Birmingham and Solihull Mental Health NHS Foundation Trust

Community-based mental health services of adults of working age

Inspection report

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Date of inspection visit: 23 November 2020
Date of publication: 21/01/2021

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Community-based mental health services of adults of working age

Inspected but not rated

The community-based mental health services for adults of working age provides assessment, specialist support, treatment and care planning for patients (aged 25 plus in Birmingham and 16 plus in Solihull) with functional mental health problems such as depression and psychotic mental illness.

We conducted an unannounced focused inspection of the services as a result of insight and concerns we had received around this service.

At the last comprehensive inspection in April 2019, we rated the trust overall as requires improvement. This service was last inspected in August 2017 and was rated as good and for all five key questions.

During the inspection we:

- Visited Lyndon, Kingstanding, Riverside and Zinnia Community mental health trust hubs.
- spoke with staff, patients and carers.
- visited four of the twelve community home treatment teams.
- observed a depot clinic, a multidisciplinary team meeting, and patient assessments.
- reviewed documentation including patients care records and policy documentation.

We spoke to two patients and four carers and two told us the nurses were excellent, others told us they had lack of continuity with the community psychiatric nurses, and they did not have a named nurse. Patients and carers told us that when they contacted the service, they had a long wait for a response. Two carers told us they had a very positive experience and two told us that they did not feel listened to.

We found the following:

- The number of patients on some Consultant community mental health team caseloads were too high.
- Staff did not always store or transport medicines safely.
- Patients and carers were not routinely provided with copies of care plans.
- Staff did not follow clear personal safety protocols. The trust lone working application was not used routinely across the trust.

However:

- All clinical premises where patients received care were safe, clean, well equipped and fit for purpose. Staff had completed and kept up to date with their mandatory training. Staff assessed and managed risks to patients well.
- Leaders had the skills, knowledge and experience to perform their roles. Staff felt respected, supported and valued.

Our findings

Is the service safe?

Inspected but not rated

We inspected four community mental health team hubs. We did not rate safe.

Our rating of good from the previous inspection remains.

- The service did not always have enough staff to provide a good service to patients. The number of patients on the caseload of individual members of staff was too high particularly for medical staff, so prevented staff from giving each patient the time they needed. Consultants had individual caseloads of up to 1,000 patients.
- We found the staff toilets at Northcroft were dirty
- At Riverside there were no records of physical health equipment being cleaned or tested.
- Staff kept records of patients' care and treatment, records were clear, up to date and easily available to all staff providing care. However, records often contained only essential information and they did not all contain the patient voice. We saw examples of identical information in different patients' records, suggesting that they might not be an accurate account of the care of individual patients.'
- The service did not always store or transport medicine safely. We saw staff at the Zinnia Hub transporting medication in bags with no locks. At Northcroft Hub we found the drug cupboard with keys in was left unattended. We were told keys were to be signed in and out via reception. The cupboard was within the locked clinic area where access could be gained only via staff ID but had drugs been removed it could not have been identified who had moved them. We also found the keys were left in the fridge in the clinic room.
- Staff did not always follow clear personal safety protocols. There was no consistent approach around lone working. The trust had introduced an organisation-wide lone worker application, but not all staff were routinely using it. Some hubs had local systems to ensure staff safety when visits had finished, and local procedure was not documented.

However:

- All clinical premises where patients received care were safe, clean, well equipped, well-furnished and fit for purpose. All areas adhered to the two-metre rule and displayed posters stating face coverings should be worn while in the building and provided adequate hand washing and sanitisation equipment. Waiting areas had reduced capacity, chairs were either removed or spaced out, clinics operated a one-way system when possible.
- Staff had completed and kept up to date with their mandatory training.
- Staff assessed and managed risks to patients well. They completed risk assessments for each patient on entry to the service, and thereafter routinely or when the risk changed.
- Staff understood how to protect patients from abuse and the services worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The staff managed patient safety incidents well. They recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learnt with the team.

Our findings

Is the service caring?

Inspected but not rated

We inspected four community mental health team hubs. We did not rate caring.

Our rating of good from the previous inspection remains.

- Staff treated patients with compassion and kindness. We saw an example of staff interactions with a service user over the phone. The staff displayed understanding, support, empathy and were informative. A carer told us that they were always spoken with in their first language and they felt very supported.
- Staff were passionate and enthusiastic about their work and serving their patient group. We witnessed this in the staff interviews and while on site. We were given an example of when an agitated patient turned up at the end of the day requesting medication. The patient did not want to leave so the team stayed to speak with him, to calm him down, and to support each other.

However:

- Staff did not always involve patients and carers in care planning and risk assessments. A carer told us that in an assessment they discussed gradually reducing the patient's medication, but they were not given a written copy and were confused around what they were required to do once they left.
- Staff did not always involve families and carers appropriately. Carers told us they did not feel listened to.

Is the service well-led?

Inspected but not rated

We inspected four community mental health team hubs. We did not rate well led.

Our rating of good from the previous inspection remains.

- Patients did not always feel that their personal details were confidential, when their name, purpose and any symptoms were requested over the intercom at the entrance to the Zinnia centre. Patients told us due to it being on a busy thoroughfare, with a bus stop outside and it being used as a smoking area for patients from the wards that they did not feel their information was confidential or that it was appropriate for them to join a queue there.
- Some patients told us that they had a long wait for a response when they contacted the service, and that they did not all have a named community psychiatric nurse. Many patients under CMHTs are on care support which did not require a named CPN to be allocated
- Patients told us that after being passed to community home treatment team from other services they could have to wait for more than a year for an appointment to see medical staff. The trust tells us that in the intervening period patients would be contacted by a CPN.
- Different professions within community teams had different lines of management, which we were told could lead to contradiction of direction and also poor communication or teams being missed out of wider issues.

Our findings

- Communication with the home treatment team did not always work well, and there were occasions when the weekly meetings with them had not taken place due to meetings being moved and poor communication with the other team.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service.
- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear or retribution.
- There were effective multi-agency arrangements We saw a multidisciplinary meeting with members of the home treatment team, consultants, admin and external agencies having good discussions around referrals.

Our findings

Outstanding practice

n/a

Areas for improvement

Action the trust MUST take that is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Actions the trust MUST take to improve:

- The trust must ensure medications are transported in an appropriate lockable bag (Regulation 15 (1)(b)
- The trust must ensure risk management and care plans are fully completed in line with trust policy (Regulation 17 (2) (c).

Actions the trust SHOULD take to improve:

- The trust should ensure it review its process around the intercom at the entrance to the Zinnia centre.
- The trust should ensure appropriate lone worker procedures are in place and followed.

Our inspection team

The team that inspected the service comprised of two CQC inspection managers, and six CQC inspectors and three expert by experience who had used community mental health teams to interview staff, patients and carers and on site we had two CQC inspectors and a specialist advisor in community mental health teams.

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment