Birmingham Women's and Children's NHS Foundation Trust

Specialist community mental health services for children and young people

Inspection report

Birmingham Children's Hospital
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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Specialist community mental health services for children and young people

Requires Improvement 

We carried out this short time announced focused inspection because at our previous inspection we rated the mental health services at the trust overall as Inadequate. We rated Safe, Responsive and Well-led as Inadequate and Effective and Caring as Requires Improvement.

At our previous inspection we rated this core service of Specialist Community Mental Health Services for Children and Young People as Inadequate overall; we rated Safe, Responsive, and Well-led as Inadequate and Effective and Caring as Requires improvement.

Birmingham Women's and Children's NHS Foundation Trust is responsible for managing Forward-Thinking Birmingham. The Trust was created following a merger of Birmingham Women's NHS Foundation Trust with Birmingham Children's Hospital NHS Foundation Trust in February 2017. The trust is one of five trusts within the Birmingham and Solihull Integrated Care System (ICS).

Forward Thinking Birmingham is registered by the Care Quality Commission (CQC) to provide the following regulated activities: Assessment or medical treatment for persons detained under the Mental Health Act 1983, Diagnostic and screening procedures and Treatment of disease, disorder or injury.

Forward Thinking Birmingham is one of the largest Child and Adolescent Mental Health Services in England. It has a dedicated inpatient eating disorder and acute assessment unit for regional referrals of children and young people with the most serious mental health concerns s (Tier 4) and provides community mental health service for 0–25-year-olds.

This was a core service inspection of the specialist community mental health services for children and young people at the Parkview clinic location. We visited all the sites where this core service operated from:

South Hub, Oaklands Centre Raddlebarn Road, Selly Oak Birmingham

East Hub, Blakesley Centre, 102 Blakesley Road, Yardley, Birmingham

North Hub, Finch Road, 2 Finch Road, Lozells Birmingham

West Hub, Finch Road, 2 Finch Road, Lozells Birmingham

At this inspection our rating of this core service improved. We rated them as requires improvement because:

- Although there had been improvements in how staff assessed and managed the individual risks of children and young people, managers did not always take timely action to ensure clinical premises where people were seen were safe and well maintained. Clinical premises were not maintained and monitored in a way that mitigated all identified risks.

Our findings

- The trust had taken some action since the previous inspection to ensure premises were fit for purpose. However, staff raised concerns about disabled access to the sites, inability to control temperature, child and adults shared facilities, lack of clinical space, and some necessary equipment was obsolete. Following this inspection, the trust told us of the plans to move the East Hub early in 2024 to a more suitable location. The trust was aware of the environmental risks and this was reflected in the trust's estate strategy. Providing alterative accommodation is dependent on capital funding and regional approval processes which we will monitor through our engagement with the trust. All environmental concerns identified on the audits were included as open risks on the trust risk register and monitored through the trust's non – clinical risk committee.

- Children and young people's privacy and dignity were not always protected and promoted. Not all interview rooms in the service had sound proofing to protect privacy and confidentiality.

- The teams did not include or have access to the full range of specialists required to meet the needs of the patients. There were nursing, multidisciplinary team and consultant vacancies. These vacancies had an impact on the internal waiting lists for allocation of these specialists.

- Managers had not ensured that all staff had accessed supervision, and appraisal.

- Staff with more limited experience supported patients and were included in the duty cover system. However, they were supported by a lead clinician who was accountable for the clinical caseloads and the duty cover system.

- Although there had been a recent reduction in some waiting lists, the service was not always easy to access. Some children and young people were waiting over 18 weeks to access services or interventions that they needed.

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

- Mental Health Act and Mental Capacity Act training were combined. At this inspection overall only 73% of staff had received training for Mental Health Act and Mental Capacity Act and at East Hub this was lower at 66%.

- The service had not acted on feedback from children and young people about the environment at the East Hub including the waiting area, hallways and entrance, and therapy rooms.

However:

- Managers and staff had made some improvements to the service following our previous inspection. We saw improvement in how staff assessed and managed individual risk concerns, identified, managed and shared learning from risk incidents, and in multidisciplinary and multiagency working, including safeguarding.
- The trust used systems to help them monitor waiting lists and staff assessed and treated patients who required urgent care promptly. The criteria for referral to the service did not exclude children and young people who would have benefitted from care. Managers monitored caseloads and had improved processes to ensure people were not 'lost to follow up' and that staff contacted children and young people who did not attend appointments.

- Staff worked well together as a multidisciplinary team and with relevant services outside the trust. Staff assessed and managed risk well and followed good practice with respect to safeguarding. Specialist safeguarding nurses offered enhanced support across sites.

Our findings

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.

- Staff understood the principles underpinning capacity, competence and consent as they apply to children and young people and managed and recorded decisions relating to these well.

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

- A family therapist at South Hub told us they involved an expert by experience in groups to assist with therapeutic support. (An expert by experience is a person who has personal experience of using services).

- We observed compassionate, kind, and caring interactions between staff, children and young people's families and carers.

What people who use the service say

We spoke with 13 children and young people and received mixed feedback about the service.

One person said their care coordinator kept changing. Some people told us some staff were rude. One person said some staff were not helpful. Another person said there was a lack of communication.

Three people said staff did not always signpost them to other groups and services. They picked up leaflets about support groups in Hub reception areas, but the staff did not know anything about the group.

Four people said when leaving a telephone message for staff, they did not always respond quickly.

One person said they liked the staff; they are all very good. None of their appointments had been cancelled, but if they had to rebook, it was no problem.

We received feedback about medicines management. 12 of the 13 people spoken with were positive about the management of their medicines. However, one person said they had fortnightly prescriptions which were never ready. They had to ring to order and ring to ask when ready and when they arrived to pick up it wasn't ready. One person said there had been problems with repeat prescriptions, but this had improved.

We spoke with people about the environment of the hubs they visited for their appointments. One person said the trust needed to brighten up the reception area at East Hub Blakesley Centre, as it made them feel depressed and worse.

Another person said, "The service helped me to get a job. If you asked me a year ago if I would be working, I would have said, no way. I am grateful."

Is the service safe?

Requires Improvement 

Our findings

Safe and clean environments

Clinical premises where children and young people received care were not always safe, well equipped, well furnished, well maintained and fit for purpose. However, they were clean.

Staff completed environmental and ligature risk assessments and took some action to reduce the identified risks. However, staff did not always identify timeframes for action identified to remove these risks and assessments had not been updated following refurbishment and remedial works at the South Hub.

At all sites, staff had completed ligature risk assessments in January 2023 and detailed ligature points. A ligature point is anything which could be used to attach a material to for the purpose of hanging or strangulation. The ligature risk assessment included a risk score coupled with a description of the actions to be taken to reduce risks where these were identified. The Risk Register entries showed the risk was reviewed in March, April and June 2023, with updates on action taken that included ligature reduction work at East Hub and risk mitigations at South Hub. Staff told us that all rooms where there were ligature risks were not used where possible or, if needed, children and young people would be supervised by staff or parents. However, this was not possible when children and young people accessed toilet facilities and lifts. Staff had identified the need for replacement of ligature risks with anti-ligature equipment where possible and monitored access to and from these areas to mitigate risk.

We reviewed the environmental risk audits for each site. At all sites, staff had identified risks related to environmental hazards. The audits included existing controls, the risk rating, action required to mitigate the risk and a target date. The audit stated that the action for medium risks should be reviewed every three months and risk controls should be in place in the interim. We found that some medium risks did not have target dates and ones that did, had not been reviewed since January 2023. These included actions to reduce or mitigate the environmental risks associated with fire and security. For all risks identified, staff had documented a range of existing controls in place to reduce these.

Not all areas were well maintained, well furnished or fit for purpose. At the last inspection the trust told us that the environment at the South and East Hubs were not fit for purpose and there were plans to relocate. However, at this inspection managers were not clear of the plans for this. Following this inspection, the trust told us there were plans to move the East Hub early in 2024 as this was assessed as the highest priority for alternative accommodation.

Some refurbishments had taken place at the South hub, including replacement of windows. However, staff told us these were not closing properly and although this had been reported to the estates team the timeframe for remedial action was unclear. We saw that therapy rooms and children and young people areas needed some refurbishment and the environment was not always welcoming to a young person or child friendly. Reasonable adjustments were not in place for people with physical disabilities. There was limited accessibility with no accessible toilets at South Hub and only one disabled car space in the car park. Due to the age of the building, conditions were cramped, and staff told us there was a lack of sound proofing in therapy rooms. One clinician told us the buildings were ‘awful’ to work in. The ground floor portacabin known by staff as the ‘cabin’ was located at the back of the main building and was a staff work area. One staff said there was poor ventilation, and the ‘cabin’ frequently became hot and uncomfortable to work in, with condensation running down the windows.

At North and West Hubs, we found the environment was hot and staff had difficulty controlling the room temperatures.

Our findings

Waiting rooms across the four sites were shared by adults and children who used the same clinical rooms and bathroom areas. However, at South Hub there was a separate toilet for children opposite the therapy room. The trust had recognised this is as a risk and had control measures in place to reduce this risk for the children which included staff presence in waiting rooms.

All environmental concerns identified on the audits were included as open risks on the trust risk register. However, these had been open for long periods of time (up to 10 years) and the actions and timeframes for resolution were unclear.

Closed-circuit television camera monitoring was present across services with an overview of the reception areas, corridor areas and car park. Reception areas had curved mirrors placed around and were used to support observation of children and young people at risk of harm during their visit.

All interview rooms had alarms and staff available to respond. The alarm call systems were regularly tested. Staff had received training to use the alarm call systems.

Clinic rooms were fully equipped but not always accessible. All clinic rooms had the necessary equipment for children and young people to have thorough physical examinations. Staff made sure equipment was well maintained and in working order. The South Hub clinic room was located upstairs on a first floor and therefore not accessible to children with mobility impairments.

Staff at East Hub were unaware of the location of the ligature cutters which may be used in an emergency. During the inspection, staff located the ligature cutters and placed them prominently with signage in the downstairs reception area and upstairs hub room.

All areas were clean and well maintained. We saw clean stickers applied when an area had been cleaned. Staff made sure cleaning records were up-to-date and the premises were mostly clean. However, at South Hub we saw cobwebs in the reception area ceiling and above the clinic door.

We saw the South Hub infection prevention and control July 2023 action plan. The person responsible for actions were mainly the Estates team. However, there were gaps where completion dates were not included.

Staff always followed infection control guidelines, including handwashing. We saw signs to encourage people to wash their hands.

Staff made sure clinic and electrical equipment was well maintained, clean and in working order. We saw equipment, had been calibrated and portable electrical appliances tested.

Safe staffing

Although staffing was improving the service did not have enough staff, who knew the children and young people well and had received basic training to keep them safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff. There were staff vacancies across all sites.

Our findings

The trust had recruitment plans across the hubs with the aim of reducing vacancies which included targeted recruitment events. The provider had recruited staff from overseas which complemented the staff team. We saw one internationally educated nurse at the West Hub joined the trust in December 2022. Another internationally educated nurse was due to join the North Hub in December 2023. Several staff retention plans were in progress to help reduce the number of vacancies and minimise the impact on children and young people's services.

The South Hub had the highest staffing vacancies with 10.5 whole time equivalent vacant posts. The North Hub had the second highest staff vacancy rates at 7.37 whole time equivalent. There were nursing staff vacancies at all sites. These vacancies were highest at the South and East hubs, which were 4.24 whole time equivalent in the East and 3.3 in the South for band 6 nurses.

Nursing staff told us that staffing had improved but there was still not enough staff to fully meet the services and children and young people's needs.

The service had low rates of bank and agency nurses across the service. Service managers limited their use of bank staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Service managers told us it could be difficult to secure agency and bank staff with the right skills and experience but they requested staff familiar with the service. This included using bank staff who had recently retired from substantive roles and long term agency bookings.

The service had low and reducing turnover rates. The trust target turnover rates were 9%. All hubs achieved this target. The trust provided staff turnover data from August 2022 to July 2023. The highest staff turnover rates were North Hub in October 2022 at 25% and decreased in July 2023 to nil staff turnover. East Hub in January 2022 at 9% reduced in July 2023 to 4%. West Hub were high in December 2022 at 9% and decreased in July 2023 to 0.61%. South Hub had been low over the last 12 months between 5% in October 2022 to nil staff turnover in July 2023.

Service managers supported staff who needed time off for ill health.

Levels of sickness were reducing. The trust sickness target rate was 4.75%. Trust data dated 31 July 2023 showed the sickness rate varied across hubs. The highest sickness levels were at North Hub with the average rate at 8% (128 lost to staff absence days). However, for February 2023 to June 2023 there were nil days lost to sickness.

At South Hub the average sickness rate was 6% (900 days lost to staff absence days) with sickness levels in July 2023 at 7%.

West Hub had an average sickness level of 5% (1,147 days staff absence days). For June and July 2023 these were at 4.5%. East Hub had an average sickness rate of 5% (709 days lost to staff absence). For July 2023 sickness levels had reduced to 4.5%.

Medical staff

The service did not have enough medical staff. The number of medical appointments had been reduced due to capacity and some children were waiting over 18 weeks to be allocated a medic. At South and East Hubs staff told us they were concerned about psychiatrists' vacancies and ongoing recruitment and retention issues.

At South hub there was 1 whole time equivalent adult consultant psychiatrist vacancy that was filled by a fulltime agency consultant psychiatrist. There was also one speciality doctor vacancy. Two speciality doctors told us they were

leaving late August so there would be three speciality doctor vacancies. Following our inspection, the trust told us they had recruited to the 2 CAMHS speciality doctor posts who are expected to start with the service in January 2024. One of these posts includes an expansion in psychiatry resource from 0.4 to 1.0 whole time equivalent in response to the sustained increase in service demand. The trust also said the CAMHS medical posts at South hub were now substantively filled.

In East Hub there was 1 whole time equivalent consultant adult psychiatrist and 1.00 whole time equivalent speciality doctor vacancies. Both posts were filled by long term agency locums who had worked for the trust for some time and were familiar with the service. Some staff told us vacancies for medical staff impacted staff morale, some clinicians felt fatigued, and were unhappy with the heavy workloads and vacancies not being filled and staff leaving.

Medics from the North Hub were supporting provision for the East Hub.

Service managers could use locums when they needed additional support or to cover staff sickness or absence. One locum psychiatrist at one Hub had a renewable contract and told us they enjoyed the flexibility working at the trust. Managers made sure all locum staff had a full induction and understood the service.

The service could get support from a psychiatrist quickly when they needed as this was covered by the crisis team who had psychiatrists who specialised in children and adolescents' mental health services and adults.

Mandatory training

Most staff had completed and kept up to date with their mandatory training. Training compliance rates across site ranged between 85% to 100%. The average mandatory rate for the 8 August 2023 were 90%. The trust target compliance rate was 95%. The exception was at East Hub where the combined training for Mental Health Act and Mental Capacity Act rates were low at 66%. CQC view mandatory compliance rates of 75% or below as non-compliant. The trust staff training target rate were 95%.

The mandatory training programme was comprehensive and met the needs of children and young people and staff. Mandatory training included for example, infection control, manual handling, fire safety, conflict resolution, cyber security, counter fraud. Staff told us bank and long-term agency staff were provided with mandatory training. Additional staff training provided were, for example, ligature training, panic alarms, learning disability training and 2-day training for working with complex client's level 1 to level 3.

Service managers monitored mandatory training and alerted staff when they needed to update their training. Service managers received regular staff training compliance reports. Staff said they were alerted via the electronic systems to remind them when their training needed to be updated.

Assessing and managing risk to children and young people and staff

Staff overall assessed and managed individual risks to children and young people and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with children and young people and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Our findings

At our previous inspection staff did not always complete risk assessments for each person and did not review these regularly. We saw improvements in people's risk assessments at this inspection.

We looked at 28 risk assessments of children and young people who were under 18 years old; completed by a range of staff including doctors, nurses, psychologists, occupational therapist, and community support workers. Staff used the trust electronic recognised risk assessment tool. Staff completed risk assessments for each person on admission, using a recognised tool called choice assessment and reviewed this regularly, including after any incident. The exception were two risk assessments at East Hub; one person's risk assessment had not been updated since 2022 and another risk assessment not updated since January 2023.

Managers told us if they saw risk assessments had not been updated, they were sent back to the relevant staff with a request to be updated.

We saw some risk assessments included a detailed formulation. Formulation is a process of developing an understanding of what is happening for a person and why, and therefore what might be helpful for them.

We saw staff recognised when to develop and use crisis plans and advanced decisions according to people's need. Staff referred the child or young person to the crisis team within the trust where needed.

Management of patient risk

Most staff responded promptly to any sudden deterioration in a patient's health. We saw staff reviewed people with high risks in a 'daily huddle' and where a person did not attend an appointment the previous day, they discussed the actions to take. Staff told us about the risk monitoring traffic light scheme. Red meant weekly contact, amber fortnightly contact and green monthly contact. This ranged from telephone calls to face-to-face meetings. In addition, there was a duty desk where children and young people could call in for support advice and guidance. We saw at South Hub a young person thought they had an appointment, but it was the wrong day, but were seen by the clinician. Staff told us service managers regularly reviewed cases and workloads that staff held using a case management tool.

At the previous inspection staff had not assessed and updated risk assessments in a timely manner. During this inspection we found that completion of risk assessments had improved. Staff mostly completed comprehensive and individualised risks management plans. However, we also found that two management plans had not been updated in response to newly identified or changing risks.

At the previous inspection the trust had identified several people who used the service had been "lost to follow up." Lost to follow up meant that staff had lost contact with the person, that they did not have a next appointment booked and had not been allocated a care coordinator. The trust had commissioned a root cause investigation into this and implemented new systems and processes.

At this inspection staff continually monitored children and young people on waiting lists for changes in their level of risk and responded when risk increased. The trust had in place several processes to ensure that children and young people were not "lost to follow up" and non-attendance was followed up. On a fortnightly basis staff held a caseload management review meeting, where a detailed review of potential "late or lost to follow up" were carried out. For example, if a person were seen or did not attend but no future appointment was booked, this was immediately visible to

the operational and clinical teams in attendance and an action set to review this person. In some cases, the person had been discharged but had not yet been updated on the system as "outcome". Staff took remedial action and updated the system. Monitoring reports showed in January 2023 there were 753 potential "lost to follow up" cases. This had decreased just after our inspection in September 2023 to 33 cases.

A new partial booking process had been established, whereby staff across sites would ask the administrative team to book appointments for people. The administrative team booked the person into an appointment that matched the plan or where there were no available appointment slots, updated a follow up waiting list with details of the plan and the need for action to resolve this. These details were then taken into the caseload management and waiting list management review meetings for action.

Staff ensured the trust electronic systems included an "outcome status" for the person after each appointment. The completion of a decision after each person's appointment were monitored. Where the data on the decision were not completed, this was highlighted in the weekly waiting list meeting and actions set to ensure staff followed this up.

Where a person did not attend a planned appointment, the clinician involved in their care routinely reviewed their case and decided on the next step. If this decision was not carried out in a timely manner, the caseload management review process picked this up and actions were agreed to progress the plan.

Staff held weekly meetings to monitor waiting lists times for people on different pathways. Any delays in treatment were highlighted and operational staff were assigned actions to work with clinical teams to rearrange capacity to see people who had been waiting. Managers reallocated resource to support specific pathways and ensured additional temporary staff were used where needed.

Managers ran regular monitoring reports on the implementation of the new processes which were shared at divisional management board and annual plan delivery group as well as to the division's quality assurance committee. These were chaired by a chief officer and reported to the trust board quality committee. The trust's performance was also discussed with commissioners each month at contract and quality review meetings.

Staff followed clear personal safety protocols, including for lone working. Across sites staff told us about lone working systems which included paired working, shared work diaries, signing in and out and calling into the Hub at the end of visits. Administration staff had received training on how to manage those situations. Staff at East, North and West Hubs had access to portable alarms, with training provided. Staff at South Hub said they had no staff alarms but if they requested these they would be provided. The trust told us there were alarms in clinic rooms for staff use. When working in the community, staff have access to lone working devices, which must be requested and logged out when in use. We saw staff using these during our inspection.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

We found improvements around safeguarding since the previous inspection. Staff received training on how to recognise and report abuse, appropriate for their role. Staff had received safeguarding training for children and adults at level 1 to level 3, depending on their role. Training compliance rates across site ranged between 79% to 93%.

Our findings

Staff told us specialist safeguarding nurses, supported by the head of safeguarding and the director of safeguarding, delivered bespoke safeguarding training face to face to 250 staff, 61% of the workforce, during May, June, and July 2023. The safeguarding training agenda was followed through at multidisciplinary meetings and in staff daily huddles.

Staff kept up to date with their safeguarding training. Staff knew how to recognise adults and children and young people at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff told us the trust safeguarding lead attended the Hubs and provided advice and guidance to staff on live cases. In addition, staff could contact the trust safeguarding lead separately with their queries. Each Hub had a safeguarding lead, who staff knew.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had made improvements to the safeguarding referrals process. For example, staff now ensured a copy of the safeguarding referral was sent to the safeguarding team via the online portal to review and quality assure. Since January 2023 specialist safeguarding nurses offered enhanced support across the Hubs. This included attending multidisciplinary meetings and increasing visibility in the community Hubs. Managers said they had established good working relationships with the specialist safeguarding nurses and provided regular consistent safeguarding supervision for staff in Hubs.

Staff access to essential information

Staff working for the community mental health teams kept detailed records of children and young people' care and treatment. Records were clear and easily available to all staff providing care but were not always up to date.

During our visit to North Hub there was an outage for half a day to the care record systems. Staff used paper records to reduce the risks of this. Where they needed to see a person who was new to the service, they visited in pairs to reduce risks. The trust used one electronic system across sites that staff could access. In September 2023 the trust was changing to a new record keeping system. Staff were in the process of receiving training to prepare for this.

Managers told us between July 2022 to December 2022 there was a complete outage of the electronic patient care record systems. Performance was also impacted upon during the patient care records recovery period from January to March 2023 with children and young people being added back onto the care records system. The trust had a business continuity plan in place for this which we reviewed during the well led inspection of the trust in August 2022 and monitored this through engagement.

Service managers said they monitored children and young people's care records to ensure they were detailed and up to date. However, at this inspection we saw three risk assessments and care records were not updated regularly.

When children and young people transferred to a new team, there were no delays in staff accessing their records. We saw when children and young people were admitted to Hubs their clinical records were appropriately shared with the new team caring for them.

Records were stored securely. We saw people's records were held electronically and managed securely.

Medicines management

Our findings

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Staff told us they worked closely with community pharmacists. Doctors told us prescriptions were completed at the end of clinic. This ensured prescriptions were generated and delivered quickly to people's home address. We observed that doctors reviewed people's medicines during appointments and spent time discussing with them and their family and carers.

Staff completed medicines records accurately and kept them up to date. Staff reviewed the effects of people's medicines on their physical health.

We received feedback from children and young people about medicines management. 12 of the 13 people spoken with were positive about the management of their medicines. However, one person said they had fortnightly prescriptions which were never ready, despite them contacting to confirm progress with this. One person said there had been problems with repeat prescriptions, but this had improved.

Staff stored and managed all medicines and prescribing documents safely. We found medicines were stored at some Hubs and these were stored and managed in line with the prescribing document and the providers policy. Staff regularly checked weighing and blood pressure equipment to ensure they were in good working order. Staff checked the temperatures of rooms and fridges where medicines were stored and checked weekly that medicines in the emergency bags and oxygen were in date.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each person's medicines on their physical health according to National Institute for Health and Care Excellence (NICE) guidance.

Arrangements were in place so that staff could safely transport medicines to people in the community when needed. However, staff told us people attended the Hubs for medicines such as depot injections.

Track record on safety

We received information about serious incidents involving children and young people some resulting in their unexpected death.

Reporting incidents and learning from when things go wrong.

The service mostly managed patient safety incidents well and staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff said they knew how to use the provider's electronic incident reporting systems.

Our findings

Staff raised concerns and reported incidents in line with trust policy. Managers closely monitored all incidents. Since our previous inspection there was an improvement in managers investigating incidents and acting to make improvements where needed. Trust data for May 2023 showed the most frequently reported category of incidents was delays in accessing services.

Staff reported serious incidents clearly and in line with trust policy. We saw fortnightly and monthly reports for incident monitoring and where needed actions were followed up. The trust was training more staff to take on lead investigator roles to investigate serious incidents.

Staff understood the duty of candour. They were open and transparent and gave children and young people and families a full explanation if and when things went wrong. Trust data provided two examples where managers had followed the duty of candour procedures and communicated with family and carers following incidents in November 2022 and July 2023.

Managers debriefed and supported most staff after any serious incident. We saw one-page summaries of past serious incidents were circulated to staff to read with recommendations. Staff told us they received debriefs in daily huddles, team meetings and supervision meetings with managers. However, some staff said they did not receive a debrief after a serious incident.

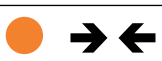
Managers investigated incidents thoroughly. Children and young people and their families were involved in these investigations. We saw children and young people and their families' views and comments recorded when reviewing investigation reports.

Most staff received feedback from investigation of incidents, both internal and external to the service. Managers shared learning across the Hubs regularly for incidents, or other safety and quality information through the daily huddles or through the monthly clinical group governance meetings. These forums allowed for learning to be shared and discussed across the Hubs.

The daily huddle also allowed for rapid feedback when required, for example, following a significant security threat made to one site and concerns being raised about the security response. Information about how to access additional security support was rapidly fed back to the team and exploration of any remaining concerns took place.

Staff met to discuss the feedback and look at improvements to patient care. Staff told us they discussed how to improve individual's people's care at weekly multidisciplinary meetings, team meetings and supervision meetings with managers.

Is the service effective?

Requires Improvement 

Assessment of needs and planning of care

Staff assessed the mental health needs of all children and young people. They worked with children and young people and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Our findings

Staff made sure that children and young people had a full physical health assessment and knew about any physical health problems. We saw children and young people received physical health monitoring and held wellbeing passports. Staff provided regular physical health check clinics including weight, electrocardiogram, and blood pressure checks. Where health concerns were identified for example a need for blood tests, children and young people were referred to their GP (General Practitioner). Some Hubs also provided blood testing. We saw at West Hub one young person had a low body weight and asked to be referred to the dietician due to their anxieties around food colour and textures.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We saw evidence of physical health care plans, self-harm reduction, well-being and risk care plans. We saw weight restoration plans with young people weighed and measured regularly in line with their eating disorder care needs.

Most staff completed a comprehensive mental health assessment of each patient. We reviewed 28 care plans. Most care plans were personalised, holistic and recovery orientated and included targets and goals.

Staff regularly reviewed and updated care plans when children and young peoples' needs changed. We saw 26 care plans out of 28 were reviewed regularly.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the children and young people in the service. Staff delivered care in line with best practice and national guidance from the National Institute for Health and Care Excellence (NICE).

Staff used recognised rating scales to assess and record the severity of children and young people' conditions and care and treatment outcomes. For example, a hospital anxiety and depression scale which aims to measure symptoms of anxiety and depression; health of the nation outcome scale - a method of measuring the health and social functioning of people with severe mental illness, and measures behaviour, impairment, symptoms and social functioning. In addition, staff used EuroQol a tool for measuring anxiety and depressive symptoms which is specific to community settings.

Staff made sure children and young people had support for their physical health needs, either from their GP or community services. Staff identified children and young people's physical health needs and recorded them in their care plans. Staff made sure children and young people had access to physical health care, including specialists as required. Children and young people had access to regular physical health checks with a nurse or community support worker.

Staff supported children and young people to live healthier lives by supporting them to take part in programmes or giving advice. Staff could refer children and young people to other professionals as their care needs required. These included the physiotherapist, dietician, and diabetic community nursing team.

Staff used technology to support children and young people. Staff told us they used the trust work mobile phones and used a social media app to message and communicate with children and young people, which worked well.

Our findings

Staff took part in clinical audits, benchmarking and quality improvement initiatives. A schedule of audits was carried out monthly. For example, care plans and risk assessments were reviewed monthly and included peer review, service manager review and reviews across Hubs. Other audits included clinic room checks of medicine held, compliance with the Mental Capacity Act, Hub waiting room areas, safeguarding and complaints audits. Managers used results from audits to make improvements. The trust had a revised audit plan to be put in place by November 2023.

Skilled staff to deliver care.

Some teams did not include the full range of specialists required to meet the needs of children and young people under their care. Managers supported most staff with appraisals, supervision, and opportunities to update and further develop their skills. However, for newly qualified nurses this programme was not robust. Managers provided an induction programme for new staff.

The service did not have access to a full range of specialists to meet the needs of the children and young people on the ward. The teams consisted of service managers, deputy service managers, psychiatrists, nurses, community support workers, psychologists, assistant psychologist, occupational therapists, occupational therapists' assistants, receptionist, medical secretaries', and administrators.

There were vacancies across Hubs for administrators except for West Hub. All Hubs had vacancies for psychiatrists and nurses. The trust was finding it hard to recruit and retain psychiatrists. At South and West hubs there were vacancies for psychologists. At South and East hubs there were vacancies for speciality doctors. The trust was recruiting internationally educated nurses to reduce the number of staffing vacancies.

Managers had not ensured all staff, including newly qualified practitioners; had the right skills, qualifications and experience to meet the needs of the children and young people in their care. At the North Hub, community support workers with limited experience were holding caseloads with high risks; and were included in duty cover systems. The community support workers said they could seek support from a designated qualified staff member if they needed to. However, there was limited management supervision and oversight of potential risks.

Managers gave each new member of staff a full induction to the service before they started work. Staff told us they received a structured induction.

Managers supported staff through regular, constructive appraisals of their work. However, they had not met the trust target for this. Managers said they supported staff through regular management and clinical supervision and appraisals of their work. The service's appraisal compliance target rate was 95%. However, trust data for August 2023 showed that the trust target was not met: South and East Hub compliance rates were both 75% and the data was combined for West and North Hub at 78%.

The trust did not provide staff supervision rates or a supervision compliance target rate. It was unclear from the data the number of staff who received supervision. The core hub quality and safety report for June 2023 confirmed the launch of a new supervision tool in August 2023. Managers said most staff received supervision every 4 to 7 weeks. Staff were expected to bring their caseloads and discuss care plans, risk assessments, current and new cases and discharge from caseloads. Staff told us they received individual or group supervision and reflective sessions.

Our findings

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Managers made sure staff attended daily huddle meetings and regular team meetings or gave information from those they could not attend. We observed daily huddle meetings which discussed staffing for the day, any appointments, any risks identified, and which staff were allocated to visits.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. New staff training was planned in September 2023 for 2 days as part of the suicide prevention strategy including attachment and trauma, stabilisation and specialist teams.

Multidisciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. Staff told us how important the weekly multidisciplinary meetings were and felt they contributed positively to this. Staff said they worked well as a multidisciplinary team. The multidisciplinary team included psychiatrists, nurses, occupational therapists, support workers and psychologists. Staff made sure they shared clear information about children and young people and any changes in their care, including during transfer of care.

Staff had effective working relationships with other teams in the organisation. Staff had established links with inpatient mental health wards, urgent care services, crisis teams, and bed management teams.

Staff had effective working relationships with external teams and organisations. Teams had effective working relationships with external teams and organisations. For example, local housing services, schools, local colleges, and social services.

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

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Where children and young people were subject to the Mental Health Act 1983, their rights were protected.

Most staff had access to support and advice on implementing the Mental Health Act and its Code of Practice from the clinical teams based across sites or with the trust Mental Health Act administrators. Mental Health Act and Mental Capacity Act training were combined. At this inspection across site 73% of staff had received training for Mental Health Act and Mental Capacity Act. The lowest compliance rates were at East Hub 66%. CQC view mandatory compliance rates of 75% or below as non-compliant. The trust staff training target rate was 95%. However, at South Hub this was 83%. Both North and West Hub had 100% compliance rates.

Our findings

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Access to policies and procedures were available online at each site and on the trust intranet.

Children and young people had easy access to information about independent mental health advocacy. We saw information across sites with information about Independent Mental Health Advocate and support with mental health tribunals and hearings. We saw leaflets aimed at children's and young people and parents and carers about young people's rights.

For children and young people subject to a Community Treatment Order, staff completed all statutory records correctly. We saw evidence of regular Community Treatment Order reviews in young people's care records.

Care plans clearly identified children and young people subject to the Mental Health Act and identified the Section 117 aftercare services they needed. All section papers were scanned onto the electronic record systems.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The trust introduced a Mental Health Act audit in April 2023 overseen by the trust Effectiveness committee. This committee oversaw audit activity and ensured that audits were completed to a high standard and led to improvements in practice. Managers completed audits to ensure staff were applying the Mental Health Act appropriately. This included a check of the Mental Health Act paperwork, that children and young people were informed of their rights regularly and that treatment authorisations had been completed appropriately.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Most staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At this inspection across site 73% of staff had received combined training for Mental Health Act and Mental Capacity Act. The lowest compliance rates were at East Hub at 66%.

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

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Records showed that staff recorded this.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff were aware that they needed to assess and record the person's capacity for each decision to be made.

When staff assessed children and young people as not having capacity, they made decisions in the best interest of children and young people and considered the patient's wishes, feelings, culture, and history. Staff held meetings to make decisions in people's best interests where the person did not have the capacity to do this. If the service had concerns about the competence or capacity of a child or young person to make a decision, staff requested an assessment under the Mental Health Act.

Our findings

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve. Managers completed audits to ensure staff were applying the Mental Capacity Act appropriately.

Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary. Staff knew how to apply the Mental Capacity Act to children and young people aged over 16 and where to get information and support on this. The Mental Capacity Act applies to people over the age of 16. For decisions about care and treatment in those under 16, staff referred to guidance on Gillick competence. This is a test established by case law to assist clinicians to determine whether a child of 16 years or under is competent to consent to medical examination or treatment. If a child is Gillick competent, they can give informed consent to an informal admission and treatment. Gillick competence training was part of staff induction. We saw in children's and young people's notes and at multidisciplinary meetings staff discussed appropriate consent Gillick competency.

Is the service caring?

Requires Improvement 

Kindness, privacy, dignity, respect, compassion and support

Staff treated children and young people with compassion and kindness. They understood the individual needs of children and young people and supported children and young people to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for children and young people. We spoke with 13 children and young people who told us they felt well supported, and staff were overall kind caring, and respectful. Some people told us some staff were rude. However, we observed and heard many positive interactions between young people and staff.

Staff gave children and young people help, emotional support and advice when they needed it. We saw many examples of staff active listening and providing verbal reassurance to children and young people. Staff understood and respected the individual needs of young people.

Staff supported children and young people to understand and manage their own care treatment or condition. We saw staff explaining to young people why tasks to reach their goals should be completed. We saw staff were person centred and "scheduled in time" to explain to young people the rationale why clinical decisions had been made.

Staff directed children and young people to other services and supported them to access those services if they needed help. We saw during home visits staff discussed and supported young people to their local school and community services. However, three people said staff do not always signpost them to other groups and services.

Most children and young people said staff treated them well and behaved kindly and had no difficulty relating to staff. We observed staff to be kind and compassionate to children and young people.

Our findings

Staff understood and respected the individual needs of each patient. Staff were discreet, respectful, and responsive when caring for children and young people. One staff member told us how they adapted their approach to meet individual needs. For example, when they met with some young people they would go for a walk or play a game during appointments because the person had difficulty sitting still and they found it easier to talk freely whilst engaged in an activity.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people.

Staff followed policy to keep patient information confidential. We observed staff closing laptops when they moved away from their desks to ensure that people's records could not be viewed by anyone in the office. Staff knew about the trust policy on record keeping and confidentiality.

Involvement in care

Staff involved children and young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that children and young people had easy access to independent advocates. Staff informed and involved families and carers appropriately.

Involvement of children and young people

Staff involved children and young people and gave them access to their care plans. Children and young people told us they were involved in their care plan, if they wished to be.

Staff made sure children and young people understood their care and treatment and found ways to communicate with children and young people who had communication difficulties. One young person's care plan included information using plain English and short sentences to communicate with the young person.

Staff involved children and young people in decisions about the service, when appropriate. A family therapist at South Hub told us they involved an expert by experience in groups to assist with therapeutic support. An expert by experience is a person who has personal experience of using services.

Children and young people were involved and discussed the importance of their physical and psychological safety and who they could approach to support or discuss this further. Staff directed children and young people to therapy, nursing team and doctors. One young person told us staff listened to them and decisions were shared. They had been given a list of telephone number to call out of hours.

Children and young people could give feedback on the service and their treatment, but this was not always acted on. Trust data showed three young people from East Hub had been consulted and provided formal feedback and suggestions for the hubs waiting area, hallways and entrance, therapy rooms and general dos and don'ts. However, there was no evidence at this inspection to show their feedback had been used to improve the service.

The trust told us the main ways of seeking feedback from children and young people were through theThink4Brum (T4B) service users' engagement group. We spoke with 13 children and young people, none of them mentioned the Think4Brum forum. Trust data showed Think4Brum had produced videos from two service users describing what was important to them in their engagement with the service and staff.

Our findings

Staff supported children and young people to make advanced decisions on their care. We saw in children and young people's care plans a section to include advanced decisions on their care Some records we reviewed did not include advanced decision plans.

Staff made sure children and young people could access advocacy services. We saw advocates contact details were clearly displayed across all sites in reception areas.

Involvement of families and carers

Staff supported, informed and involved families or carers. Some families and carers were invited and involved in their child or young person's multidisciplinary and care programme approach meetings.

Staff provided some families and carers (where appropriate) with a non-violent resistance (NVR) booklet as part of a therapy programme that supported families and carers to respond effectively to their child or young adult.

Staff helped families to give feedback on the service. Families and carers were able to provide feedback at any time by calling the Hub as well as during the appointments. The trust had a mental health carers voice charter which described the way the service committed to engage with and listens to carers and families. The trust provided CQC with a copy of a draft charter dated 31 October 2019. We spoke with 9 of the families and carers. One family member told us they had been invited to attend groups and co-production activities.

Staff gave carers information on how to find the carer's assessment. Young people, families and carers were allocated a social worker who would work with the families and the multidisciplinary team to assess families and carers needs. If considered beneficial the social worker would request a for assessment from the local authority.

Is the service responsive?

Requires Improvement 

Access and waiting times.

The service was not easy to access. Children and young people who did not require urgent care wait too long to start treatment.

However, the service's referral criteria did not exclude children and young people who would have benefitted from care and staff assessed and treated children and young people who required urgent care promptly. Staff followed up children and young people who missed appointments.

The service ensured that children and young people, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the patient's care.

The service had clear criteria to describe which children and young people they would offer services to and offered children and young people a place on waiting lists. Staff referred to an entry and exit document which outlined the criteria for each service type. Where children and young people met the entry criteria for more than one service, staff

from each service completed a joint assessment to clarify the most appropriate interventions and service to meet the child or young person's needs. We were told where this happened the child or young person would be discussed at a local weekly multidisciplinary meeting. People and their families could self-refer, or their GP or other health professional could make a referral on their behalf through a central city-wide Referral Management Centre (RMC). A small team of child and adolescent analytic psychotherapists had started working in the referral management centre to help support with appropriate triage and signposting.

The trust reported to Birmingham and Solihull Integrated Care Board their compliance with the 18-week referral to treatment target. The service did not always meet these targets. We found that in July 2023 33% of children and young people had waited over 18 weeks from referral to treatment. However, no children and young people had been waiting more than 52 weeks from referral.

We found that some children and young people waited over 18 weeks to receive a service or secondary intervention they needed. This included 122 out of 290 children and young people waiting over 18 weeks to be allocated a medic, and 62 out of 131 children and young people waiting over 18 weeks to be allocated to the psychological therapies team.

The trust had systems to monitor treatment waiting lists. The trust provided data up to 31 August 2023 which showed 145 of the 419 children and young people on waiting lists had a treatment appointment booked in the future. Staff reviewed waiting lists, referrals and allocations at regular team meetings.

Managers told us the overall number of children waiting for the service had increased and this was due to increased referrals for attention deficit hyperactivity disorder (ADHD) services. However, over the previous three months the number of children waiting to access other core services had reduced. The trust had recently recruited an access performance manager.

Staff screened urgent referrals quickly and within the trust target time.

The trust implemented the National Health Services England (NHSE) Mental Health Services Data Set (MHSDS) a proposed national standard regarding the clinical response for mental health crisis services. Children and young people who required a very urgent face to face response (within 4 hours); or an urgent face to face response (within 24 hours) would be referred to the trust crisis home treatment service and not the Hubs. Therefore, the children and young people who were referred to Hubs would fall into the routine category. This does not have a mandatory response time from NHSE aligned to it.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services through the review of referrals, waiting lists and sign posting. We saw staff gave information during triage about support agencies, and signposted children and young people to groups where appropriate.

Since our previous inspection the trust had improved monitoring systems to ensure children and young people were not "lost to follow up" and staff followed up people who did not attend appointments.

Staff tried to contact people who did not attend appointments and offered support. On a fortnightly basis a caseload management review meeting took place, where a detailed review of potential late or lost to follow up cases were carried out. The trust had reduced the number of cases since the beginning of 2023. They were able to maintain small numbers of cases that required validation on a weekly basis which were typically resolved within 7 to 14 days. There were also weekly Friday meetings to review waiting lists and people who were lost to follow up/did not attend and these people

were reallocated. Where a child or young person did not attend a planned appointment, the clinician involved in their care routinely reviewed their case and decided on the next step. If a decision on next steps was not carried out in a timely manner, the caseload management review meeting process would pick this up and actions were agreed to progress the plan.

Children and young people had some flexibility and choice in the appointment times available. Children and young people told us there was flexibility with appointments. They said if they preferred to meet with their clinician in the community this was arranged.

Staff worked hard to avoid cancelling appointments and when they had to, they gave children and young people clear explanations and offered new appointments as soon as possible. We spoke with 13 children and young people and none of them told us their appointments had been cancelled.

Appointments ran on time and staff informed children and young people when they did not.

Facilities that promote comfort, dignity and privacy.

The design, layout, and furnishings of treatment rooms did not support children and young people' treatment, and their privacy and dignity.

The service did not have a full range of rooms and equipment to support treatment and care. The buildings at South and East hubs were cramped and not accessible to people with limited mobility. At South Hub the environments were not always welcoming to a young person or child friendly. For example, in the reception area we saw a broken upright games console for children with no plans for repair. Staff told us since the COVID-19 pandemic children's toys had been removed and not replaced.

At the North and West Hub, we saw reception areas were bland and clinical and not welcoming to children and young people.

One young person said the reception area at East Hub needed brightening up as it made them feel depressed and feel worse. However, at East Hub we saw colourful artwork displayed on the reception area back wall.

One young person said the service need to brighten up the reception area at East Hub. They said, "The reception area makes you feel depressed, it just makes you feel worse". Staff at the Hub told us, and we saw that corridors were narrow. The staff room was also used as a meeting room and frequently booked, so there was nowhere for staff to rest.

Not all interview rooms in the service had sound proofing to protect privacy and confidentiality. At the previous inspection at South Hub, we identified a lack of sound proofing. At this inspection at this hub there had been no improvements to sound proofing. Staff told us that they could hear external sounds, including distressed children and banging of doors, during sessions which caused distractions and impacted on their ability to deliver therapy.

At North and West Hubs some rooms could not be used for family therapy as the recording equipment was out of date. Managers told us they had raised this as a risk and a business case had been approved to replace the equipment. However there was no timescale to complete this work.

Meeting the needs of all people who use the service

Our findings

Staff helped children and young people with communication, advocacy and cultural and spiritual support. However, the service did not meet the needs of all people who used the service as two of the hubs could not easily accommodate people who had a physical disability.

The service had not made suitable adjustments for disabled people and those with communication needs or other specific needs. At South Hub we saw bathrooms were small and not accessible. The children and young people's clinic area was upstairs with no lift facilities available. Staff said children and young people with limited mobility would meet with staff in the cabin area, where there was an accessible ramp to this building. However, there was no accessible toilet facilities or clinic room in the cabin. There was one disabled car space in the car park. The new sliding screen in the reception area was difficult to hear and speak through.

Staff overall made sure children and young people could access information on treatment, local services, their rights and how to complain. We saw a range of written information that children and young people could access, with appropriate symbols and pictures. We saw information about self-harm, eating disorders, and people at risk of developing bipolar disorder. However, three people told us they had picked up leaflets about support groups in Hub reception areas, but reception staff did not know anything about the group. We saw at South Hub in the reception area a poster about Support for care leavers, but this was dated 2014 so may not be up to date information.

The service provided information in a variety of accessible formats so the children and young people could understand more easily. The service had information leaflets available in languages spoken by the children and young people and local community. Managers made sure staff and children and young people could get hold of interpreters or signers when needed. Managers told us if they needed any information translated this would be arranged centrally by the provider. One administrator told us they had arranged a face-to-face Arabic speaking interpreter for one young person. We saw leaflets included written information about access to signers and interpreters.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Children and young people, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern. In reception Hub areas there were complaint and feedback forms. Staff understood the policy on complaints and knew how to handle them. Written information was provided to young people, families and carers which outlined how the complaints process worked.

Managers investigated complaints and identified themes. The trust complaints data from April 2023 to June 2023 showed there were 4 complaints received from the 4 hubs. Themes of these were around delays in clinical treatment, appointments, delays in admission and discharge (excluding delayed discharge). There were 13 contacts open to Patient Advice and Liaison Service (PALS) from the 4 hubs. Themes of these were around appointments, communication and patient care.

Staff protected children and young people who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and children and young people received feedback from managers after the investigation into their complaint. Feedback was provided to staff at daily huddles, team meetings or at supervision.

Our findings

Managers shared feedback from complaints and compliments with staff and learning was used to improve the service. Staff said these were fed back in team meetings, daily huddles and through supervision.

Is the service well-led?

Requires Improvement 

Leadership

Team managers had a good understanding of the services they managed and were visible in the service and approachable for children and young people and staff.

Team managers had the right skills, knowledge, and experience to perform their roles. Most managers had a good understanding of the services they managed. Managers and staff confirmed development opportunities for career progression were available and were encouraged to take these up.

Vision and strategy

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

Staff we spoke with knew about the trust values of being Ambitious, Brave and Compassionate. We saw evidence of the trust's vision in numerous service meeting minutes and on notice boards. Staff were able to articulate the philosophy of the service.

Some staff felt listened to and able to influence service delivery. Many staff spoke positively about the service and were proud of their work and enjoyed their role.

Culture

Most staff felt respected, supported and valued. They said the trust promoted equality and diversity in their daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Some staff at South and West Hubs told us of the challenges of working in a poor environment and how this affected their morale. Some staff told us the lack of medics impacted their wellbeing and clinicians felt fatigued, unhappy with the heavy workloads and recruitment and retention rates. However, other staff spoke positively about the service and told us that the provider was a good employer to work for and were focused on providing high quality care. Staff were supportive of each other and their immediate mangers. We saw evidence of effective teamwork and that staff had a good rapport with children and young people.

The service promoted equality and diversity in daily work. One staff member told us how satisfying it was to see how far young people developed on their journey, watching them develop confidence, life skills and soon to live in the community using the skills they had learnt.

Most staff reported they felt listened to and able to speak up if they had concerns. Staff knew about the whistleblowing process with posters around the service with contact details.

Our findings

Governance

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

We saw the trust had not acted on all the breaches from the previous inspection. These aspects were identified on the trust risk register but were not actioned. The trust had not made these improvements and there were not timescales for works to be completed by. This included work to improve the buildings in South and East hubs to reduce ligature risks, provide accessibility for people with limited mobility and promote people's privacy and dignity.

It was not clear who had oversight and monitored environmental risk audits and the risk register. Managers were not reviewing audits or developing action plans in line with the document guidance and policies.

Although the trust provided examples of the preceptorship programme resources, and supervision processes, this was not monitored centrally, and it was unclear whether managers had full oversight of supervision compliance and the robustness of the preceptorship programme. Staff raised concerns with the level of supervision and support available for unregistered staff and newly qualified staff who were managing caseloads and duty for people presenting with high risks and complex needs.

Although the trust had mechanisms in place to seek feedback and suggestions from children and young people, these processes did not lead to improvement or action in some cases.

The trust had implemented new processes to monitor and reduce waiting lists and the number of people 'lost to follow up'. Staffing vacancies and capacity remained an open risk on the service risk register, and this was impacting on internal waiting lists for allocation of specific clinicians or interventions.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but did not use this information effectively to reduce service risk and issues and improve performance.

Some risks identified on the service risk register had been open for a number of years. We raised these areas of concern during our previous inspection. However, it was unclear what action had been taken to reduce or improve the risks and performance issues as the register did not evidence action plans, timeframes or regular reviews.

We found there were ligature risks identified across all Hubs. The trust risk register included an entry from 10 October 2018 and updated in August 2023 and rated this as high risk. The trust said that they were developing a plan to reduce ligature [points but this had not been developed with action to reduce risks to children and young people.

At our previous inspection, the trust had identified the South and East Hubs were not fit for purpose and were identifying potential sites to relocate to. We saw on the trust risk register a risk entry from 2 July 2010 which was updated August 2023. This showed that the trust acknowledged the buildings were unfit for purpose. The trust had stated in the core Hub quality and safety report for June 2023 that they needed to further engage with the Integrated Care Board (ICB) regarding a potential relocation of East Hub. However, managers we spoke with during our inspection did not know about this development.

Our findings

We saw on the trust risk register for August 2023 the South Hub was rated as high-risk due to the environment and East Hub rated as moderate to high risk due to unsupervised or vulnerable children and young people sharing waiting rooms and toilet facilities with other service users. This entry had been on the risk register since 17 May 2016. However, we found that action was not taken to minimise the risk.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local quality improvement activities.

Since our previous inspection the trust had completed work to improve the number of children and young people who were "lost to follow up." Managers had information and used this to ensure that risks to children and young people being lost were reduced. They held fortnightly meetings with staff looking at their caseloads and analysed any risks and how they can be reduced.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. There were local protocols for joint working between agencies involved in the care of children and young people.

The trust was changing to a different patient records system. This system was also used by the local adult mental health NHS trust and staff from there were assisting in training staff to use the new system. Staff told us how this had increased joint working with the other trust.

Managers told us how they were working with midwives and health visitors from the local community NHS trust for children and young people. They recognised how important it was to work with families promoting wellbeing and positive mental health in young children.

Records reviewed showed that staff worked with schools, social services and local voluntary organisations to support children and young people and their families.

Staff were aware of joint working protocols and the need to report any safeguarding concerns to other agencies and work together to promote the safety and wellbeing of children and young people.

Learning, continuous improvement and innovation

Staff told us how they could nominate another colleague for a trust award and how this increased staff morale and improved teamwork.

Staff told us they shared learning within the team at multidisciplinary meetings, team meetings and daily huddles. They also shared learning with other teams within the trust and vice versa. They worked well with the Urgent Care team and shared learning. They developed ways of how the learning could impact what they did differently to improve the service for children and young people.

Our findings

We found at this inspection that there had been improvements to people's individual risk assessments. These had improved since our previous inspection by managers undertaking audits and staff learning from these to make improvements.

Our findings

Areas for improvement

- The trust must ensure that action is taken to mitigate or remove environmental risks, identified in audits and risk assessments. (Regulation 12)

- The trust must ensure premises are suitable for the purpose for which they are being used; and ensure suitable adjustments for disabled people. This should include ensuring premises maintain children and young people's privacy and dignity, are sound proofed, and family therapy equipment is replaced. (Regulation 15)

- The trust must ensure that governance processes support oversight of risk, issues and performance improvement. (Regulation 17)

- Managers must ensure that action is identified to manage environmental and service risks, and that timeframes for completion and review are recorded and adhered to (Regulation 17)

- The trust must ensure sufficient numbers of suitably qualified staff are employed including psychiatrists, psychology staff, and registered nurses to meet the needs of children and young people. (Regulation 18. (1) Staffing)

- The trust must ensure that newly qualified nurses receive a robust preceptorship programme which includes, supervision, assessment and feedback to support achievement of the required competence for their role. (Regulation 18)

- The trust must ensure staff receive regular supervision and appraisal to support them in their role and ensure that competence is maintained. (Regulation 18)

SHOULDS

- The trust should ensure that staff assess, and update children's and young people's risk assessments in response to changing needs and in a timely manner. (Regulation 12)

- The trust should listen to and act on feedback received through consultation from children and young people from East Hub for improvement.

Our inspection team

This was a focused inspection and looked at all the key questions, and reviewed the improvements made since our previous inspection in June and October 2022. Following the previous inspection in June 2022 we issued the trust with a Letter of Intent to take urgent enforcement action if significant improvements were not made. We revisited in October 2022 and found that improvements were still required in the quality of healthcare relating to the management of risk due to issues with records.

The inspection team consisted of 3 inspectors, 4 specialist advisor nurses and 2 experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

The inspection team carried out the following activities during the inspection:

- Undertook tours of 4 hubs, looked at the quality of the premises environment and observed how staff were supporting children and young people.
- Reviewed 28 children and young people's care plans.
- Reviewed 28 children and young people's risk assessments.
- Reviewed 31 prescription charts.
- Spoke with 13 children and young people who were using the service.
- Spoke with 9 children and young people families and carers, including 7 remotely.
- Spoke with 31 staff including head of nursing, service managers, assistant service managers, consultants, speciality doctors, junior doctors, nurses, community support workers, senior support worker, occupational therapist, clinical psychologists, psychologists, family therapist, peer support worker, student nurses, patient involvement lead, and administrators.
- Observed staff in Hubs, and during community visits, and on home visits with children and young people.
- Reviewed a range of policies, procedures and other documents relating to the running of the service.

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

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

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 18 HSCA (RA) Regulations 2014 Staffing