Worcestershire Health and Care NHS 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)
RQ301	South Community Hub	Early Intervention Service	B29 6JB

This report describes our judgement of the quality of care provided within this core service by Worcestershire Health and Care NHS 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 Worcestershire Health and Care NHS Trust and these are brought together to inform our overall judgement of Worcestershire Health and Care NHS Trust.

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.

Summary of findings

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

- Staff could not hear emergency alarms, which delayed their response. Medicines were not always stored within optimal temperature ranges in the clinic room.
- Caseloads for care coordinators had increased and delays in discharging people who did not require their service prevented staff from providing a fully effective early intervention service.
- Information technology problems prevented staff from completing their mandatory training, therefore, training compliance was lower than the expected national targets.
- Risk assessments had not always been updated to reflect the patient's risks. Patients reported they had not been routinely offered a copy of their care plan.
- Staff within the early intervention team reported they did not receive information following incidents or other changes in Forward Thinking Birmingham. They did not feel integrated within the HUB. Staff worked effectively and enjoyed working within the early intervention team although morale was low.

However,

- Staff received regular supervision and an annual appraisal identified staff learning needs.
- People who use the service reported polite, courteous and knowledgeable staff, who provided a good standard of care to enable them to recover from their illness.
- Staff were responsive to patients when in a crisis, and were meeting national referral and treatment time targets.

Summary of findings

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

Are services safe?

- All interview rooms were fitted with alarms however, there could be delays in response to emergencies or when assistance was required as staff could not hear them and there was no organised procedure to respond.
- Procedures to ensure physical health equipment was cleaned after use were not in place and staff could not produce records to show equipment had been serviced regularly to confirm it was working effectively.
- Staff did not always comply with procedures to escort people who use the service around the building. This meant people could enter restricted areas and obtain items that may cause harm to themselves or others.
- Compliance with mandatory training was low and staff could not always access mandatory training due to information technology issues.
- We could not see risk management and crisis plans in the patient electronic record, and the system did not appear to support this.
- The clinic room was not always within optimal temperature ranges during hot weather, which could impair the effectiveness of some of the stored medicines.
- Staff were aware of when and what incidents they should be reporting, however they said they did not receive feedback and any lessons learnt were not cascaded down to the team from senior managers.

However,

- Patients did not have to wait for a care coordinator and knew who to ring if they were in a crisis.
- Staff were knowledgeable about safeguarding policies and procedures and had good lone working practices in place.

Are services effective?

- Assessments and care plans were detailed, holistic and recovery orientated with evidence of participation from people who use the service, and the multidisciplinary team met regularly to discuss and plan appropriate treatment plans.
- The team were able to provide National Institute of Health and Care Excellence (NICE)recommended psychological therapies, and provided practical help and support.

Summary of findings

- Staff were able to monitor patients' physical health and ensured they received an annual health check, although staff did not always document this in care records.
- The team were experienced in providing the early intervention model and received regular supervision and an annual appraisal to identify learning needs.

However,

- There had been delays in providing care and treatment due to a lack of communication from other teams within Forward thinking Birmingham.

Are services caring?

- All patients we spoke to said staff had always been polite, courteous, approachable and helpful. They said staff understood their individual needs and worked in collaboration with them.
- Patients said they had been involved in planning their care and staff had listened to their needs and wishes, although only two people we spoke with had received a written copy of their care plan.
- Staff had kept families and carers involved and provided them with written information about their family member's illness and they could access an advocacy service if they wanted to.

Are services responsive to people's needs?

- A lack of effective administration procedures had meant people waiting for first assessments had been unaware of appointments made however, a new protocol was due to be implemented imminently to prevent this happening in the future.
- The team were not always able to discharge people who did not need their service in a timely manner, due to a lack of resources within other Forward Thinking Birmingham teams. Therefore, caseloads had increased, preventing staff from always providing adequate time to their patients'.
- Environmental resources were insufficient to meet the needs of the service, and staff did not always have rooms to complete tasks or complete electronic patient records.
- People waiting within the reception area could not be afforded full confidentiality, due to having to speak loudly to be heard by the receptionists through a glass partition.

However,

Summary of findings

- The team were adhering to National Institute of Health and Care Excellence guidelines (NICE) and could assess and allocate a care coordinator within the recognised timeframe.
- Staff and patients who use the service agreed the team were responsive to the needs of their patients' and a duty worker was available within core hours. An out of hour's system was in place which people who use the system were aware of.

Are services well-led?

- Staff were not aware of the vision and values of Forward Thinking Birmingham and did not feel fully integrated into the model. Morale was low amongst the staff group.
- Staff did not receive feedback following incidents and any lessons learnt were not cascaded to the staff group.
- Staff told us they did not regularly see senior managers and when they did forward their concerns, they did not feel they were acknowledged or acted upon.
- Targets relating to physical health monitoring and behavioural family therapy had not been met.

However,

- Staff received regular supervision and an annual appraisal to identify learning needs and measure performance.
- Staff worked effectively as a team and enjoyed working within the early intervention service.

Summary of findings

Information about the service

The Early Intervention Service (EIS) provides a comprehensive service to young people aged from 16 to 35 who have experienced a first episode of psychosis and maintains support and recovery throughout the following three years.

The team had been providing services within a neighbouring trust until the formation 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. The 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
- Worcestershire Health and Care NHS Trust– clinical care and support for patients aged 18-25 and 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 the South early intervention service, provided by Worcestershire Health and Care NHS trust. The team was based in a hub (team base) with other teams providing community care within the Forward Thinking Birmingham Model.

The CQC had not inspected the service since becoming part of Forward Thinking Birmingham.

Our inspection team

The team was comprised of three CQC inspectors.

Why we carried out this inspection

We carried out an unannounced responsive inspection following concerns raised.

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?
- Is it well-led?

During the inspection visit, the inspection team:

- visited the hub and looked at the quality of the environment.
- spoke with four patients who were using the service
- spoke with the manager of the team and the manager of the hub
- spoke with 11 other staff members; including doctors, nurses and support workers

Summary of findings

- spoke with the operational director from Worcestershire Health and Care NHS Trust and the associate deputy director of nursing and service development lead from Forward Thinking Birmingham who had responsibility for this service
- spoke with one of service commissioners
- looked at five patients' care records
- carried out a specific check of the medication management and 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 who use the services told us staff were always polite and courteous and involved them in all aspects of their care. The team had offered them a variety of holistic treatments to aid their recovery. People told us staff had really helped them and were complimentary and grateful for the services they had received. Although not all people had received written copies of their care plans, they knew who to contact in a crisis and had found the team responsive to their needs when they contacted them.

Areas for improvement

Action the provider MUST take to improve

- The provider MUST ensure that all medicines are stored within optimal temperatures in the clinic room.
- The provider MUST ensure all physical health equipment is properly maintained in line with the manufacturers recommendations
- The provider MUST ensure adequate information is fed back to staff regarding incidents and any lessons learnt cascaded to the team.
- The provider MUST ensure staff have completed their mandatory training requirements.
- The provider MUST work with other partners within Forward Thinking Birmingham to ensure that the alarm system can be heard by staff who are required to respond when it is activated.

Action the provider SHOULD take to improve

- The provider SHOULD work with other partners within Forward Thinking Birmingham to ensure cleaning records are maintained and staff are able to access them.
- The provider SHOULD ensure risk assessments are updated following changes to a person's risk status
- The provider SHOULD work with other partners within Forward Thinking Birmingham to improve the environment for patients' carers and staff.
- The provider SHOULD work with other partners within Forward Thinking Birmingham to ensure effective processes are in place or adhered to, that facilitate effective communication between their teams to keep services safe for people that use it.
- The provider SHOULD ensure patients receive and are offered a copy of their care plan and this is recorded in the patient's care record.
- The provider SHOULD ensure effective systems are in place to ensure patients' receive correspondence in a timely manner of appointments made.

Worcestershire Health and Care NHS 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
Early Intervention Service - South	South Community Hub

Mental Health Act responsibilities

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

We did not look at the providers responsibilities under the Mental Health Act 1983 on this inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were aware of the principles of the Mental Capacity Act and Deprivation of Liberty safeguard authorisations. Staff told us they sought advice from senior clinicians with the team when they were unsure.

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

- We saw alarms fitted in interview rooms in the main building where staff saw patients. However, some early intervention staff reported that they were unsure how to operate them. Personal alarms were available but staff did not use them. Staff told us they could not hear the alarms when based in team offices and there was no organised procedure when responding to alarms. This meant that there could be delays in staff receiving assistance and support in emergencies on activation of an alarm.
- Staff had access to a well-equipped clinic room. This included physical health monitoring equipment to check height, weight and blood pressure. Staff did not keep records to show that equipment was regularly calibrated and maintained. This meant staff could not be sure equipment produced accurate readings.
- Interview rooms looked to be clean and furniture appeared to be in good condition. We saw a cleaning schedule for the buildings. However, staff were unable to show us cleaning records to confirm that staff followed the schedule.
- Staff did not routinely clean physical health equipment after use, although stickers to show when equipment had been cleaned were available, staff did not use them. This meant infection control procedures were not followed.
- Sanitary bins were not available in any toilets around the building. Staff told us they had not been available for over 12 months.

Safe staffing

- The team consisted of 3.6 band six nurses, one-band five nurses and one band four social inclusion worker. There were 2.4 nursing vacancies; the provider had recruited into one vacancy and the other had been one recently advertised.
- Early intervention staff told us their caseloads had increased; the average was 28. The national recommended average for cases on a care coordinators caseload for early intervention services is 15. Staff told us their increased caseload prevented them from providing some interventions such as family therapy.
- Patients did not have to wait for allocation of a care coordinator following initial assessment.
- The team manager regularly monitored staff caseloads in supervision.
- Current vacancies were filled by agency staff on long-term contracts, which meant they would work with the team for long periods and knew staff and their caseloads.
- A team psychiatrist was always available within core hours, and an on call psychiatrist was in place in the evenings, nights and weekends.
- Worcestershire Health and Care trust provided all mandatory training for the team. Data received from the provider showed the team had completed 50% of required training. Staff told us they were not always able to access on line training modules due to information technology problems within the HUB building. EIS staff reported that they had to travel many miles to access face-to-face training, provided in Worcestershire. Senior managers within Forward Thinking Birmingham told us they were aware of these problems and planned in the near future to provide staff with a local road show to ensure completion of outstanding training requirements. Early intervention staff were also given protected time to complete their training at home and dates had been arranged at Birmingham Women and Children's Trust sites for staff to attend.

Assessing and managing risk to patients and staff

- We reviewed five sets of patient care records. We were able to locate four completed risk assessments; however, some information had not been updated following a change in risk. Staff had documented changes in risk within clinical entries but had not transferred this data or updated the risk assessment tool. Risk management plans were not evident. This was because the electronic patient notes system did not have a section for these to be completed. Staff found

Are services safe?

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

the system confusing and told us they were often unable to locate specific documents within the record system such as risk assessments when they needed them.

- Early intervention staff provided patients and their families with crisis numbers of people to contact in an emergency; however we did not see crisis plans within patient care plans. This was because the electronic patient notes system did not have a section for these to be completed.
- To minimise risks, a member of staff would escort people who use the service through the building. However, staff told us of an incident when an unescorted person wandered into a staff area and we saw an unaccompanied minor walking through the building. Other areas around the building included an unlocked staff kitchen and we saw rat traps all around due to a previous rat infestation. This meant staff could not always be sure where people who used the service were, and they could access items that may cause harm to themselves or others
- Staff told us they could respond promptly to a sudden deterioration in people's health. Patients told us staff had been responsive when they had contacted them.
- All staff we spoke with were knowledgeable about safeguarding practices and were aware of when and how to make a safeguarding alert or referral. Safeguarding leads had recently visited the hubs and staff were aware of who they were.
- Good lone working practices were in place when staff visited patients in the community and staff were aware of the provider's policy. The duty worker monitored when staff had not returned as scheduled and was available to speak with staff throughout the day.
- We saw that medicines were appropriately stored within the clinic room and only accessed by suitably qualified staff. Staff checked the temperature of the clinic room and fridge on a daily basis. However, the temperature for the clinic room had been above the maximum 25 degrees Celsius on eight occasions in the last 37 days. We saw records to show this had occurred during hot weather over the last year. Staff had escalated this to senior managers and the pharmacy department had provided them with interim advice, such as placing required medicines in the fridge. Senior staff told us this was on the provider's risk register and they were awaiting the agreement to install air conditioning.

Track record on safety

- One serious incident had been recorded in the last six months. However, the provider had postponed an internal investigation until the conclusion of legal proceedings.

Reporting incidents and learning from when things go wrong

- Early intervention staff told us they were aware of how to report incidents, and what they should report. However, all staff we spoke with told us they did not receive feedback and were unaware if incident reporting had resulted in any changes within the organisation. As a result of this, they had become disinclined to report incidents as they saw no benefit to themselves or their work environment. Staff told us there was a lack of information following investigations or dissemination of any lessons learnt following incidents, internal and external to the service. We saw evidence to show quality and governance groups within Forward Thinking Birmingham reviewed incidents.
- Staff were open and honest with people who use their service when something went wrong and we were given examples of how they had done this.
- Following a recent serious assault on a member of staff, local managers had provided support and a debrief to the staff member involved, however this was not opened up to the wider team who may have also benefitted. Senior managers had investigated the incident and made recommendations, although the staff member affected by the incident was not aware of what these recommendations were.

Are services effective?

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 reviewed five sets of electronic patient care records. We found that the assessing team recorded detailed information onto the assessment documents and devised an appropriate and mutually agreed plan of treatment and care with the patient.
- All patients' records we saw included an up to date care plan, three of which were personalised, holistic and recovery orientated. Care coordinators told us they discussed care plans with their patients and we saw patient's views included in four of them.
- All staff working within Forward Thinking Birmingham used the same electronic patient record. This meant that staff could monitor patients' progress when they were being looked after by another team. However, when patients' were admitted for in-patient care, staff could not access their notes and told us they did not always receive information required for effective patient follow up following discharge.

Best practice in treatment and care

- The team psychologist provided National Institute for Health and Care Excellence (NICE) recommended psychological therapies such as cognitive behavioural therapy, cognitive analytical therapy and mindfulness sessions to people who use the service.
- The social inclusion worker could signpost to external agencies and provided help for people who required assistance with benefits, employment and housing. The team also worked with local voluntary organisations that provided support for young people to help develop personal and social skills.
- The social inclusion worker provided a physical health clinic and took blood tests. The team had access to an electro cardiogram machine on a weekly basis. However, staff could not access blood results on the computer and had to wait for a neighbouring hospital to send them. Care coordinators told us they ensured people on their caseload received an annual health check. However, we did not see documentation related to physical health monitoring in the patient care records.
- The team ensured patients' received the correct treatment pathway for their diagnosis, by using rating scales and outcome measures.
- We saw evidence of audits undertaken across the citywide early intervention service such as social recovery, family work and a clozapine audit.

Skilled staff to deliver care

- There were a range of staff disciplines available to provide care for people who the service, these included psychiatrists, nurses, a social inclusion worker and a psychologist. However, the team did not have an occupational therapist, but could access one when required within the wider team hub.
- Staff were experienced in providing the early intervention treatment model to patients, and most staff had worked in the team for many years.
- Early intervention staff told us they received regular supervision and annually appraisals. However, team meetings had become less regular. We were told this was due to care coordinators having increased caseloads and less time to spend on other tasks.
- Data received from the provider showed 100% of eligible staff had received an appraisal in the last 12 months.
- Staff told us they had not been provided with opportunities for specialist training since the commencement of Forward Thinking Birmingham. Many staff had received training in psychological therapies before the commencement of Forward Thinking Birmingham. We saw evidence within senior meetings of developing a leadership programme for staff.
- No staff were on performance management at the time of inspection. The team manager showed awareness of when this would be applicable.

Multi-disciplinary and inter-agency team work

- There was a weekly multi-disciplinary team meeting which was attended by all staff disciplines to discuss care and treatment plans for patients.
- Early intervention staff had developed good relationships with other teams within Forward Thinking Birmingham over the last year. However, staff told us communication was not always effective with other

Are services effective?

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teams within Forward Thinking Birmingham. Staff gave an example of when a patient was discharged from in-patient care without their knowledge that meant medication ran out before the team were aware. This had caused delays in the team being able to respond in a timely manner to the needs of their patients'.

- Staff said they worked effectively with external organisations such as the neighbouring mental health trust, GPs and social care services.

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

- We did not review adherence to the mental health act during this inspection.

Good practice in applying the Mental Capacity Act

- Staff we spoke with showed a good understanding of the Mental Capacity Act and knew where to seek advice when unsure. They said doctors would often take the lead when assessing a person's capacity to consent to treatment.

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

- We did not attend visits with staff on this inspection, however staff spoke respectfully of patients when talking about them.
- We spoke to four people who used the service and they told us staff were respectful, polite and courteous. Staff were approachable and provided practical support and advice when needed.
- Patients' told us that staff understood people's individual needs and worked in collaboration with them.
- Patients' we spoke with said they felt that staff had maintained confidentiality.

The involvement of people in the care that they receive

- All patients we spoke with said they had been involved in planning their care and staff had listened to their needs and wishes. Staff had given them information on their illness and ways in which they could recover and stay well. Two people said they had received a written copy of their care plan. All received written information of who to contact in an emergency. Staff accessed other agencies such as the Prince's trust to help maintain people's independence and develop skills.
- Staff had provided information to families and carers and had offered support and education to them. The team had previously provided carers groups although were unable to currently due to staffing pressures and lack of available venues to do this. One person told us staff had escorted their family member to an external carers group. They had received written information on their family member's illness.
- Staff told us they had access to an advocacy service and provided details to patients who wanted to use their services.
- People we spoke with had not been formally asked to feedback into the service, although felt confident they could speak with their care coordinators about anything they were worried about.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- The team received referrals from the single point of access triage centre, other teams within Forward Thinking Birmingham, acute hospital mental health liaison teams and a neighbouring trust.
- The National Institute for Health and Care Excellence (NICE) recommends assessment and allocation of a care coordinator within two weeks of referral for people experiencing first episode psychosis. The team were meeting these targets.
- The team could be responsive during their core hours and a duty worker was available to speak with people who were experiencing a crisis. Patients confirmed that staff were available when they needed them. However, staff told us there could be delays in getting through to the team as only one telephone line was available, and this was often busy. Staff referred patients' they were concerned about to the out of hour's home treatment and crisis team for extra support if needed.
- The service did not exclude people who would benefit from it, except for individuals diagnosed with a physical cause to their psychotic illness.
- Staff generally visited patients in their homes or somewhere mutually convenient. They could be flexible with the times and places of the appointments, and persevered when trying to engage someone who may be initially reluctant.
- On occasions when the team needed to cancel an appointment, staff rescheduled them as soon as possible.
- The team had experienced problems getting letters for initial assessment delivered in time for new appointments. Patients referred to the service were often unaware an appointment had been made, therefore appointments were missed and had to be re-arranged. This was due to lack of administration staff for the team and no clear processes regarding completion of letters. Clinical staff had resorted to posting appointment letters through people's doors to ensure people received them. However, senior managers told us they were in the process of putting procedures in place to support the need for letters and correspondence from the early intervention service being prepared and delivered in a timely manner. This was due to be implemented shortly after our inspection.
- The team experienced delays in discharging their patients to the community mental health teams. Staff told us that the community team for patients under 25 was not fully staffed which meant staff caseloads were high and managers could not allocate care coordinators in a timely manner. This meant the early intervention team supported their patients for longer than they needed.

The facilities promote recovery, comfort, dignity and confidentiality

- Early intervention staff generally saw their patients at home, however could see people at their base if they wished, or if they required a physical health check or blood test. All staff told us that there were insufficient rooms and facilities for them to use at the team base. The clinic room would also be used by other teams to see their patients without the early intervention team's knowledge, so often consultations were disturbed and staff were not able to complete their own tasks. Staff told us there were frequently difficulties accessing computers as staff from other hubs would 'hot desk', which meant there were less computers for staff from south hub to use. Senior staff within Worcestershire Health and Care trust told us another partner within Forward Thinking Birmingham managed the property, although discussions on the impact this had on staff and people who use the service were on-going. The environment was on the Forward Thinking Birmingham risk register.
- The interview rooms were small and on the day we visited quite hot. They were plain, with little decoration on the walls. However, they were sound proofed and allowed people who use the service private consultations.
- The reception area had adequate seating, but we saw little information displayed on walls. Limited information leaflets were available in the waiting area; we did not see any on how to make a complaint or advocacy services.
- We saw that the reception area did not afford people any privacy or confidentiality. People had to talk loudly

Are services responsive to people's needs?

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

through a glass partition so the receptionist could hear them. Despite two members of staff being available to talk to people who approached the reception desk, only one could speak at one time. The glass partition had to be slid to one side to be able to speak to people, blocking the other side off.

Meeting the needs of all people who use the service

- There were provisions in place for people with disabilities, including toilet facilities and use of a room downstairs for physical health checks. However, some people in wheelchairs might find the main corridor difficult to access due to its limited size.
- We did not see any information leaflets in other languages. Staff told us they were available if required and they had good access to interpreting services.

Listening to and learning from concerns and complaints

- The team had not received any complaints in the last six months.
- People who use these services told us they were unaware of how to complain but would ask their care coordinator for information. Staff told us information was available but not routinely given out.
- Managers that we spoke with said that where possible, they tried to resolve complaints informally at the earliest opportunity.

Are services well-led?

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

- The values for Worcestershire Health and Care trust were embedded in staffs' annual appraisal, although staff told us they were not aware of the vision and values for Forward Thinking Birmingham.
- Most staff told us they were not aware of who the senior managers were from either Worcestershire Health and Care trust or Forward Thinking Birmingham.

Good governance

- Early intervention staff had problems accessing on-line mandatory training and had to travel many miles to complete face-to-face training.
- We were told there had been confusion about how to access occupational health. This had caused a delay in acquiring adapted equipment for a member of staff with dyslexia.
- We saw evidence to show staff received regular supervision and appraisals.
- Staff told us they found the electronic patient record system confusing and it often took a long time to find relevant information. This meant that
- Staff reported incidents, although they told us they did not know who reviewed them and did not receive feedback. Staff reported they did not always receive information about any lessons learnt internally or externally. This meant staff were not aware of any recommendations or changes required within the service or HUB, and missed opportunities to improve their service.
- The citywide early intervention service had undertaken audits to identify areas of good practice and areas staff could make improvements.
- Staff had awareness of safeguarding and mental capacity act procedures.
- The early intervention service lead monitored key performance indicators for the team and reviewed them with senior managers within the organisation. Minutes of meetings we reviewed showed the early intervention teams were not meeting targets set for physical health monitoring and for behavioural family therapy standards.
- All staff told us a lack of administration support impacted upon their time and the smooth running of the team.
- Five items relating to the hub were on the risk register, including the accommodation issues, alarm system not working, medical devices overdue their annual check, overall staffing issues within the hub and the clinic room temperature exceeding safe ranges. It was unclear what actions had been taken for the alarm system not working or the medical devices requiring annual checks.

Leadership, morale and staff engagement

- Staff sickness and absence was low and well below the national average of 4%.
- Managers told us there had not been any bullying or harassment cases reported.
- Early intervention staff were able to raise their concerns however they told us they did not feel they were acted upon or acknowledged. For example, staff had been complaining of a lack of sanitary bins in toilets for a year. This was still unresolved at the time of inspection.
- Staff told us they worked well as a team and enjoyed working in early intervention services. Many staff had worked together for a number of years and were mutually supportive of each other. However, morale was low; reasons for this included the poor work environment and lack of resources and facilities, perceived lack of support and guidance from senior managers and increased workloads.
- Staff told us there had not been opportunities for leadership training since staff had joined Forward Thinking Birmingham.
- Staff told us of examples when they had been open and honest with patients when things had gone wrong.
- Staff told us they were frustrated at the lack of opportunities were they could give feedback which would input into service development. They felt it had taken a long time to fully understand elements of the

Are services well-led?

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.

Forward Thinking Birmingham model and did not feel integrated and part of it. However, senior managers told us they had implemented listening events in the past to capture staffs views.

Commitment to quality improvement and innovation

- We did not ask for data about quality improvement and innovation during this inspection.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured medicines stored in the clinic room were maintained within optimum temperature ranges. Physical health equipment had not been adequately maintained to ensure it produced accurate readings. The provider had not ensured alarms for summoning assistance could be heard across all south hub buildings. This was a breach of Regulation 12 (2) (b) (e)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that staff received adequate feedback following incidents reported This was a breach of Regulation 17 (2) (e)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Data provided showed low levels of staff compliance with their mandatory training requirements.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 18 (2) (a)

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.