a service level agreement was being drafted for adult psychiatrists employed as part of Forward Thinking Birmingham to participate in the on call medical rota for the neighbouring trust who were providing care for people aged 16-25 until their care was transferred over to forward thinking Birmingham. expected to be October 2016
- The average compliance rate with mandatory training for the community hubs was 84%. This was above the national target of 75% for training for the National Health Service. Areas of training that fell below this target included equality, dignity and diversity training, basic life support, fire safety, information governance, medicines management, health safety and clinical risk management and safeguarding children level 3. However, managers we spoke with identified that there had been inputting issues that affected the accuracy of the data as a result of staff changes and moving to the new provider. This meant that data relating to staff training was not always complete and up to date.

Assessing and managing risk to patients and staff

- There were variations in the risk assessment tools used by the teams in the community hubs and the crisis and home treatment teams based at Parkview hospital. Community teams used a locally developed risk assessment tool whilst the crisis and home treatment teams used the Galatean Risk and Safety Tool. We found that of the 15 records reviewed at the North and South community hubs, a risk assessment had been completed for each patient at their initial choice appointment. However, this had not subsequently been updated. Staff had documented changes in risk within clinical entries but had not transferred this data or repeated the risk assessment tool. Risk assessments that had been completed at the crisis team were in paper form and had not been uploaded to the electronic care notes system. We reviewed the records of a young person that had been referred to the home treatment team and had no risk assessment in place. The assessment information had not been entered into electronic patient records. This meant that information needed to assess and manage the risk of young people may not be available for staff.

Requires improvement

Are services safe?

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

- We looked at five sets of records out of the 18 admissions to the children's place of safety during the year prior to our inspection. We found that all records reviewed contained risk assessments and showed evidence of collaborative working with the police as part of this process.
- Crisis plans were developed for patients using the crisis team and these were shared with the young person and other agencies, including the local accident and emergency department in case the young person presented in crisis. We saw that within care records at the north and south community hubs, discussions with young people and families about strategies to keep safe were documented as having taken place, but clinical entries did not always evidence the young persons or families views and wishes.
- Not all staff were clear how they could respond to a sudden deterioration in a young persons health. Some staff we spoke to said that young people would be given an emergency appointment at a community hub if they were already under the care of the team. Other staff said they would direct the young person to attend the local accident and emergency department or that they could refer to the home treatment team based at Parkview Hospital.
- We were able to see that managers in the community hubs had taken steps to monitor people on the waiting list for choice and partnership appointments. Referrals had been rated using a red, amber and green rating scale and reviewed them on a weekly basis. The manager of the West community hub had recently had their first "access and capacity" hub meeting to review the waiting list. Dates had been booked for this to take place in future and leads of each staff discipline were expected to attend and review the waiting list. The manager at the South and North community hub explained they would signpost people on the waiting list who were rated green to the voluntary services and would attempt to see those rated red at the earliest opportunity. Choice appointments were scheduled to take place each Friday, with an aim for nine slots per week. It was unclear if this was always possible due to staff shortages and delays in staff recruitment.
- Attendance at level one safeguarding children training was 100% for all community hubs. The average attendance for safeguarding children level 3 was 90.6%, this was below the trust target of 95%.
- Staff were able to identify who the safeguarding leads within the trust were and said that they felt well supported by the safeguarding team. Staff at the South community hub gave examples of being supported by the trust safeguarding teams who visited the hub on the days of planned choice assessments and who assisted staff who had safeguarding queries or concerns with new referrals. A safeguarding policy was also available for staff via the intranet. There had been a total of 62 safeguarding referrals made by the community hubs during the period April 2015 to March 2016
- The trust had a lone worker policy, ratified in June 2015 and due for review in April 2018. Most staff that we spoke with were able to describe the strategies they used to work safely in the community. This included the use of a buddy system where a colleague would monitor their whereabouts and planned return time from community visits.
- The crisis team and home treatment teams were using an electronic mobile device that could be listened to and monitored remotely if they activated them in an emergency. The team leaders received monthly updates about the devices and whether staff were using them. This was then reviewed in individual supervision. The trust planned to make these devices available to those staff based in community hubs and the manager at the West community hub confirmed they had been ordered. The trust also planned for staff to have electronic tablets that would contain lone working apps that monitored the staffs location.

Track record on safety

- There had been two serious incidents during the period January 2015 to January 2016. One had been classified as "major" and the other as "catastrophic". Both were referred to the trust risk management department for investigation and situation, background, assessment and recommendation forms were completed. A table top review was then held locally by the team involved in the young persons care to identify whether there had been any care management or service delivery failures.
- Improvements in safety and changes in practice were identified following investigations by the trust. These included the need for closer working with youth offending services and the use of integrated clinical care and youth offending services management plans.

Requires improvement

Are services safe?

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

Reporting incidents and learning from when things go wrong

- All staff that we spoke with knew what to report and how to report incidents using the trusts electronic incident reporting system.
- Staff at the crisis team were able to give examples of where lessons had been learnt. The system for forwarding office phones to mobile telephones had not worked when the team went live, this meant that calls were not being received by staff in the crisis team. A voicemail forwarding system had been set up to provide patients with details if they were not automatically transferred to staff, and a procedure for staff to check the systems were working was put in place.
- The manager of the crisis and home treatment team told us that debriefs from incidents took place during individual supervision and team meetings. Staff at the community hubs acknowledged that debriefs had not been happening regularly and stated that staff were good at completing the trusts IR1 forms, but not feeding back outcomes.
- Due to the restructure of the community services, regular team business meetings had not been taking place consistently. This meant that staff did not always have the opportunity to meet with each other following incidents to discuss learning and possible changes in practice.

Are services effective?

Requires improvement

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

- Children and young people had received an assessment of their needs at an initial choice appointment, this formed part of the nationally recognised choice and partnership service delivery model being used by the community child and adolescent mental health services. The choice assessment used a standardised tool to ensure that the young person received a comprehensive assessment of needs.
- Staff did not ensure care plans were up to date, personalised, holistic and recovery oriented . We reviewed 15 care records at the North and South community hubs and four of these did not contain a care plan. The remaining 11 care records contained an initial care plan but it was recorded in only two that the young person had been given a copy and it was unclear if staff had updated the care plans following the initial choice appointment.
- Four sets of care records were reviewed at the West Community hub. We found that in two set of notes, the plan of care had been recorded in the correspondence section as a letter to the child and family. The entry contained detailed information about the young personand strategies to engage them in their care. Staff had gained consent to share details about the plan of care with relevant organisations. However, we were unable to find a care plan that correlated with these clinical entries. In one set of notes at the West community hub we found that there were no details entered on either the electronic care notes, or in paper notes for a recent meeting with the young person. A care plan was found but did not evidence patient involvement and it was not signed by either the parent or young person.
- We reviewed five care records of the 18 admissions to the place of safety in the 12 months prior to our visit. The length of stay for young people using the place of safety was under 72 hours, and as such we did not see formal care plans. However, there were comprehensive records of the care provided to young people in the place of safety.These included a record of the provision of food and drink, informing them of their rights under the Mental Health Act and the involvement of their family.
- Staff at the place of safety recorded the views of the young people in their care. Staff worked collaboratively with young people, their families and other agencies to identify solutions when they were in crisis.
- Information needed to plan and deliver care was not always stored in an available or accessible format. The community children and adolescent mental health services were in the process of changing from a paper format to an electronic care notes system. This was also in use at the crisis team and the home treatment team based at Parkview Hospital. The change to electronic care records was in a staged process but had not reached full implementation or effectiveness at the time of our inspection. For example, we reviewed clinical notes for the crisis team prior to a home visit. Staff had completed an initial assessment a week earlier but it had not been uploaded it to the care notes system or recorded in the clinical notes that it had taken place. Most staff we spoke to across all of the community hubs cited problems with the implementation of the new electronic note systems. The assessment documents were not available on the electronic system. Staff had to complete them on paper and they would then be scanned into the system. Staff told us that documents were not always scanned and uploaded to in a timely manner. There would sometimes be sheets missing or they were scanned in upside down.
- There were variations in how paper records were being stored at community hubs. At the South community hub, records were stored on shelves in a locked room with a keypad for access. At the North community hub, records were stored in locked cabinets within a secure room, although this was open at the time of our inspection.

Best practice in treatment and care

- Medical staff had completed annual audits to review best practice and compliance to the management of attention deficit hyperactivity disorder in accordance with the national institute for health and care excellence.
- Staff in the community hubs were able to access psychological therapies for young people in accordance with national guidance. This included dialectical behavioural therapy and cognitive behavioural therapy. However, psychology staff we spoke with raised

Are services effective?

Requires improvement

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.

concerns that a reduction in experienced staff following the change to Forward Thinking Birmingham meant that delays in accessing this service were growing and would continue to do so.

- As part of the improving access to psychological therapies service, the trust had developed a clinical pathway for children and young people. This involved the provision of cognitive behavioural therapy for young people experiencing anxiety, depression and post traumatic stress disorder. Protocols for this pathway had been developed in line with national institute for health and care excellence guidance; CG22, CG159, CG113 and CG26.
- Staff documented in care plans the physical health needs of children and young people including young people on the specialist eating disorder pathway. Care plans that we reviewed showed evidence of young people agreeing to have their weight, blood pressure and pulse monitored weekly through visits at the community hubs. Medical staff that we spoke with said they felt that general practitioners were helpful in monitoring the physical health of young people in the community.
- Staff at the crisis and home treatment team completed baseline and on-going physical health assessments and completed a weekly medical review for all young people on their caseload. Staff reported effective links with local hospitals to access the results for blood tests and electrocardiograms and this could be done electronically
- Staff within the community hubs were using recognised and standardised outcome measures and rating scales.These included the strengths and difficulties questionnaire, the children's global assessment scale and the health of the nations outcomes scale for children and adolescents. Care records reviewed at the South community hub showed that outcome measures and rating scales were used inconsistently and we did not find evidence of their use in all records reviewed.
- Clinical audits of the effectiveness of the service had been carried out as part of the child outcome research consortium. This reviewed the outcomes of the service using a range of outcome measures and rating scales. Included within this were results from the outcomes of child and parent experience of service questionnaires and results of the audits of the Sheffield learning disabilities outcome measure. At the time of our inspection, the trust was awaiting the outcome from the child outcome research consortium report from 2015-2016.

Skilled staff to deliver care

- There were a range of staff disciplines available to provide care for children and young people, these included specialist child and adolescent psychiatrists, clinical psychologists, occupational therapists, nurse prescribers and substance misuse workers.
- Team managers were able to show evidence of the monitoring of staff compliance with disclosure and barring service checks. Staff that did not have in date disclosure and barring services checks to work with adults and children received written prompts from human resources and were then required to attend investigatory meetings with managers.
- We reviewed evidence of the management of poor staff performance with the associate service director. We saw that where staff performance had fallen below the required standard, managers had taken action in a timely manner and support had been available from the trust's human resources department.
- Staff raised concerns that they had not had specialist training that would assist them in safely managing the changing demographics of their caseloads following the implementation of Forward Thinking Birmingham. During our inspection we observed staff assessing young people's potential risk of self-harm although they reported they had not received training for this.
- Staff working at the place of safety received a specific induction for that service due to the specialised care it provided for young people in crisis.
- Supervision attendance for staff at the community hubs and the crisis and home treatment teams was inconsistent and not centrally monitored by the trust. During our inspection of the South community hub, we requested to see staff supervision and personnel files, but were unable to do so as they were held at a different location. One person we spoke with at the home treatment team had received clinical supervision recently, but had not received managerial supervision since January 2016. The trust had recognised at the time of our inspection that supervision of staff was not happening consistently. They had recently written a new policy and begun implementing a supervision tracking tool to resolve this.

Are services effective?

Requires improvement

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.

- A continuous professional development meeting had recently started. This was trust wide and was available for all psychiatrists, trainee's and nurse medical prescribers.
- Appraisal rates for community staff were low. Data provided by the trust showed that as of March 2016, 53% of community staff had received a performance and development review, this was a decrease on the previous years position which was 69%.

Multi-disciplinary and inter-agency team work

- Staff at the place of safety described good working relationships with outside agencies including the police. They had completed training with the local police response teams and had built links with the street triage service which covered Birmingham and was provided by a neighbouring trust.
- Staff reported that multi-disciplinary team meetings were happening inconsistently following the reconfiguration of the community services. Staff felt that collaborative working between different professions had been impacted upon.
- Staff at the crisis team and the home treatment team had weekly team meetings with a business meeting held monthly. Shift handovers were carried out three times a day by the crisis team and the home treatment team completed them daily.
- As part of our inspection, we observed a handover meeting at the crisis team based at Parkview Hospital. The meeting was attended by staff of different disciplines and roles including a child protection nurse and psychiatrist. Staff discussed the needs all patient's and minutes were recorded and stored electronically. We reviewed these after the meeting and found them to be complete.
- Staff reported effective working links with external organisations and social services, including multi agency safeguarding hubs.

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

- The trust provided details for staff attendance at Mental Health Act training. This included all of the child and adolescent mental health services, including the inpatient services. Figures provided by the trust indicated that 76% of qualified nursing staff had completed training. The trust had recently provided Mental Health Act training for staff working in the community as part of Forward Thinking Birmingham and future dates were planned. It was unclear how attendance at Mental Health Act training would be monitored in future for community teams.
- There were no children or young people detained at the place of safety at the time of our inspection. However, we reviewed five care records of the 18 admissions to the place of safety in the twelve months prior to our visit. There were comprehensive records of the care provided to young people in the place of safety. These included a record of the provision of food and drink, informing them of their rights under the Mental Health Act and the involvement of their family.
- Staff we spoke with said that it was possible for Mental Health Act assessments for children and young people to be carried out by professionals with child and adolescent mental health expertise, although this may cause delays.
- The place of safety policy had been updated in September 2015. However, all Mental Health Act Code of Practice references were to the 2008 edition, rather than the revised code which came into effect in April 2015.
- The Mental Health Act manager provided administrative support and legal advice on the implementation of the Mental Health Act and its code of practice. The Mental Health Act manager and support team delivered training for staff at the crisis team, assisted with arranging Mental Health Act assessments and arranged detention for young people under the Mental Health Act if appropriate.
- The section 136 Mental Health Act monitoring forms were generally well completed, including outcomes of assessments and police involvement. However, staff could not tell us about any audits of section 136 data. This was not in line with Mental Health Act Code of Practice guidance.
- Staff had not made accurate records of the start and end times of the use of section 136 in any of the five records we looked at. In two cases, start and end times were identical. In another, the patient was recorded as having been at the place of safety for six days.

Are services effective?

Requires improvement

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.

- Records showed that staff had involved families and carers in Mental Health Act assessments. Staff made them aware of the role of advocacy services and advocates had attended assessments to support the families and young people.

Good practice in applying the Mental Capacity Act

- The trust did not deliver Mental Capacity Act training as part of the statutory and mandatory training package. The trust told us that training in the Mental Capacity Act and Deprivation of Liberty Safeguards had been provided to senior managers and would be cascaded to their staff. Figures for how effective this had been were not available at the time of our inspection.
- The Mental Capacity Act would apply only to children and young people over the age of 16. There was no record that any young person had, or had required, a best interest's assessment.
- Evidence of consent was variable within clinical notes. In one set of notes we saw that the staff member had clarified with the young person and gained their consent to share information with relevant professionals. However, we found no evidence that consent had been recorded within four sets of notes reviewed at the crisis team.
- There had been no recent training for staff regarding Gillick competence. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
- Staff reported that guidance on the use of the Mental Capacity Act was available from the Mental Health Act manager and team based at Parkview Hospital.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Families and carers of children and young people reported that they received care that was respectful and promoted their involvement. We observed staff using creative suggestions for engaging young people in different treatment techniques and problem solving strategies.
- During the inspection process we attended clinical reviews for children and young people and attended a home visit with the home treatment team. During these meetings we observed care that was focussed and responsive. We saw that staff had an understanding of the individual needs of the people using their services and used sensitive language when discussing difficult issues.
- People we spoke with said that they found staff to be approachable and friendly, staff explained the goals for planned interventions clearly and worked well with other agencies, including schools.
- Families and carers that we spoke with said that the care they received from the service was good. One family member said the service went above and beyond what was expected of them. Families of young people with attention deficit hyperactivity disorder said that the communication they received about medication options was good and that appointments could be increased in frequency to reflect their needs.
- All people that we spoke with said they felt that confidentiality had been maintained by staff when working with them.

The involvement of people in the care that they receive

- Staff did not always update care plans following changes in planned care that they had documented in progress notes. This meant that we were not always able to see that care plans demonstrated the involvement of children and young people or their families and carers. Not all care plans that we reviewed had evidence of being signed by either the young person, or their families and carers.
- The trust had developed a range of initiatives to involve people in decisions about planning their services. This included supporting training for young people to be involved in the recruitment of staff, involvement of young people in the identification, naming and design of the city centre hub, and the development of a young persons advisory group.
- The trust had recently held a workshop focussing on attention deficit hyperactivity disorder and autistic spectrum disorder care for young people and their families and carers. The workshop focussed on feedback from people using the services, including the assessment process and provision of information about the services available. Suggestions that were made included more plug sockets being made available within waiting areas for young people to use electronic devices, and improved communication on waiting times at community hubs.
- Staff from the trust ran a young peoples group called "be about change". This provided information on opportunities to become involved in research, updates on the referral process and developments of digital apps for youth mental health.
- Parents ran a support group for parents and families affected by adolescent mental health issues. Staff from the trust attended this if required and provided information sessions for families and carers.
- Volunteering opportunities were available for young people at the city centre drop in hub alongside permanent youth workers and therapists. Young people were also being supported to produce a training video for staff. This was based on their experiences of receiving care from mental health services. Young people were also developing a social media group to raise awareness of services available for young people in the Birmingham area.
- Senior staff from Birmingham Children's Hospital, in partnership with other organisations part of Forward Thinking Birmingham, had set up an innovations think tank . The innovations think tank aimed to represent the views of children and young people and their families and carers and to identify areas for future development and innovation.
- Staff in the learning disabilities team had developed a letter which was sent to the parent and carers of young people prior to their initial appointment. The letter invited parents to complete two outcome measures, the developmental behavioural checklist and the Sheffield Learning Disabilities Outcome Measure. This was to enable the service to consider in advance of the appointment what interventions may be effective.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- The trust reported that the average waiting time for referral to triage for the child and adolescent mental health services was 24 hours. This was due to the centrally located access team which operated a 24 hour service.
- The trust had a key performance indicator that 90% of patients should be offered a first appointment (choice appointment) within 13 weeks from their date of external referral into the service. During the 12 months prior to our inspection, an average of 87% of patients met this criteria. There had been a decrease in the performance of the community services between June and December 2015. During the period October to December 2015, 79% of patients were receiving initial appointments within 13 weeks. However, between January and March 2016 this had increased to 94%.
- The learning disabilities team scored lower in the key performance indicator for patients that had been referred externally into the service and seen within 13 weeks. The average for the previous year was 67%. The data provided showed a similar trend to the community hubs and performance was lower between June and December 2015, but increased to 80% for the period of January to March 2016.
- The trust had set a referral to treatment target of 18 weeks and were monitoring this as a key performance indicator with a target of 90% of patients being seen within this time. During the 12 months prior to our inspection an average of 89% of patients met this target. The performance data provided by the trust showed a decrease in the amount of patients meeting the target of 90% between June and December 2015. However, performance had improved again and were meeting targets between January and March 2016. The learning disabilities team had a lower performance in this area than the community hubs, and the average amount of people seen within 18 weeks for the previous year was 57% and remained below the trust target during the period January to March 2016.
- The data provided by the trust for the key performance indicator of under 18 weeks for referral to treatment times included only external and emergency referrals. Most staff we spoke to across all of the community teams raised concerns that internal waiting lists for patients were increasing. Due to a lack of staff, there were not always sufficient resources for cases to be reallocated, this meant that although a child or young person had received an initial choice or partnership appointment, there could be significant delays in accessing treatment after this.
- Staff that we spoke with said that changes in staffing, redundancies, staff leaving and delays with recruitment had led to an increase in waiting lists for the community hubs for young people. Data provided by the trust identified that there were 252 people on the waiting list for allocation at the North, South and West hubs. The team with the lowest number on their waiting list was the West community hub (69), the team with the highest waiting list was the South community hub (111). At the time of our inspection, there were no waiting lists for the crisis team or home treatment team.
- The trust were able to provide details on the waiting lists for each community hub, broken down by postcode. The team with the highest number of children and young people on the waiting list was the South community hub, with a total of 111 people. The team with the lowest number of people on their waiting list was the West community hub with 69. Most staff we spoke with across all the community hubs raised concerns that since the change in service delivery from 0-16 to 0-25, waiting lists were growing. Staff reported that waiting lists were a recent development and prior to autumn of 2015, there had been no waiting lists for the community hubs. Staff attributed the increased waiting list to staff turnover and staff leaving without replacements, meaning that cases couldn't be reallocated. Staff reported that clinical activity was now also taking longer due to changes in the notes systems. Most staff we spoke with also raised concerns that with a current waiting list that they were unable to work through due to staff shortages, this would become a more acute need from June 2016. This was when patients that were aged 16-25 would begin being transferred to Forward Thinking Birmingham from the neighbouring trust currently providing their care.
- Staff raised concerns that as part of the service reconfiguration and the development of forward thinking Birmingham, the services were now responsible for the city wide care and treatment of young people with attention deficit hyperactivity disorder. At the time of our inspection there were 441 children and young people on the waiting list for this

Are services responsive to people's needs?

Requires improvement

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

service. Staff had put a triage system in place to work though the waiting list but had not realised it would be as large as it was, prior to the transfer of the caseload of approximately 400 from a previous trust. Staff were processing between two and four referrals and receiving eight new referrals per week and as a result the waiting lists for treatment continued to increase.

- Staff at the home treatment team raised concerns that young people had been receiving care from the team for extended periods of time due to a lack of capacity within the community teams. One set of care records we reviewed showed that a young person had been receiving care as part of the urgent care pathway for four months. The urgent care pathway being used due to capacity issues within the community teams was on the trust risks register at the time of our inspection.
- The trust measured the percentage of patients that did not attend their first offered appointments as part of their key performance indicators. The target set for the community teams was 10% or less. The average rate for patients not attending appointments for the year prior to our inspection was 6%. These rates had increased between June and December 2015 but had decreased to 3% between January and March 2016. The learning disabilities team had an average of 7% for the year 2015 to 2016.
- The trust measured the percentage of patients that did not attend their follow up appointments as part of their key performance indicators. The target set for the community teams was 10% or less. The average rate for community patients not attending their follow up appointments was 9%. These rates had also increased between June and December 2015 but had decreased between January and March 2016. The learning disabilities team had a significantly lower rate of patients that did not attend their follow up appointments, and the average for the year 2015 to 2016 was 3%.
- Staff that we spoke with described working with external agencies and families to reduce the amount of young people who missed appointments. Staff described a change in the culture of the teams classifying the appointments not as "did not attend", but as "was not brought". Young people who missed appointments were given multiple opportunities and letters notifying them of non attendance were copied to general practitioners and referral agencies. A final review meeting was also held between the multi disciplinary team prior to closing cases due to non attendance.
- The community teams were able to give examples of strategies and initiatives they used to engage with people who found it difficult or were reluctant to engage with mental health services. Home visits could be carried out where required and the manager at the South community hub said that a Saturday morning clinic they had held was well attended. The community child and adolescent mental health services had developed links with voluntary sector organisations including Pattigift and the Lateef project. Staff said that they felt these initiatives helped them to work with young people in communities where there may be increased rates of non attendance at appointments, and where there may be increased stigma attached to involvement with mental health services.
- We met with staff that were in the process of developing the schools link. This was a pilot project funded by NHS England and the department for education. Birmingham was one of 20 country wide sites chosen to take part in the project with the focus being early intervention for children in primary and secondary schools. Staff within the schools link project said that they used a variety of approaches to work with hard to reach young people and to engage young people and their families in accessing support. This included working initially with parents and carers to build understanding of what the service could offer. Staff could also work with young people during school holidays which offered greater continuity of care. Staff in the schools link project did raise concerns that staffing issues within the community hubs may impact on their ability to provide their service and worried they may be required to make up staff shortfalls.
- Families and carers that we spoke with said that they were offered flexibility in appointment times and that they generally ran on time and were rarely cancelled. When appointments were cancelled, a future appointment was offered and families and carers were invited to contact the community hubs if they required support in the interim period.

Are services responsive to people's needs?

Requires improvement

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

The facilities promote recovery, comfort, dignity and confidentiality

- There were enough rooms at the North community hub for staff to see patients in. However, staff at the South community hub told us that that there were insufficient rooms and facilities available for them to use. Staff that we spoke with said that there were frequently difficulties accessing computers, and this had become an increasing issue following the change to an electronic patient records system. Staff were being encouraged to complete incident forms to ensure the trust had oversight of problems caused by lack of facilities and equipment and there had been a recent increase in reported incidents as a result of this.
- The therapy rooms at the North community hub were very hot and some did not have windows. The families we spoke with in the waiting area commented how hot it was. The staff were unable to control the heating as the building was rented by the trust.
- The rooms were not sound proofed at the North community hub and voices could be heard from room to room. The partitions between therapy rooms did not always provide adequate soundproofing and staff raised this as a concern. At the North community hub some rooms had windows between them, and the blinds were not sufficient to ensure privacy. The manager was aware of this and said privacy covers for the windows had been ordered.
- The waiting rooms at the North and South Community hubs were being refurbished at the time of the inspection and were not child or adolescent friendly and there were no toys in them or child friendly seating. Waiting rooms were also not adolescent friendly; there were no activities or magazines suitable in them for adolescents except for information leaflets. Staff explained that waiting rooms had previously been child friendly, and there were toys available for use by young people and children. However, there had been a recent discussion about the provision of toys and whose responsibility it was to clean them. It was decided clinical staff could not be expected to clean the toys and it was not in the contract of the cleaners, therefore toys had been removed.
- There were leaflets in each of the waiting rooms with information appropriate to young people's needs, accessing advocacy and support services and making complaints. We also saw that there was psycho-educational information available for families, this included a range of topics including social anxiety. There were several ways of giving feedback; in each area, there was a suggestion tree that young people could write on a post it note and stick on. The manager then reviewed these. There were feedback forms in every room for young people and families to complete. Staff we spoke with said that if people required information in a different language this could be made available.

Meeting the needs of all people who use the service

- The North community hub was not compliant with the Disability Discrimination Act as the only access was via stairs. Staff we spoke with said that to mitigate this they ensured any disability requirements were noted at referral and the patient offered an alternative venue.
- Staff said that if people required information in a different language this could be made available An interpreting service was available for staff to use and was provided by the trust. Staff reported that they could also access the language line interpreting service without issue.

Listening to and learning from concerns and complaints

- There were three formal complaints made regarding the community child and adolescent mental health services during the time period January 2015 to February 2016. One complaint related to waiting times, delays and cancellations, one complaint related to the overall quality of the service and the third complaint related to access to specialist interventions. Two of the three complaints had been resolved at the time of our inspection and one complaint was in the process of being investigated. The average waiting time in days for the complaints to be closed was 183 days.
- There had been no complaints referred to the parliamentary health service ombudsman regarding the community child and adolescent mental health services during the time period January 2015 to February 2016.
- Evidence was available demonstrating duty of candour where complaints had been investigated. Families had been contacted by the trust via letter, outlining issues identified by the complainant, actions taken by the trust in response and offering an apology for any distress caused.

Are services responsive to people's needs?

Requires improvement

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

- Managers that we spoke with said that where possible, they tried to resolve complaints locally. Some managers told us that they would maintain records of actions taken by following the process of a formal complaint including keeping all paperwork and letters to the complainant to form an audit trail, this did not appear to be happening consistently however.
- Formal complaints were processed by the trusts complaints team, and a response was provided by letter from the chief executive. Each team also received a quarterly update via the complaints team for dissemination to all staff.

Are services well-led?

Requires improvement

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

Leadership, morale and staff engagement

- The senior leadership structure for Forward Thinking Birmingham included a service specific managing director, associate service director, interim medical director and a lead nurse. Each community hub also had a designated hub manager who we met with as part of our inspection activity.
- Local and Trust leadership were committed to the success of the Forward Thinking Birmingham programme. There was a focus on achieving this at senior management and executive level in the trust
- Sickness rates for the child and adolescent community mental health services were low at 3.1%. However, staff turnover was high at 22.2% and more than twice the trust's target of 9%. There were high numbers of vacancies in the community teams and the crisis and home treatment teams and most staff we spoke with raised staffing levels as a concerns. This was on the trust's risk register at the time of our inspection.
- Staff that we spoke with said that they felt able to use the whistle blowing process if required. The trust had a raising concerns policy which set out the responsibilities for staff to report incidents and provided details of senior staff within the organisation that they could contact directly for support. It also contained a list for staff of possible sources for independent advice if they required it.
- There were no reported bullying or harassment cases in the 12 months prior to our inspection.
- Morale was variable across the community teams. Staff that we spoke with raised concerns that there were insufficient staff to meet the capacity of demand following the reconfiguration of services. Staff reported that they felt clinicians with experience had left the teams and that access to psychological therapies had reduced and waiting lists were growing.
- Staff were open and transparent and offered explanations to patients and their carers and families when things went wrong.
- Staff reported that they did not always feel that they had been consulted with effectively during the change to Forward Thinking Birmingham. The trust had provided staff consultation sessions as part of the change, but staff reported that they did not always feel their views had been listened to or acted upon.
- The trust had developed a role for staff as cultural ambassadors. The aim of this role was to feedback concerns raised by staff about how services were performing and to provide information directly to the chief executive.

Vision and values

- The trust had both a mission statement and a set of values. The mission statement was "To provide outstanding care and treatment to all children and young people who choose and need to use our services, and to share and spread new knowledge and practice, so we are always at the forefront of what is possible." The trust's values were "To be the leading provider of healthcare for children and young people, giving them care and support – whatever treatment they need – in a hospital without walls."
- The community child and adolescent mental health services also had a set of values that they worked towards as part of Forward Thinking Birmingham. This was termed "No wrong door", with a vision, "To be the first city where mental health problems are not a barrier to children, young people or young adults achieving their dreams".
- Reports from staff varied about whether they knew who the senior managers were within the organisation and most people we spoke with said that there had been a period of managerial change within the organisation following the service reconfiguration and the change to Forward Thinking Birmingham. During our inspection we met with the lead nurse and the associate medical director for Forward Thinking Birmingham and staff reported that they were approachable and supportive.

Good governance

- All staff had not received mandatory training at the time of our inspection and the average compliance rate was 84%, this was below the trust target of 95%. Staff also raised concerns that they had not had specialist training that would assist them in safely managing the changing demographics of their caseloads following the implementation of Forward Thinking

Are services well-led?

Requires improvement

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.

Birmingham. During our inspection we observed staff assessing young people for potential risk of self harm although they reported they had not received training in this specialised area.

- Appraisal rates across the community teams were low and staff reported that supervision was happening infrequently. One staff member we spoke with had not received managerial supervision for five months prior to our inspection. The trust were in the process of developing a supervision policy and tracking tool to monitor this in future, but it was not yet functional.
- Staff were not always able to maximise their time on direct care activities. Staff reported having difficulties with the new electronic notes systems, that some parts of it were not available for use and that having to scan in copies of written notes and clinical work were slowing processes down.
- Incidents were being reported by staff and all staff we spoke to knew the trust procedure for doing so. Staff and senior managers raised concerns that the number of incidents being reported were increasing following the service reconfiguration. This included concerns raised by staff about the lack of infrastructure and facilities in community hubs to support them.
- Staff participated in clinical audits and were awaiting the publication of the annual audit into the service's clinical effectiveness by the child outcome research consortium. The trust had a clinical audit programme that was reviewed as part of the senior management governance meetings and included auditing of the services clinical effectiveness, and the implementation of guidance by the national institute for health and care excellence.
- Learning from incidents was happening inconsistently within the community teams. Some staff we spoke with described a supportive and consistent structure of team meetings with incidents discussed and de-briefs taking place. However, other staff we spoke with reported that multi disciplinary team meetings were no longer happening regularly and that individual professions were now working separately rather than collaboratively.
- Safeguarding children training was available for staff and all staff we spoke with were able to describe the processes they would follow if they had a safeguarding concern and how it would be reported. Staff reported effective and supportive links with safeguarding leads who were able to visit the community hubs and provide support for the staff.
- The trust used key performance indicators to measure the effectiveness of the community teams. Data collected included referral to treatment times, sickness rates, attendance at mandatory training and rates of patients that did not attend either first or follow up appointments. A Forward Thinking Birmingham monthly governance report had previously been used to communicate the services performance to staff, and also to provide feedback from patients obtained using comment cards. However, governance reports had not been available since January 2016, and staff reported that this was due to staff changes.
- Staff were able to submit items to the trust risk register and we saw that a number of recent concerns identified were reflected in the risk summary for the period January to April 2016. These included capacity issues within the community teams due to staffing shortages, longer waiting times as a result of this and increased use of the urgent care pathway. Risks that had been identified were being monitored through the governance structure for Forward Thinking Birmingham. Progress was reported monthly to the Birmingham Children's Hospital quality and audit committee, and the Forward Thinking Birmingham board

Commitment to quality improvement and innovation

- The trust formed part of Forward Thinking Birmingham. This was an integrated community and inpatient mental health service for 0-25 year olds. The aim of Forward Thinking Birmingham was for children and young people to receive mental health care which supported the transition between child and adolescent mental health services, and adult mental health services.
- The trust participated in the quality network for community child and adolescent mental health services.
- The service participated in the national child outcome research consortium. This reviewed the effectiveness of the service using a range of standardised outcome measures and rating scales.

Are services well-led?

Requires improvement

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.

- The trust was part of the schools link pilot project. This was a nation wide project focussing on early intervention for children and young people in primary and secondary schools.

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 17 HSCA (RA) Regulations 2014 Good governance The provider did not maintain securely an accurate complete and contemporaneous record in respect of each service user. Care plans and risk assessments were incomplete and stored in multiple formats within services. Records relating to the place of safety contained inaccuracies about the duration of young people's stay. The provider's policies did not accurately reflect the updated Mental Health Act code of practice This was a breach of regulation 17 (2) (a) (b, c, d)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Vacancy rates in the community mental health services for children and young people were high. This was on the trust risk register at the time of our inspection. The provider did not ensure that all staff received a regular appraisal of their performance in their role from an appropriately skilled and experienced person Staff did not routinely receive clinical supervision. This was a breach of regulation 18 (1) (2) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Requirement notices

The provider did not ensure that consent to treatment was routinely recorded and documented within patient care records

This was a breach of regulation 11 (1).

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.