Good

Somerset Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RH576	Holford, Rydon, and Pyrland 1 & 2 Wards	Wellsprings Hospital site, Taunton Health-based place of safety	TA2 7AU
RH572	Rowan and Magnolia Wards	Summerlands Hospital site, Yeovil Health-based place of safety	BA20 2BX
RH5AA	Mallard Court	West Somerset crisis and home treatment team	TA2 7PQ
RH5AA	Mallard Court	South Somerset crisis and home treatment team	BA20 2BN
RH5AA	Mallard Court	Somerset Coast crisis and home treatment team	TA6 5AT

Summary of findings

RH5AA	Mallard court	Mendip crisis and home treatment team	BA5 1TH

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated mental health crisis services and health-based places of safety as **good** because:

- the crisis and home treatment teams assessed and managed risk to a high standard. Staff were well equipped to manage risk and skilled in identifying and mitigating risks.
- the environments where patients were seen were clean and well presented.
- staffing was safe throughout working hours and staff numbers and sickness were monitored closely. No agency staff were used and backfill for absences was provided through a local staff bank system.
- the health-based places of safety were monitored well by staff. Their locations were safe with good access and exits to and from the facility. Areas were secure, well-lit and had observation windows and panic alarms fitted. There were no ligature points within the assessment suites or areas where people were detained under section 136.
- the crisis and home treatment teams had good access to mental health disciplines needed to support people using the services. We saw there was multidisciplinary input within the teams and access to other agencies was good.
- teams were made up of experienced and knowledgeable staff. Staff said they could access training needed to fulfil their roles and were encouraged by local management to access additional training for their development.
- we saw excellent examples of interactions between staff and people using the service. All the staff we observed were caring, compassionate and kind, and treated the people using the crisis and home treatment teams and health-based places of safety with respect, warmth and professionalism.
- we saw good evidence of respect for people's privacy and dignity. There was flexibility around times and locations of visits, for example, if a person wished for a carer to be present and preferred it to be at their home, this would be arranged.
- all the crisis and home treatment teams had local leadership in place that was described by the staff we spoke with as supportive, approachable and efficient.
- all facilities used by people using crisis and home treatment teams were accessible by people in wheelchairs. The clinic rooms were all downstairs and there was access to disabled toilets. The health-based places of safety were both on the ground floor and with accessible toilet facilities.
- all the crisis and home treatment teams offered extended hours including weekends. People were able to access advice and support out of hours by telephone or at either Musgrove Park or Yeovil District Hospital for assessment. The trust were planning to extend the crisis and home treatment team to a 24 hour services; at the time of our inspection there was telephone and hospital liaison support only.

However:

- within the health-based place of safety the wait for assessment was too long out of hours. Some people waited up to fifteen hours to be assessed. There was also a lack of clarity or understanding of procedures when a person was placed in a health-based place of safety, with regard to when doctors and Approved Mental Health Professionals for assessments should be accessed.
- Mental Capacity Act and Mental Health Act training were not mandatory in the trust. However some of the crisis and home resolution team members had completed this online. Staff in the health-based places of safety had received training on section 135 and 136 of the Mental Health act and had requested updated training.
- recording of mental state examination was not consistent and difficult to find in the clinical records in the Wells crisis and home treatment teams. We found some care plans were brief and did not consistently involve the person.
- some people using the service told us they had not been involved in their care planning nor been offered a copy of their care plan.

Summary of findings

- there was no clock for orientation or means of distraction on the Rydon health based place of safety ward suite. On the Rowan ward health-based place of safety there was a clock however no other means of distraction or activity when waiting to be assessed.
- formal feedback from incidents and in particular serious untoward incidents was sometimes not being received in a timely way.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- in the crisis and home treatment teams risk assessments and management of risk was of a high standard. Staff were well equipped to manage risk and skilled in identifying and mitigating risks.
- the environments were clean and well presented in all areas.
- staffing was safe throughout working hours and staff numbers and sickness were monitored closely. No agency staff were used and backfill for absences was provided through a local staff bank system.
- staff were able to describe how they would ensure the safety of themselves and their colleagues. They described clear risk management, lone working procedures and the use of regular risk screening. The Taunton crisis and home treatment team staffing was on the risk register for the out of hours part of the service, however, there was a clear plan for managing risk and safety of staff.
- the health-based places of safety were monitored well by staff on the wards. Their locations were safe with good access and exits to and from the facility. Areas were secure, well-lit and had observation windows and panic alarms fitted. There were no ligature points within the assessment suites or areas where people were detained under section 136.
- staff received feedback from their managers following incidents. This was discussed in supervisions, handovers and team meetings. Staff were offered debriefing sessions following serious incidents. We were told that investigation outcomes from serious untoward incidents were slow to be received by the teams, staff told us they could be waiting a lengthy period of time to receive feedback and action plans around the incidents.

However:

- we saw action plans in the Taunton crisis team and the Bridgwater crisis teams following serious incident reviews. We received feedback from the clinical commissioning group that the trust have a monthly serious incident group with robust review of incidents.

Summary of findings

Are services effective?

Good

We rated effective as **Good** because:

- Mental Capacity Act and Mental Health Act training were not mandatory in the trust, however some of the crisis and home resolution team members had completed this online. Staff in the health-based places of safety had received training on section 135 and 136 of the Mental Health act and had requested updated training.
- on looking at care records we saw recording of physical needs was poor. We did not find in many of the crisis and home treatment teams that physical needs were being assessed or documented. When we questioned this, we saw physical health needs were managed overall by the general practitioner but the records still provided sparse information about the physical health of the person using the service. We did see, however, that there was generally good communication and liaison with general practitioners in most of the crisis and home treatment teams. Recording of mental state examination was not consistent and difficult to find in the clinical records in one crisis and home treatment team.
- documentation within the clinical running record was of a very high standard. This was the area of the care records where clinicians recorded details of interventions with people using the services. The detail was relevant, concise and showed a thorough understanding of the needs of people using the service.
- the crisis and home treatment teams had good access to the range of mental health disciplines needed to support people using the services. There was multidisciplinary input within the teams and access to other agencies was good.
- teams were experienced and knowledgeable. Staff said they could access training needed to fulfil their roles, and that they were encouraged by local management to access additional training for their development.

However:

- everyone using the crisis and home treatment services had a care plan following assessment however we found some care plans were brief and did not consistently involve the person using the service. There was variation in quality and content of care plans. Some documented people's views and wishes within the plan and some within the progress notes.

Summary of findings

Are services caring?

Good

We rated caring as **good** because:

- we saw many excellent examples of interactions between staff and people using the service. All the staff we observed were caring, compassionate and kind, and treated the people using the crisis and home treatment teams and health-based places of safety with respect, warmth, interest and professionalism.
- feedback to the person using the service following the assessment was respectful and professional and the person's needs were in the centre at all times.

However:

- some people using the service told us they had not been involved in their care planning nor been offered a copy of their care plan.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **Requires Improvement** because:

- within the health-based place of safety the wait for assessment was too long out of hours, we found evidence that people had waited up to fifteen hours for assessment.
- there was also a lack of clarity or understanding of procedures when a person was placed in a health-based place of safety, with regard to when doctors and approved mental health professionals for assessments should be accessed.
- there was no clock for orientation or means of distraction on the Rydon ward suite. On the Rowan ward health based place of safety suite there was a clock however no other means of distraction or activity when waiting to be assessed.

However:

- when people did not fit the criteria for acceptance into the crisis and home treatment team service, the crisis and home treatment teams worked proactively with external agencies, such as alcohol and housing agencies, to ensure they received help and support.
- all the crisis and home treatment teams offered extended hours including weekends. People were able to access advice and support out of hours by telephone or by presenting at either Musgrove Park or Yeovil District Hospital for assessment. The trust were planning to extend the crisis and home treatment team to a 24 hour services, at the time of our inspection there was telephone and hospital liaison support only. We saw good

Summary of findings

evidence of respect for people's privacy and dignity. There was flexibility around times and locations of visits, for example if a person wished for a carer to be present and preferred it to be at their home, this would be arranged.

- all facilities for people using crisis and home treatment teams were accessible by people in wheelchairs. The clinic rooms were all downstairs and there was access to disabled toilets. The health-based places of safety were both on the ground floor and with accessible toilet facilities.

Are services well-led?

Good

We rated well-led as **good** because:

- all the crisis and home treatment teams had local leadership in place that was described as supportive, approachable and efficient by the members of staff we spoke with.
- staff told us that morale was good across the teams and there were no incidents around bullying or harassments. Staff told us they felt safe to raise concerns with their managers should they need to.
- most of the staff we spoke with in all the crisis and home treatment teams told us they enjoyed the challenge of their roles and were proud of the service they provided.

However:

- there were concerns from staff teams we spoke with that formal feedback from incidents, and in particular serious incidents, were sometimes not received in a timely way.

Summary of findings

Information about the service

Somerset Partnership NHS Foundation Trust have two health-based places of safety, also known as section 136 suites. One is on Rydon Ward at the Wellsprings Hospital site in Taunton, the other on Rowan Ward at the Summerlands Hospital site in Yeovil. The place of safety is a place where people may be detained when they are subject to either section 135 or 136 of the Mental Health Act. Police officers have powers under section 136 to detain people believed to have a mental disorder in a public place, and take them to a place of safety to have their mental health and wellbeing assessed.

There are four crisis and home treatment teams in the county. Taunton and Bridgwater cover the west of the county; Wells and Yeovil cover the east. The crisis and home treatment teams provide short term mental health crisis support to help people remain at home, where they might otherwise be admitted to hospital. The teams also help facilitate early discharge from hospital when support at home is appropriate.

The crisis and home treatment teams have psychiatric liaison staff based within Musgrove Park Hospital with a team available during the day. A night assessor provides assessment and support to Accident and Emergency Department overnight. In Yeovil this service is provided by the crisis resolution and home treatment team, with the night assessor often based at Yeovil District Hospital.

Our inspection team

The inspection team was led by:

Chair: Kevan Taylor, Chief Executive Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Karen Wilson-Bennett Head of Inspection for Mental Health, Learning Disabilities and Substance misuse, Care Quality Commission

The team that inspected the mental health crisis services and health-based places of safety consisted of eight people, divided into two smaller teams:

- Two inspectors
- Two mental health act reviewers
- Three mental health nurses
- One social worker

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information provided to us about these services, asked other organisations for information and sought a range of feedback from people using the services through focus groups and telephone contact.

During the inspection visit, the inspection team:

- Visited four crisis teams and two health-based places of safety. We looked at the quality of the environment and response times for assessments
- Spoke with 13 people who were using the service

Summary of findings

- Spoke with four carers of people using the service
- Spoke with the team leaders
- Spoke with 16 staff members including doctors, nurses, occupational therapists and support workers
- Attended two multidisciplinary meetings
- Looked at six medication charts
- Looked at 52 care records in total. This consisted of 40 in the crisis and home treatment teams and 12 in the health-based places of safety.
- Observed four assessments
- Received feedback from two external stakeholders
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We received very positive feedback from people who were currently using the service. They told us they all knew how to contact them if they needed and found the teams helpful and supportive in a crisis. We also received positive feedback from carers who told us the teams went of their way to help and were extremely accommodating.

Some people using the service told us they had not been involved in their care planning nor been offered a copy of their care plan. The majority of feedback was positive however we did receive a negative comment about the outcome of one person's care.

Good practice

Very low numbers of people were detained in police custody as opposed to the health-based place of safety.

Areas for improvement

Action the provider MUST take to improve

- The provider must demonstrate that action is being taken to ensure that limitations on access to Section 12 doctors out of hours are not responsible for delays to Mental Health act assessments in order to work within the trust's Section 136 joint protocol and the Mental Health Act code of practice.
- The provider must ensure that the senior managers in the trust clarify procedures and joint working arrangements when the section 136 joint protocol is reviewed, so that staff can be confident and assured of support out of hours and clear on their responsibilities and expectations

Action the provider SHOULD take to improve

- The provider should ensure all physical health is considered and that staff communicate and document clearly with physical health providers such as general practitioners.
- The provider should ensure all care plans reflect the risks detailed in the risk assessments.
- The provider should explore joint training with external agencies including ambulance service, police, accident and emergency to recognise and improve standards around use of the health-based places of safety and ensure clear pathways.
- The provider should ensure people's views and wishes are clearly included in care plans as well as in the progress notes.
- The provider should ensure there are working clocks in the health-based places of safety, as well as access to activities to promote comfort and distraction.
- The provider should ensure a clear and consistent approach to documenting mental state examination in all crisis and home treatment teams, so information can be found quickly and easily.

Somerset Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Health-based place of safety	Wellsprings Hospital site, Taunton
Health-based place of safety	Wellsprings Hospital site, Taunton
Somerset Coast Crisis and home treatment team	Bridgwater
West Somerset Crisis and home treatment team	Taunton Deane
South Somerset Crisis and home treatment team	Yeovil
Mendip Crisis and home treatment team	Wells

Mental Health Act responsibilities

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

- Approved mental health professionals (AMHPs) were accessed through a rota system. The duty AMHP was responsible for identifying and arranging section 12 doctors for assessments. It was identified there was regular problems in accessing both AMHP and section 12 doctors for Mental Health Act assessments during the night in the health-based places of safety if indicated.
- Information was recorded on how long people spent in the health-based places of safety suite, and the outcome of their care.

Detailed findings

- Rights under Section 132 of the Mental Health Act were not consistently being recorded or given in the health-based places of safety.
- In addition to the duty rota, there was an AMHP hub (two AMHPs on duty daily). The AMHP hub dealt with planned assessments on the wards and Community Treatment Orders. The AMHP lead was also based in the AMHP hub.
- Staff in all the crisis teams and staff managing the health-based places of safety were able to refer for Mental Health Act assessments if needed.

Mental Capacity Act and Deprivation of Liberty Safeguards

- We noted that Mental Capacity Act and Deprivation of Liberty Safeguard training was not mandatory within the trust. However, this had been completed by the majority of crisis resolution and home treatment team clinical staff using an online module. There was good support from the Mental Health Act coordination lead for advice and support to staff, all staff we spoke to were able to identify how to access this support and guidance.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- The majority of the crisis and home treatment teams' work was carried out in people's own homes, GP surgeries or clinic rooms. Interview rooms in the buildings used by the crisis and home treatment teams were fitted with alarms. All staff we spoke with knew how to use the alarm systems and able to demonstrate how the system worked.
- The environments where people were seen were clean and very well maintained in all the locations.
- Both health based places of safety were located on the ground floor of mental health hospitals, with good access to entrances and exits. The areas were secure, well-lit and had observation windows and panic alarms. People using the service could access ensuite bathroom facilities.
- The areas within both suites for making hot and cold beverages could be safely closed off if any risk to patient safety was identified.
- The health based place of safety on Rydon ward used CCTV to observe and monitor the person in the suite. Staff mitigated some blind spots in one corner of the room by regular monitoring. There were no ligature points in the health-based places of safety.
- Emergency resuscitation equipment was available via the main wards for the health-based places of safety. We were informed by our inspection colleagues visiting Rowan ward that some items in the resuscitation bag were out of date. This was raised with management at the time and a new checking schedule put in place.
- The smoking areas for people accessing the suites attached to Rydon and Rowan wards were via the main ward to the garden area and people were escorted to the garden area for fresh air or to smoke tobacco.

Safe staffing

- There were no vacancies within the crisis and home treatment teams. Teams were multi-disciplinary and had a mix of nurses, occupational therapists, social workers and support workers. The total number of substantive staff was 62 across the four teams in Somerset. Sickness within the team based in Yeovil was 12% due to long term sickness however this had been resolved at the time of our inspection. In other local teams sickness levels were low.
- There was on call psychiatrist support throughout the day and night. Staff told us they had no problem accessing rapid support from a psychiatrist during daytime working hours. However, during the night the psychiatrist support was mainly by telephone. Records we looked at in the crisis and home treatment teams reflected this.
- Staff we spoke with in all the teams told us it was rare that staffing numbers fell below the number required. Uncovered shifts were covered by familiar staff working within their own teams or by staff from one of the community mental health teams. We looked at electronic staffing rotas and confirmed this.
- There was no use of agency. Bank staff covered vacant shifts using the trust internal bank system, again this was confirmed during our visit by the staff rota records.
- The average caseload for the crisis resolution and home treatment teams was between 10-20 per team. During our inspection Taunton team had ten, Wells had 20, Bridgewater had eight and Yeovil had 20 on their caseload. Nobody was awaiting allocation to a care co-ordinator.
- On the health-based places of safety staffing was provided by the attached ward, Rydon, or Rowan. Staffing numbers on these wards included staffing needed for the 136 suites.
- Staff received mandatory training; the compliance rate set by the trust was 85%. Taunton had 95% compliance, Yeovil 95%, Bridgewater 93% and Wells had 85%.
- Rowan ward team (health-based place of safety) had achieved 99% and Rydon ward team (health-based place of safety) 92%.
- In Yeovil only 80% of staff had completed fire training, however outstanding training had been booked.

Good

Are services safe?

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

- In Bridgwater 80% had completed infection control, prevention and management of violence and aggression PMVA model one and two, and fire training. This was due to a member of staff on long term sickness.
- In Wells the team fell below compliance with scores of 80% for infection control, 78% for PMVA module one conflict resolution; 78% safeguarding adults; 80% information governance; and 60 % for fire training.
- Mental Capacity Act and Mental Health Act training were not mandatory in the trust which meant that people using the services could not be assured that staff were up to date with changes in legislation and consent and mental capacity issues. However the majority of the crisis and home treatment team members had completed online training. We saw that staff in the health-based places of safety had received training on management of people in health-based places of safety and had requested updates in line of the Mental Health Act new code of practice.

Assessing and managing risk to patients and staff

- We looked at 52 care records in total over the crisis and home treatment teams and health-based places of safety.
- In the health-based places of safety the nurse in charge of the attached ward agreed to receive the detained person. They also had responsibility for contacting the approved mental health professional (AMHP) to co-ordinate a Mental Health Act assessment. Records were kept on the relevant ward for the person detained in the health-based place of safety. The ward staff were responsible for ensuring the person using the health-based place of safety was safe whilst waiting for assessment.
- Staff told us, and records confirmed, that the wait for Mental Health Act assessments could be lengthy at night time due to poor access to AMHP's or Section 12 doctors needed to complete the assessments. This did not appear on the local risk register.
- Patients had comprehensive risk assessments which were updated regularly. We found the risk assessments to be of a high standard.
- Identified risks were reflected in care plans on the majority of occasions. In the Wells team 15 care records were viewed and all had up to date Health of the Nation Outcome Scales (HONOS) and risk screening and risk information. This information had not always been incorporated into care plans, however, risks were discussed and reviewed on a regular basis and highlighted on white boards within team offices for reference.
- We attended morning handovers at Taunton, Bridgwater and Yeovil which included the handover from the night assessor to the day team. The staff discussed the risks for each person using the service and updated this where necessary. Planning of the team workload took any amended risk into consideration.
- On two separate occasions during our inspection, we observed staff responding to situations where the person's mental health person using the service had deteriorated. Staff receiving the phone calls acted quickly and calmly, adjusting their planned activities for the day in order to prioritise the crisis situation. Risk was clearly communicated to colleagues and records updated accordingly.
- There was no waiting list for people, each referral received was triaged quickly and efficiently, and a worker allocated.
- We saw that all the staff had completed safeguarding training with the exception of the Wells team whose compliance was 78%. All staff we spoke with were confident about identifying abuse and how to make an alert. Safeguarding procedures and contacts were clearly visible in the offices and on the backs of staff badges.
- We observed a team discussion about safeguarding and whether it should be escalated as a safeguarding alert. We saw this was addressed carefully and knowledgeably.
- The Taunton team had identified a risk in respect of providing out of hour assessments with reduced staffing numbers. This was on the local risk register and there was a clear plan for managing risk and safety. Staff were able to describe how they would ensure the safety of themselves and their colleagues. They described clear risk management, lone working procedures and the use of regular risk screening.
- There was a lone working policy for the trust and staff we spoke with were clear about how they kept

Good

Are services safe?

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

themselves and colleagues safe. They explained what they would do if a colleague hadn't returned at the proposed time, and that they assessed risk and visited in pairs if needed.

- Prescribing of medicines for people using the crisis and home treatment service was carried out by either the psychiatrist or the person's general practitioner. Medication charts were not held by the teams when medicines were prescribed by the person's general practitioner. In Taunton, Bridgwater and Yeovil there was very clear and thorough communication between the teams and the general practitioner. In the Wells team we could not see this communication documented which meant there was no assurance that medication or physical issues were being monitored or joint working was taking place with the general practitioner.
- The crisis and home resolution treatment teams had small medicine cabinets in their work area for storing patient medication if needed. The cabinets contained only small stores of medication, which were checked regularly and accounted for.
- During our inspection we looked at medicines charts in Bridgwater and Wells. They were completed correctly and clearly.
- We saw communication from the medical director from June 16 2015 ensuring all staff knew the protocols and their accountabilities around clozapine prescribing. The trust had a temporary prohibition on clozapine titration. This was in relation to a serious incident involving clozapine. Nobody accessing services from the crisis and home treatment team was being prescribed clozapine at the time of our inspection. The nursing staff we spoke with were able to tell us why this prohibition was in place and knew the details of the incident.

Track record on safety

- There were eight serious incidents involving the crisis resolution and home treatment teams between April 2014 and January 2015, which involved serious self-harm, unexpected deaths and serious assault.
- Comprehensive investigations and reviews had taken place and action plans were implemented. For example, we saw that handover procedures and discussions around individual risks were more comprehensive and clearly documented. Records showed that liaison and information sharing with other agencies had improved, however in the Wells team there was a lack of communication with general practitioners documented around prescribing issues.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to report incidents using the trust electronic recording system. All incidents were reviewed by the line manager or team manager and forwarded to senior managers of the trust for further review. There was a clear audit trail available of incidents reported and actions taken.
- Staff told us they received good feedback from their managers following incidents. This was discussed in supervisions, handovers and team meetings. Staff were offered debriefing sessions following serious incidents.
- We were told that investigations from serious untoward incidents were slow to be received by the teams, staff told us they could be waiting up to a year to receive feedback and action plans around the incidents, however we saw action plans in the Taunton crisis team and the Bridgwater crisis teams. We received feedback from the clinical commissioning group that the trust had a monthly serious incident group with robust review of incidents.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- Care records in the Taunton, Yeovil and Bridgwater teams were holistic with information regularly reviewed and up to date risk assessments in place. We saw good documentation in the progress notes which were clear and relevant.
- All crisis and home treatment teams had daily handover meetings which were thorough and comprehensive. These meetings were used to discuss and update risks and formulate plans. New referrals and overnight activities were discussed at length
- People's needs were assessed and plans of care created and delivered in accordance their needs. There was however variation in quality standard of the assessments and care plans. Some of the Wells team crisis and home treatment team care plans were basic and brief, not person centred, and used phrases such as 'we will – you will' implying plans of care were being done to people as opposed to 'with' people.
- In Bridgwater, Taunton and Yeovil all care plans were available and up to date and the person's view had been documented in the progress notes. There were occasions it was not documented that the person had been offered or given their care plans.
- Recording of physical needs was poor. We did not find in many of the crisis and home treatment teams that physical needs were being assessed or documented. We questioned this and were told physical health needs were managed overall by the general practitioner. However, the records still provided sparse information around physical health of the person using the service. We did see that there was generally good communication and liaison with general practitioners in most of the crisis and home treatment teams.
- Consent or the recording of consent was not consistently recorded in all of the care records. Out of 40 care records seen in the crisis and home treatment teams there were 25 that did not explicitly document that people had consented to commencing treatment.
- We reviewed 15 care records in the Wells team, and in all cases mental state examination information was not recorded in the mental state examination assessment part of the electronic record system. We asked about this and were told mental state examination information was being completed but the information was stored in 'uploaded documents'. It took us some time to locate these assessments as they were not consistently documented in the same place in the records. When we asked staff to show us we found that they also had difficulty in locating the information we requested.

Best practice in treatment and care

- The police informed us it was sometimes difficult to access support for officers who attended calls on private premises, whether for Mental Health Act assessment or advice about making risk based decisions as police officers acknowledge they lacked the skills or training. We were told that plans were in place to provide this out of hours support as the trust moved into a new integrated model, however there was no definite date for this was given, nor any plans of how this would be implemented at the time of our inspection.
- People using the crisis and home treatment services were assessed using the Health of the Nation Outcome Scales (HoNOS) in line with NICE guidance. These assessments support clinicians to monitor and build a social and health picture over time within the service.
- We were informed a planned audit of crisis and home treatment team handovers had taken place in August. We saw signage in the team bases stating that they were commencing care plan and documentation audits.
- We saw good examples of discharge planning between inpatient acute wards and the crisis and home treatment teams. We observed a discharge planning meeting with the Taunton crisis and home treatment teams. This involved detailed clinical discussion where the person's needs were carefully considered.
- The Taunton team told us about access to a county wide employment service. They also had good links with community resources such as citizen's advice bureau and a wellbeing clinic which was on the same site.
- We saw there was generally timely attendance by approved mental health professionals (AMHPs) and Section 12 doctors at the health-based places of safety when people were admitted during normal working hours. AMHPs were trained professionals who worked in

Are services effective?

Good

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

conjunction with medical practitioners to implement elements of the Mental Health Act 1983, as amended by the Mental Health Act 2007, they were professionals authorised by the local authority to co-ordinate Mental Health Act assessments. However, people's wait for assessment could be lengthy outside of normal working hours.

- The crisis and home treatment teams had monthly reporting requirements to their commissioners. Information provided was the number of new people accepted onto the caseload, number discharged, number currently in the service, number completing psychological therapy and number of advice or support episodes given to professionals per month.
- Commissioners told us they were satisfied with the service provided by the crisis and home treatment teams.

Skilled staff to deliver care

- The crisis and home treatment teams had good access to the range of mental health disciplines needed to support people using the services. We observed effective multidisciplinary input within the teams and access to other support agencies was good.
- Staff working within the health-based places of safety had requested further training to ensure compliance with new Mental Health Act code of practice. The previous training took place over a year ago, since then a new code has been published. The code states that all staff involved in the implementation of section 136 powers should receive training.
- Staff within the teams were experienced and knowledgeable. Staff told us they could access the training needed to fulfil their roles. Staff said they were encouraged by local management to access additional training to support their development. We saw training records for staff and saw that some team members were completing leadership training. Others had been given opportunities of secondments to other areas of the trust for development.
- Staff in the crisis and home treatment teams received appropriate supervision and professional development. We accessed a selection of staff supervision and appraisal records and saw regular supervision took place. Records demonstrated this was a two way process between staff and supervisor. Staff told us they were satisfied with the level of support and supervision available.
- Team meetings were held regularly and we reviewed two sets of minutes from each crisis and home treatment team. The standing agendas covered clinical risk, staffing, team development, process and procedures. In addition staff were able to raise non-agenda items within the meetings.

Multi-disciplinary and inter-agency team work

- The crisis and home treatment teams visited and communicated with the wards regularly and worked closely to establish opportunities for discharge.
- We were told by the crisis and home treatment team staff that relationships and communication was good with the other community teams within the trust. We spoke with the duty approved mental health professional, team members from the community mental health team and acute ward staff who confirmed they had good working relationships.
- We saw positive examples of liaison and communication between the teams and other agencies, for example GPs and the local authority. Records showed that the needs and risks of people using the service were considered and shared appropriately.
- The managers from crisis and home treatment and mental health liaison teams held routine meetings with both acute hospital accident and emergency departments.
- Police liaison meetings were held across the four localities and co-ordinated by the trust security manager. Attendance at these meetings included inpatient staff, community mental health teams, crisis and home treatment teams and other members of the trust.
- The trust had a section 135/6 monitoring group which was attended by representatives from both Musgrove and Yeovil hospitals, chaired by the head of division for mental health, inpatient, crisis and specialist care in the trust as well as police, ambulance and the local authority.

Are services effective?

Good

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

- Police informed us that relationships between them and the trust mental health services had improved greatly recently. They were optimistic that the trust's commitment to the crisis care concordat action plan would continue to improve relationships and care pathways.

Adherence to the MHA and the MHA Code of Practice

- Approved mental health professionals (AMHPs) were accessed through a rota system. The duty AMHP was responsible for identifying and arranging section 12 doctors for assessments. It was identified there was regular problems in accessing both AMHP and section 12 doctors for Mental Health Act assessments during the night in the health-based places of safety if indicated.
- Information was available on how long people spent in the health-based places of safety, and the outcome of their care.
- Explanation of rights under Section 136 of the Mental Health Act were not consistently being recorded or given.
- In addition to the duty rota, there was an AMHP hub (two AMHPs on duty daily). The AMHP hub dealt with planned assessments on the wards and Community Treatment Orders. The AMHP lead was also based in the AMHP hub.

Good practice in applying the MCA

- Mental Capacity Act and Deprivation of Liberty Safeguard training was not mandatory within the trust. However this had been completed by the majority of crisis resolution and home treatment team clinical staff using an online module. There was good support from the Mental Health Act co-ordination lead for advice and support to staff, all the staff we spoke with knew how to access this support and guidance

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed the staff in the crisis and home treatment teams to be very caring, compassionate and kind. People using the service confirmed this.
- During all the visits we attended we observed the staff treated the people using the service with respect and courtesy. We saw very positive use of rapport and communication skills to engage people.
- Feedback to the person using the service following the assessment was respectful and professional, the person's needs were central at all times.
- Confidentiality was maintained at all times during our inspection. Staff ensured people were in agreement for a member of the CQC to attend their assessment prior to the visit. All staff we spoke with understood the need to maintain confidentiality and to keep information secure.

The involvement of people in the care they receive

- We observed during assessments and care episodes that people were listened to and treated in a non-judgmental manner at all times. The majority of people we spoke with said they had received a copy of their care plan and agreed with its content. Three people using the service told us they hadn't seen their care plan, however they were happy with the support they were receiving.
- During clinical discussions and handovers we observed good understanding of people's individual needs. Care was taken to assess emotional and social needs and this was evident in the care provided.
- Carers and families were involved in assessments where appropriate. Consent was documented in respect of sharing information and involving family members. Consent to share information was clearly documented in the clinical records.
- Most people using the service told us they were consulted about their care on an ongoing basis and that staff respected their wishes about consent and information sharing. We were told that staff usually checked with people when care plans changed. Most people told us they were involved in decision making.
- People told us they knew how to access an advocate if needed.

However:

- Care plans in the Wells team did not make it clear that people had been involved in decisions about their care. Progress notes within records did not contain people's views and tended to be prescriptive rather than collaborative.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- The crisis and home treatment teams did not offer a comprehensive 24 hour service. The Mental Health Crisis Care Concordat 'Improving outcomes for people experiencing mental health crisis' stated local mental health services needed to be available 24 hours a day, seven days a week. Signatories believed responses to people in crisis should be the most community based, closest to home, least restrictive option available and should be the most appropriate to the particular needs of the individual. Though there was out of hours support by telephone or by presentation to Yeovil district hospital or Musgrove Park hospital, no home assessment provision was in place from crisis and home treatment services out of hours. We were told the night assessors however offered appointments for assessment in mental health facilities where appropriate, often supported by the Police. This was to support reduction of the need for detention under Section 136.
- The code of practice 16.47 stated the person should be seen by an AMHP and Section 12 doctor within three hours in cases where there are no clinical grounds for delay. The joint agency protocol part 5.13 stated the AMHP should 'attend the place of safety at the earliest opportunity to assess, together with a doctor, the detainee. The assessment should be completed within three hours'. Part 5.14 of the joint protocol states it is the doctors responsibility to 'attend as quickly as possible once informed of the need for an assessment under Section 136, bearing in mind the need to ensure the detainee is assessed within three hours'.
- We looked at six sets of Section 136 documentation on Rydon ward health-based place of safety in Taunton. On two occasions in September a person was admitted to health-based place of safety between 2am and 5am, and an AMHP had not been contacted until after 9am the following day. We accept that there may be reasons to delay attendance for a MHA assessments in some circumstances (for example, in cases where the detainee is under the influence or drink or drugs, or where a delay until working hours would enable better liaison with services that might provide alternatives to hospital admission), but in the two cases we examined the assessments had not been carried out until after 2pm on that day.
- Records were unclear on one occasion on 29 August 2015 when police attended at 5.35am. The outcome of the assessment was not recorded, nor time the assessment ended. There was no paperwork available regarding the attendance by doctors or approved mental health act professionals (AMHPs).
- A person detained under Section 136 on Rydon Ward during our inspection, had been transferred to the de-escalation room on Holford Unit as a seclusion episode. The person had been administered rapid tranquillisation then transferred to a bedroom on the ward whilst awaiting an assessment under the MHA. This treatment was given under the Mental Capacity Act as the person was deemed not to have capacity. The Mental Health Act reviewers were concerned about the length of time the assessment took, as it was not concluded until the following day at 3pm and whether the seclusion episode could have been avoided.
- We looked at six records on Rowan ward in Yeovil to check the use of Section 136 of the Mental Health Act. There was a person who had been awaiting assessment for 16 hours at the time of our inspection. Four people admitted out of hours had waited between seven and 15 hours for assessment.
- We were told by several professionals within the trust, that there was an agreement between Section 12 doctors and Approved Mental Health Professionals to stop Mental Health Act assessments in the health-based places of safety from 2am until the Approved Mental Health Practitioners' team came back on duty at 9am. We could not find formal agreement of this nor establish where the directive had originated but have been told subsequently by the Trust that this was a local agreement and subject to exception in cases of clinical urgency.
- We received similar feedback from the police who expressed concerns that the emergency duty team have no effective access to section 12 doctor cover, which made it difficult to for them to arrange or conduct out of hours Mental Health Act assessments.

Are services responsive to people's needs?

Requires improvement

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

- We raised this with the local management who informed us they had escalated concerns over poor access to Section 12 doctors to senior management in the trust.
- We were told by a consultant psychiatrist that they had tried to recruit an approved Section 12 doctor due to a recognised shortage, but this would not have had any impact on out of hours access.
- We saw medical managers meeting minutes dated 27 January, 30 March, 21 April and 19 May 2015. Out of hours psychiatrist cover and access to section 12 approved doctors was discussed. It was highlighted there were problems in availability of Section 12 doctors, and though an agreement had been made with primary care services to provide one doctor to support Section 136 assessments, this had not taken place. This was not a formal arrangement. There was no clear formality around this arrangement. It was further noted in the minutes that Section 12 doctor rotas were not working effectively due to a lack of available doctors willing to be on the working hours daytime rota. A business case was suggested within the minutes to address the consultant on-call rota issues.
- We found that staff we spoke with in the health-based places of safety did not consistently describe the procedures for out of hours when someone was admitted on a section 136. We were informed by the trust that this function was managed by the inpatient wards who were clear on the procedures for when a patient is admitted to the health-based place of safety, however there were conflicting responses from the staff when asked to describe these procedures specifically about times doctors would or would not attend during the night.
- As the trust had two health-based places of safety, one in the west and one in the east of the county, this meant the journey time for a detained person was minimised.
- Referrals to the crisis and home treatment teams were received via a single point of access. Main referrers were GPs, community mental health teams, local drug and alcohol services, housing providers, assertive outreach teams, early intervention teams and the acute inpatient wards. People who had previously accessed the service were able to self-refer.
- All referrals were screened and prioritised according to the presented risk. All assessments were arranged within 24 hours of contact.
- Crisis and home treatment teams worked between 8am and 9pm, with a member of staff working in a mental health liaison role in the accident and emergency departments out of hours. The agreed timeframe to see and assess people in the accident and emergency departments was within two hours. Decisions were made dependent on the level of risk presented. We saw that this target was being met by the mental health liaison workers within the crisis and home treatment teams.
- The local risk register reflected a lack of back up facility should the night assessor go sick. This was mitigated by local teams offering flexible cover as bank. There was a best practice group which raised this and had agreed the issue of funding be addressed by the local clinical commissioning group.
- People could access support by telephone out of hours. Telephones were diverted from the crisis and home treatment teams to the two acute inpatient wards Rowan and Rydon, where a member of staff would answer calls and offer support and advice.
- There was clear criteria for acceptance into the service for people who were at risk of hospital admission. The crisis and home treatment teams also facilitated early discharge from the wards where possible.
- People who may not be appropriate for the service, for example people who had alcohol or drug use as a primary problem were supported by working proactively with external agencies to ensure they could access help. During our inspection we observed a telephone conversation where a crisis and home treatment team member handed over information and details to the alcohol service.
- During our inspection 58 people were receiving active treatment across the services.
- All the crisis and home treatment teams offered extended hours including weekends, but this was through telephone support or mental health liaison in the hospitals and not a 24 hour home treatment service.
- People spent up to six weeks under the care of the crisis and home treatment teams. We observed clinical

Are services responsive to people's needs?

Requires improvement

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

discussions and handovers that displayed clear discharge planning on assessment, clear plans of care and consideration of onward referral to other relevant services outside the trust.

- The police told us that access to health-based places of safety was generally good, including for young people. There was an agreement with a neighbouring trust that when the Somerset health-based places of safety were full, detainees under 18 years of age could access the nearest health-based place of safety which was Mason ward in Bristol or Green Lanes in Devizes.
- We were given an example by police where good local professional links and communication had resulted in a positive outcome for a person under 18. They were unable to access Rydon health-based place of safety so the trust worked with the police to ensure the person accessed Rowan health-based place of safety and Musgrove Park hospital as alternatives in the interim.
- Section 136 of the Mental Health Act was used by the police approximately 300 times per year. Trust data for 2013 showed this facility was used 314 times, and of those approximately 30% result in admission.

The facilities promote recovery, comfort, dignity and confidentiality

- The health-based places of safety were situated in Rowan ward in Yeovil and Rydon ward in Taunton. The layout of the suites was appropriate for their use and made comfortable for the person using the facility.
- People using the health-based places of safety were given food and drink and supervised when they wished to smoke tobacco.
- The crisis and home treatment teams ensured they worked to promote and respect people's privacy and dignity. There was flexibility around times and locations of visits, for example if a person wished for a carer to be present and preferred it to be at their home, this would be arranged. Likewise male staff would not routinely visit female patients alone.
- The clinic rooms used by the crisis and home treatment teams were adequately private though not completely soundproofed. Doors and blinds could be closed to maintain privacy.
- There was good provision of leaflets in the waiting areas of the team buildings. Information provided included services and team contacts, information on mental illnesses and advocacy services.
- There was neither clock for orientation or any means of distraction or activity on the Rydon health based place of safety ward suite. However, on Rowan health based place of safety ward suite there was a clock but no other means of distraction or activity while people waited to be assessed.

Meeting the needs of all people who use the service

- People could access an interpreter if needed and written information was available in different languages if required. There were recent examples of teams using an interpreter.
- All the facilities for people using crisis and home treatment teams were accessible by people in wheelchairs. The clinic rooms were all downstairs and there was access to disabled toilets.
- The health-based places of safety were both on the ground floor of mental health hospitals with accessible toilet facilities.

Listening to and learning from concerns and complaints

- Information about how to complain was on the trust website and leaflets around the trust premises. During visits with the teams we observed members of staff giving people information on complaints procedures.
- Only two formal complaints were reported by the trust, neither of which was upheld. Staff and managers told us complaints were generally managed within the teams by meeting the person and resolving the issue locally where possible. Alternatively they would go through the patient advice liaison service formally.
- Staff we spoke with were able to tell us the complaints process and how they would process any complaints.

Are services well-led?

Good

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

Our findings

Vision and values

- Staff we spoke with were unclear about the vision and strategy for the trust, although they were aware of changes due to an integration project planned by the provider to streamline mental health services and improve outcomes for people using the services. They told us integration phase meetings were planned for further consultation, however the outcome for the crisis and home treatment teams would be a comprehensive 24 hour service of assessment and home treatment.
- All staff and management we spoke with were clear about their team values which were strongly based on person centred care. Staff told us they received good support and guidance from their team managers. Staff told us they were committed to providing high quality care for people using their services.
- Staff we spoke with were aware of who the most senior managers were in the trust, and told us they had visited the teams recently.

Good governance

- Local managers had ensured that their staff had completed or were booked onto mandatory training, received supervision and appraisals, were supportive and encouraging of their teams' development. Staff we spoke with told us they felt respected and valued by their team managers.
- Staff were required to complete information governance training each year as part of their mandatory training. The staff we spoke with felt the governance frameworks were clear, and understood and managed risks.
- The crisis and home treatment teams had access to governance systems which enabled them to manage their teams. This information could be accessed by the senior managers in the trust.

Leadership, morale and staff engagement

- We found the crisis and home treatment teams to be well-led with team managers in position. Team managers were providing good leadership despite the uncertainty of services going through a period of significant change.
- All staff we spoke with told us they would feel comfortable raising concerns or grievances with their team managers, and felt them to be approachable and open.
- Whistleblowing procedures were understood by the teams we inspected and staff told us they felt they could whistle blow without fear of retribution and would be supported by management. Staff were aware this could be done on the trust intranet.
- There were no grievances or cases of whistleblowing during our inspection.
- We were told by staff and managers that morale was good within the crisis and home treatment teams, and the team members respected and supported each other. During our inspection we observed positive interactions and warmth and professionalism from both staff and managers.
- Most of the staff we spoke with in all the crisis and home treatment teams told us they enjoyed the challenge of their roles and were proud of the service they provided.
- Formal feedback from incidents and in particular serious untoward incidents was not being received quickly. Staff we spoke to told us in order to learn from them they needed to receive them in a more timely way.
- Local team managers told us they were aware of problems accessing section 12 doctors and Approved Mental Health Act Professionals, particularly for the health-based place of safety out of hours. They had raised this as a concern however had received little communication regarding how the problem would be addressed.by the trust senior managers or executive team.

Commitment to quality improvement and innovation

- The trust signed the Crisis Care Concordat to work in partnership to support improvement in accessing support prior to crisis point, by providing 24 hour availability of crisis and home treatment 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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12(2)(i) HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.** **Systems or processes must be established and operated effectively :** • Admissions into the Health-based place of safety out of hours sometimes resulted in a lengthy wait for assessment. This meant timely assessment was not always taking place to ensure the health, safety and welfare of the service users. Staff were not always confident or clear on provision of support out of hours, or around the joint working arrangements under the Section 136 joint protocol. This was a breach of regulation 12(2)(I)