Requires improvement

Black Country 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)
TAJHQ	Trust Headquarters	Crisis and Resolution Home Treatment team Psychiatric Liaison Team	B69 2DG
TAJ20	Hallam Street Hospital	Hallam Street Hospital 136 Suite	B71 4NH
TAJ52	Penn Hospital	Referral and Assessment Service Home Treatment Team Penn Hospital 136 Suite	WV4 5HN

Summary of findings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated mental health crisis services and health-based place of safety as requires improvement because:

- The Crisis and resolution home treatment (CRHTT) team did not have emergency equipment such as automated external defibrillators and oxygen on site.
- Observation levels carried out by staff at Hallam street 136 suite to manage the potential risk of ligature points compromised patients' privacy and dignity when using the facilities.
- The kitchen area had open access to boiling water from the instant water boiler fitted to the wall. Portable appliance tests to electrical equipment used such as toaster and instant water boiler were not carried out to ensure they were safe to be used.
- The flats used by CRHTT as crisis beds at 'P3' were not risk assessed before patients were admitted. The CRHTT did not complete, update or review detailed risk assessments. We could not find evidence from both health based places of safety that they carried out risk assessments when patients were admitted to the 136 suite.
- The CHRTT did not have robust arrangements for safe storage of medicines. There was no safe and secure transportation of medicines procedure that was followed. Medicines stocks were not consistently checked.
- Three out of nine care plans we reviewed for (CRHTT) were not holistic and recovery orientated. They did not fully address the needs identified in the assessment stage.
- Records across all teams were not well organised and different team members could not access patients' records when needed. There no clear systems of records management in the health based places of safety.
- We could not find records in the 136 suites that showed physical healthcare needs were assessed and supported. Records viewed in all teams showed that there was no clear monitoring of physical health needs.
- Staff in the Home treatment team (HTT) and CRHTT did not receive regular supervision. The HTT did not have regular staff meetings. Training records indicated that staff had not received training in Mental Health Act (MHA) and the Code of Practice.
- The teams did not have arrangements in place to monitor adherence to the MHA and Mental Capacity Act to ensure that it was being applied correctly.
- Some patients told us they were not given copies of their care plans and some copies of care plans that we saw were not signed by patients. The teams did not have information leaflets specific to their teams on how the services were run.
- Staff spoken with in the Home treatment team were not aware of how to access advocacy services for patients. Patients and their families told us that they were not aware of how to access advocacy services when needed.
- The systems or methods to monitor the effectiveness of quality and safety of the service provided were not effective and robust enough. The inspection team identified such areas where improvements were required.
- Staff were not participating in a range of quality improvement and innovative practice initiatives.

However:

- All the places we visited were clean and well maintained. Staff practiced good infection control procedures such as hand hygiene to ensure that patients and staff were protected against the risks of infection.
- The staffing levels in each team were appropriate ensuring patient safety. The caseloads were low in each team. All teams had no patients on waiting list to be allocated to nurses. This meant that patients were not waiting long to be seen by nurses.
- Training records showed that staff received safeguarding training. They demonstrated a good understanding of how to identify and report any abuse. Patients and their relatives told us that they felt safe with staff from all the teams.

Summary of findings

- The teams had an effective way of recording incidents, near misses and never events. They knew how to recognise and report incidents through the reporting system.
- Staff received training in areas such as cognitive behavioural therapy (CBT) and solution focussed therapy. The teams held regular reflective practice sessions with the psychologist to discuss areas of practice specific to their roles.
- All teams had regular and effective multi-disciplinary team meetings that discussed patients' needs in detail to ensure that patients got the treatment they needed. The teams had good working links with the external organisations such as GPs, acute hospitals, independent organisations, local authorities, and police.
- We observed good interactions between staff and patients. Staff were polite, kind, respectful and compassionate.
- Patients and their families were complimentary about the attitudes of staff and the support that they received. Staff showed that they understood the individual needs of patients and could describe how they supported patients with a wide range of needs.
- Staff involved patients in their clinical reviews and care planning and encouraged them to involve relatives and friends if they wished.
- The teams were meeting their targets for referral to assessment times. The teams could respond on time and effectively when patients required crisis and routine care. The teams had access to interpreters when needed. Staff could to tell us how they could access interpreting services.
- Patients knew how to raise concerns and make a complaint. Patients told us they felt they would be able to raise concerns should they have one and were confident that staff would listen to them.
- Staff knew and agreed with the trust's values. Staff knew who the most senior managers in the trust were. These managers had visited the teams. Staff told us that they knew how to use the whistle blowing process and felt free to raise any concerns.
- Staff were open and transparent when things went wrong. They were aware of duty of candour and were able to give us examples of having been open and honest when mistakes had been made, apologising for mistakes, and learning from them.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- The Crisis and resolution home treatment (CRHTT) base did not have emergency equipment such as automated external defibrillators and oxygen on site.
- There were ligature points on the toilet taps and door handle in Hallam street 136 suite.
- Observation levels carried out by staff to manage the potential risk of ligature points compromised patients' privacy and dignity when using the facilities.
- The kitchen area had open access to boiling water from the instant water boiler fitted to the wall.
- The flats used by CRHTT as crisis beds at 'P3' had a lot of potential ligature points such as door and window handles, taps and curtain rails. We were told that there was no risk assessment carried out before patients were admitted.
- Portable appliance tests on electrical equipment used such as toaster and instant water boiler were not carried out to ensure they were safe to be used.
- The CRHTT did not complete, review or update detailed risk assessments. Four out of nine risk assessments we looked at in CRHTT did not reflect the risk highlighted in the patient's history. Only four out of nine were up to date. We could not find evidence from both health based places of safety that they carried out risk assessments when patients were admitted to the 136 suite.
- The CHRTT did not have proper arrangements for safe storage of medicines. There was no safe and secure transportation of medicines procedure that was followed. Medicines stocks were not consistently checked.

However:

- All the premises we visited were clean and well maintained. Staff practiced good infection control procedures such as hand hygiene to ensure that patients and staff were protected against the risks of infection.
- The staffing levels in each team were appropriate in ensuring patient safety. The caseloads were low in each team. All teams had no patients on waiting list to be allocated to nurses.

Requires improvement

Summary of findings

- The records reviewed showed that patients had emergency plans in place that informed staff what to do in the event of a crisis. The teams had access to on-call psychiatrists out of hours and a staff team that worked during the night so that patients could access the service anytime.
- Records showed that staff received safeguarding training. They demonstrated a good understanding of how to identify and report any abuse.
- The teams had an effective way of recording incidents, near misses and never events. They knew how to recognise and report incidents through the trust incident reporting system.

Are services effective?

Requires improvement 

We rated effective as requires improvement because:

- Three out of nine care plans we reviewed for Crisis and resolution home treatment team (CRHTT) were not holistic and recovery orientated. They did not fully address the needs identified in the assessment stage.
- Records across all teams were not well organised and different team members could not access patients' records when needed. There were no clear systems of records management in the health based places of safety.
- Records viewed in all teams showed that there was no clear monitoring of physical health needs.
- Staff in the Home treatment team (HTT) and CRHTT did not receive regular supervision. We saw the records that some staff had received supervision only twice in the last 12 months.
- The HTT did not have regular staff meetings. Records showed that in the year 2015 only three staff meetings had been conducted.
- Records indicated that staff had not received training in Mental Health Act (MHA) and the Code of Practice. Staff in charge of the place of safety did not receive any special training for section 136 of MHA although the MHA Code of Practice requires this.
- The teams did not have arrangements in place to monitor adherence to the MHA and Mental Capacity Act to ensure that it was being applied correctly.

However:

- Patients could access psychological therapies as part of their treatment. For example, anxiety management, cognitive behavioural therapy and solution focussed therapy were offered within the services.

Summary of findings

- Staff carried out a range of regular clinical audits such as care records, care programme approach and medicines to monitor the effectiveness of the service provided. The results were used to identify and address changes needed to improve outcomes for patients.
- Staff told us they had undertaken training relevant to their role. Staff received training in areas such as cognitive behavioural therapy (CBT) and solution focussed therapy.
- The teams held regular reflective practice sessions with the psychologist to discuss areas practice specific to their roles.
- All teams had regular and effective multi-disciplinary team meetings that discussed patients' needs in detail to ensure that patients got the treatment they needed. These meetings involved doctors, nurses, social workers, occupational therapists, support workers and housing officers.
- The teams had good working links with the external organisations. They had effective partnership working with GPs, acute hospitals, independent organisations, local authorities, police, housing associations and the citizens advice bureau. There were multi-agency groups in Wolverhampton and Sandwell to monitor and discuss the use of section 136.

Are services caring?

Good

We rated caring as good because:

- We observed good interactions between staff and patients. Staff were polite, kind, respectful and compassionate.
- Patients and their families were complimentary about the attitudes of staff and the support that they received. Staff showed that they understood the individual needs of patients and could describe how they supported patients with a wide range of needs.
- Staff involved patients in their clinical reviews and care planning and encouraged them to involve relatives and friends if they wished.
- Staff carried out formal carers' assessments. Families and carers were provided with support where it was appropriate.
- Staff gathered the views of patients through surveys. The responses of patients were fed back to staff, to enable them to make service changes where needed.

However:

- Some patients told us they were not given copies of their care plans and some copies of care plans that we saw were not signed by patients.

Summary of findings

- Staff spoken with in the Home treatment team were not aware of how to access advocacy services for patients. Patients and their families told us that they were not aware of how to access advocacy services when needed.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The teams had clear referral pathways and set out clear lines of responsibilities, time-frames and actions to be taken.
- The teams were meeting their targets for referral to assessment times. The teams could respond on time and effectively when patients required crisis and routine care.
- Staff rarely cancelled appointments. When cancellations did occur, patients were seen at the earliest possible opportunity. Staff maintained their appointment times and when they were running late, patients were informed.
- All Mental Health Act assessments in 136 suites took place within 72 hours and most within three hours of admission.
- The teams took active steps to engage with patients that were not willing to engage with their services. The teams offered patients opportunities to be seen where they felt most comfortable.
- The teams had access to interpreters when needed. Staff could to tell us how they could access interpreting services.
- Patients knew how to raise concerns and make a complaint. Patients told us they felt they would be able to raise concerns should they have one and were confident that staff would listen to them.
- The teams provided patients with accessible information on common mental health issues, medications, treatments, local services, patients' rights, advocacy services, and how to complain.

However:

- The teams did not have information leaflets specific to their teams on how the services were run.
- One of the interview rooms at Penn hospital was cold and small.

Are services well-led?

Requires improvement

We rated well-led as requires good because:

Summary of findings

- The systems or methods to monitor the effectiveness of quality and safety of the service provided were not effective and robust enough to ensure that quality and safety was maintained at all times. The inspection team identified such areas where improvements were required.
- The teams did not participate in any quality improvement programmes such as home treatment accreditation scheme and psychiatric liaison accreditation network from the Royal College of Psychiatrists or involved in any research.

However:

- Staff knew who the most senior managers in the trust were. These managers had visited the teams.
- Staff told us that they knew how to use the whistle blowing process and felt free to raise any concerns.
- Staff told us that they were supported by their line managers and were encouraged to access clinical and professional development courses.
- Staff were offered the opportunity to give feedback on services and input into service development through the annual staff surveys.
- Staff were open and transparent when things went wrong. They were aware of duty of candour and were able to give us examples of having been open and honest when mistakes had been made, apologising for mistakes and learning from them.

Summary of findings

Information about the service

The referral assessment service was based at Penn hospital and operated over a 24 hour period, seven days a week. It provided an assessment and short term intervention service for the people of Wolverhampton. The service aim was to assess if mental healthcare was needed. The team worked with individuals for up to two weeks if short term intervention was required. People with more complex mental health needs were referred to other teams for treatment.

The adult Home treatment team was based at Penn hospital. The team operated from 8am to 10pm seven days week. The team received most of its referrals from inpatient wards and the referral assessment service after triage and assessment and was responsible for providing care and treatment. The team worked using a multi-disciplinary approach to support patients in their own homes to reduce inpatient admissions and facilitate early discharge from hospital.

The Crisis resolution and home treatment team was based at Quayside in Sandwell. This service was for people suffering severe mental health crises. The team operated 24 hours, seven days a week and provided both an assessment and treatment service. The team was responsible for receiving referrals and would carry out a triage; assessment and providing care and treatment. The team worked using a multi-disciplinary approach to support patients in their own homes to reduce inpatient admissions and facilitate early discharge from hospital.

The Psychiatric liaison teams were based at the A&E departments in Sandwell hospital and New Cross hospital. They provided specialist assessment and treatment for patients that had medical and mental health problems who presented at A&E or were high users of acute hospitals.

The health based places of safety (HBPoS) section 136 suites were based at Penn hospital and Hallam street hospital. Patients were brought to this place of safety by a police officer because they were concerned that the patient had a mental disorder and should be seen by a mental health professional. Patients were kept in the suite under section 136 of the Mental Health Act so that they can be assessed to see if they required treatment. The 136 suite was managed by staff from ward one (a mixed acute mental health ward). Patients were cared for in the HBPoS for up to 72 hours until they could be assessed by a psychiatrist and an approved mental health professional.

The teams also worked with the street triage services that included a qualified mental health professional who worked alongside the police to provide an immediate assessment of anyone that presented as possibly having a mental health problem.

Our inspection team

The inspection team was led by:

Chair: Dr Oliver Shanley, Hertfordshire Partnership Foundation Trust;

Head of Inspection: James Mullins, Head of Inspection for Mental Health, Learning Disabilities

and Substance Misuse, Care Quality Commission;

Team Leaders: Kenrick Jackson and Paul Bingham, Inspection Manager, Care Quality Commission;

The team that inspected this core service was comprised two CQC inspector, one psychiatrist, one Mental Health Act reviewer, one mental health specialist nurse.

Summary of findings

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 that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the Penn hospital, Hallam hospital, Quayside, New Cross hospital A&E, Sandwell General hospital and patients in their own homes. We looked at the quality of the environments and observed how staff were caring for patients;
- visited crisis beds at 'P3' in Sandwell;
- spoke with 12 patients who were using the service and five of their relatives;
- spoke with the four managers;
- spoke with 24 staff members; including doctors, nurses, nursing assistants, psychologists, occupational therapists, and social workers;
- interviewed the three police officers with responsibility of section 136 and street triage;
- spoke with four A&E staff;
- attended two clinical reviews;
- attended and observed two handover meetings;
- looked at 27 care records of patients;
- looked at 18 assessment records in the 136 suite;
- carried out a specific check of the medication management in the home treatment teams;
- 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 mainly positive comments from patients and carers. Staff were described as kind and respectful and patients and carers felt involved in choices about their care and treatment.

Patients and their relatives told us that they felt safe with staff from all the teams.

Patients told us that they attended their clinical review meetings and were encouraged to involve their relatives if they wished to.

Patients told us they were given information on how to take their medication and encouraged to do themselves.

Patients told us that staff always visited them on time for their appointments.

Patients said they felt able to ring the team when they needed them and staff always got back to them and were available in the evenings and weekends. However, one patient told us that they were not given information on how to contact the team in an emergency.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all areas visited by patients for their clinical reviews have emergency equipment such as automated external defibrillators and oxygen on site.
- The trust must ensure that management of potential risk from ligature points in 136 suite does not compromise patient's privacy and dignity. The trust must also ensure that an environmental risk assessment to include ligature risk is carried for flats used as crisis beds at 'P3'.
- The trust must ensure that risk assessments are completed for patients and regularly reviewed and updated.
- The trust must ensure that there are appropriate arrangements for the safe management of medicines. They must have proper arrangements for safe storage of medicines and safe and secure transportation of medicines. Medicines stocks must be consistently checked.
- The trust must ensure that patients have care plans that are holistic and recovery orientated and fully address the needs identified in the assessment stage.
- The trust must ensure that there are clear systems of records management so that records are well organised and different team members can access patients' records when needed
- The trust must ensure that health checks are carried out and that physical health needs are monitored.
- The trust must ensure that there are effective and robust governance systems and methods to assess and monitor performance around quality, safety and risk.

Action the provider SHOULD take to improve

- The trust should ensure that portable appliance tests are carried out to all electrical equipment used to ensure they are safe to use.
- The trust should ensure that the kitchen area at Hallam street 136 suite does not have open access to boiling water from the instant water boiler fitted to the wall.
- The trust must ensure that receive regular supervision and have regular staff meetings.
- The trust should ensure that staff receive training in Mental Health Act (MHA) and the Code of Practice. Staff in charge of the place of safety should receive special training for that role.
- The trust should ensure that there are arrangements in place to monitor adherence to the MHA and Mental Capacity Act to ensure that it was being applied correctly.
- The trust should ensure that staff participate in quality improvement and innovative practice initiatives.
- The trust should ensure that patients are given copies of their care plans and sign their and care plans.
- The trust should ensure that staff are aware of how to access advocacy services for patients.
- The trust should ensure that all teams have information leaflets specific to their teams on how the services are run.

Black Country 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
Crisis Resolution and Home Treatment Team	Trust Head Quarters
Referral and Assessment Service	Penn Hospital
Adult Home Treatment Team	Penn Hospital
Health Based Place of safety	Hallam Street Hospital
Health Based Place of safety	Penn Hospital
Psychiatric Liaison Teams	Trust Head Quarters

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.

Training records indicated that staff had not received training in Mental Health Act (MHA) and the Code of Practice. Staff corroborated this. Staff in charge of the 136 suite did not receive any special training for the role although the MHA Code of Practice requires this. The policy on the use of section 136 and the 136 suite had not been updated since the revised MHA Code of Practice was introduced in 2015.

Staff at both places of safety reported explaining to patients their rights under the MHA. Nursing staff knew about the rights of patients detained under section 136, such as their right to refuse medication. Records of admission to 136 suites contained basic information such

as dates, times and personal details on the Mental Health monitoring form. The form used by the trust also recorded whether staff had told the patient about their rights and carried out risk assessments. However, there were no more detailed records until the completion of the Approved Mental Health Professional (AMHP) report. Therefore we could not tell whether staff were following the guiding principles of the MHA Code of Practice.

Staff knew how to contact the Mental Health Act team for advice when needed. This meant staff could get support and legal advice on the use of the MHA when needed.

Staff were aware of how to access and support patients to engage with the independent mental health advocacy when needed. Information on independent mental health advocacy services was readily available to support patients.

The teams had not conducted any recent audits to ensure that the MHA was being applied correctly.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training records showed that staff had received training in the Mental Capacity Act. We were told that Mental Capacity Act training was part of safeguarding training. Staff demonstrated a good understanding of Mental Capacity Act and could apply the five statutory principles.

Staff were aware of the policy on Mental Capacity Act and knew the lead person to contact about Mental Capacity Act to get advice.

The teams did not document information on how capacity to consent or refuse treatment had been sought.

All documents we viewed did not have any information on where patients lacked the capacity to consent. Staff were able to explain how patients would be supported to make decisions where appropriate. They were able to tell us how procedures were followed so that decisions were made in patients' best interest.

Staff spoken with demonstrated that they understood what type of actions could be viewed as restraint and knew situations when it was the right thing to do.

The teams did not have arrangements in place to monitor adherence to the Mental Capacity Act to ensure that it was being applied correctly.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean ward environment

- The 136 suites and interview rooms where patients visited were fitted with alarms and staff followed the security procedures. Staff signed for personal alarms at reception before meeting patients in interview rooms and were able to activate the alarms when at risk.
- The 136 suite at Hallam street had a well-equipped clinic room with a couch and emergency equipment that was checked regularly to ensure it was in good working order. The 136 suite at Penn hospital did not have a clinic room but had emergency equipment that was checked regularly. The teams at Penn hospital had access to emergency equipment from the wards. Quayside had a clinic room but did not have emergency equipment such as automated external defibrillators and oxygen on site. Patients visited this site for their clinical reviews.
- Both 136 suites facilities met the Royal College of Psychiatrists section 136 health based place of safety standards. They were separate from the main ward area, suitably furnished, clean and with toilet facilities. The suite at Penn hospital was purpose built with a shower room, locked kitchen and anti-ligature fittings. However, there were ligature points on the toilet taps and door handle in Hallam street 136 suite. There was no ligature assessment in place for this identified potential risk. Staff told us that this was managed through maintaining observations on patients deemed to be at risk of suicide when using the facilities. This had an impact on people's privacy and dignity when using the facilities.
- The kitchen area at Hallam street had open access to boiling water from the instant water boiler fitted to the wall. The ward manager told us that this was reported to senior management in May 2015 and no action had been taken.
- The Crisis and resolution home treatment team used four self-contained flats as crisis beds at 'P3', a voluntary organisation. The rooms had several potential ligature points such as door and window handles, taps and curtain rails. We were told that the flats were not risk assessed before patients were admitted. The clinical team told us that they would not place any patients with high risk of suicide in those beds.
- All the locations that we visited were clean and well maintained. Cleaning records were up to date and showed that the environments were regularly cleaned.
- Staff practiced good infection control procedures such as hand hygiene to ensure that patients and staff were protected against the risks of infection.
- Portable appliance test to electrical equipment such as toaster and instant water boiler at the 136 suite at Hallam street were not being conducted. Portable appliance tests in all other teams were carried out for the equipment used. The equipment was checked regularly to ensure it continued to be safe to use and clearly labelled indicating when it was next due for service.

Safe staffing

- The teams consisted of care co-ordinators who came from a range of professional backgrounds such as social workers, nurses and occupational therapists. All teams were led by band seven managers with operational and clinical responsibilities.
- The Referral and assessment service (RAS) had 12 nurses and three support workers and no vacancies. The Home treatment team (HTT) had 11 nurses and three support workers. It had one support worker vacancy. The Crisis and resolution home treatment team (CRHTT) had 14 nurses and four support workers. It had one nurse and one support worker vacancies. The psychiatric liaison teams had seven nurses and three support workers each.
- The health based place of safety at Penn hospital was supported by staff from RAS. The Hallam street equivalent was supported by staff from the wards at that hospital.
- The sickness rate in the 12 month period for RAS and HTT was one percent and for CRHTT was 14%. The staff turnover rate within the services was very low. There

Requires improvement

Are services safe?

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

were proper arrangements and use of bank staff in place to cover staff sickness, leave and vacant posts to ensure patients' safety. The teams used their own staff on bank to cover most of the shifts. Rarely was agency staff used.

- The staffing levels in each team were appropriate ensuring patient safety. The number of staff on the duty roster matched the number of nurses, social workers and nursing assistants on shifts and we found that this was consistent.
- All teams did not have an average caseload allocated per care co-ordinator. The teams allocated cases to each individual per shift. These were based on the needs of the patients and the cases were allocated to a nurse with the most appropriate skill set to meet the needs. The managers told us that they allocated the same nurses to the same patients where possible in order to provide consistency. The caseloads were low in each team. All teams had no patients on waiting list to be allocated to nurses. This meant that patients were not waiting long to be seen by nurses. The caseloads and case allocations were discussed and regularly assessed in staff handover meetings.
- All of the teams told us that there was quick access to a psychiatrist when required. The psychiatrists were available on site during working hours and out of hours there was an on-call psychiatrist to ensure that patients had quick access to one when needed. The teams had a three doctors on call, junior doctor who was first point of call then middle grade doctor then a consultant.
- Records showed that the average rate for completed staff mandatory training for the teams was 82% and the trust's target was 95%.

Assessing and managing risk to patients and staff

- The Home treatment team (HTT), Crisis and resolution home treatment team (CRHTT) and the Referral and assessment service (RAS) carried out risk assessments on every patient at the initial assessment. The HTT and RAS updated and regularly reviewed the risk assessments. The CRHTT did not complete detailed risk assessment and were not regularly reviewed and updated. Four out of nine risk assessments we looked at in CRHTT did not reflect the risk highlighted in patient's history. Only four out of nine were up to date. We could not find evidence from both health based places of safety that they carried out risk assessments when patients used the 136 suite. The Psychiatric liaison teams had excellent risk assessments completed at initial contact with the patient.
- The teams used the Sainsbury risk assessment tool.
- The records reviewed showed that patients had detailed emergency plans in place that informed staff what to do in the event of a crisis. Advance decisions were recorded where appropriate.
- The teams had arrangements in place to respond to sudden deterioration in a patient's mental state. The teams would provide an emergency assessment by two professionals from the referral and assessment team or crisis resolution team within four hours. If the patient was known to services, the home treatment team would respond. The teams had on-call psychiatrists out of hours and a staff team that worked at night so that patients could access the service anytime. Patients likely to call due to signs of relapse or increased risk were handed over to night staff to ensure quick response. Patients told us that they were able to get assistance out hours and the teams responded quickly most of the time.
- Training records showed that staff received safeguarding training. They demonstrated a good understanding of how to identify and report any abuse. There was information about awareness and how to report safeguarding concerns displayed around the team bases. Staff knew who the designated lead for safeguarding was and knew how to contact them for support and guidance.
- Safeguarding issues were shared with the staff team through staff meetings, handover and emails. Information on safeguarding was readily available to inform patients, relatives and staff on how to report abuse. Patients and their relatives told us that they felt safe with staff from all the teams.
- All staff were aware of the lone working policy and told us that they followed it. The teams had established systems for signing in and out with expected times of return so that staff whereabouts were known at all times. Staff saw patients in pairs where the risk was deemed high. Staff did not have any safety personal alarm devices to call for help when at risk in the community. They used their mobile phones to call for help.
- Medication management varied. The RAS and HTT teams had appropriate arrangements for the

Requires improvement

Are services safe?

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

management of medicines. We reviewed nine medicine administration records across both teams and the recording of administration was complete and correctly recorded as prescribed. The medicines were appropriately stored. Staff consistently recorded the temperatures of the medicines room. The CRHTT shared the same clinic room with five other teams and each team had an allocated medicines cupboard. There was one key to access all the cupboards and we found that the key was left on one of the cupboards door. All nurses from other teams could access all the medicines cupboards. We saw nurses from CRHTT team taking medicines out and put it in the handbag. There was no safe and secure transportation of medicines procedure that was followed. Medicines stocks were not consistently checked. We saw that there were gaps were stocks of medication were not checked on a weekly basis.

Track record on safety

- In April 2015 a serious untoward of a patient's death occurred in Sandwell. The team did not have up to date information and the patient was not willing to engage with the service. The clinical team investigated the incident and developed an action plan to address the key issues from the investigation.
- The root cause analysis investigation identified that if patients were reluctant to engage with the service, there should be a system to follow to ensure that patients were assessed. The trust put in place a system called 'call call' where staff would call the relatives, GP and then a cold call to the house.

Reporting incidents and learning from when things go wrong

- All teams had an effective way of recording incidents, near misses and never events. Incidents were reported via an electronic incident reporting form. Staff knew how to recognise and report incidents through the reporting system.
- The teams had a clear structure which reviewed all reported incidents. Incidents sampled during our visit showed that investigations took place, with clear recommendations and action plans for staff and sharing within the team.
- Staff were able to explain how learning from incidents was shared with all staff. Their responses indicated that learning from incidents was distributed to staff. Learning from incidents was discussed in staff meetings, handovers and through learning lessons newsletter.
- Changes in practice had been made as a result of learning from incidents. The teams had improved information sharing and communication with relatives and GPs. They were now including regular discussion of patients who were reluctant to engage with the services.
- Staff were open and transparent and explained to patients if and when something went wrong. Incidents were discussed with patients and their families. We saw that the HTT had written letters of apology to patients and their families were things had gone wrong. Patients told us that they were informed and given feedback about things that had gone wrong.
- Staff were offered debrief and support after serious incidents.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- We looked at 27 records across all teams. They all contained assessments that had been completed when patients were admitted. Of the 27 patient records we looked at, 22 had up-to-date care plans. The referral and assessment service and home treatment team had 14 out of 18 care plans that were holistic, recovery orientated and personalised. Three out of nine care plans we reviewed for Crisis and resolution home treatment team were not holistic and recovery orientated. They did not address the needs identified in the assessment stage and lacked clear guidelines on how staff should support patients to meet their needs.
- All teams stored information and care records securely in locked cupboards and secure computers. Records were not well organised and different team members could not access patients' records when needed. This was as a result of teams using different electronic record systems and some teams using paper records. For example, staff from referral and assessment service could not access records at A&E department when they took over from the psychiatric liaison team. The home treatment team at Penn hospital kept medical notes in a different place away from the nursing notes and were not easily accessible to all staff. Teams in Wolverhampton used 'Care Notes' and those in Sandwell used 'Oasis'. Staff had difficulties in identifying where certain care plans and records were located.
- There were no clear systems of records management in the health based places of safety. We could not find records of patients who were not detained after using 136 suite and we were told patients that had been detained move with their records. At Penn Hospital, there were entries in the duty senior log book about patients admitted to the place of safety. These entries did not form part of the patient's care records.
- We could not find records in the 136 suite that showed physical healthcare needs were assessed and supported. Records viewed in all teams showed that there was no clear monitoring of physical health needs. Health checks were not carried out and there were no care plans in place for patients with physical health needs to ensure that their individual needs were being monitored. Staff told us that physical health needs were monitored by the GPs and they supported patients with their appointments.
- We looked at 18 Mental Health monitoring forms. Information was missing and there were other errors on all the forms including calculations of the length of time in the place of safety.
- All teams used the health of the nation outcome scales (HoNOS) and clustering as clinical outcome measures. We looked at the use of clustering and HoNOS in 12 sets of records and found that this was up to date in all of them. This meant that staff had standard ways to monitor changes in a patient's presentation.

Best practice in treatment and care

- The doctors had access to information from National Institute for Health and Care Excellence (NICE) guidance updates that they shared with the teams. We saw information on patients' medicines based on NICE guidance which included information on drug interactions, dosages, contra-indications, side-effects and health checks required. Patients prescribed lithium had regular blood tests.
- Patients could access psychological therapies as part of their treatment. For example, anxiety management, cognitive behavioural therapy and solution focussed therapy were offered as part of the services. Home treatment teams had full time psychologists as part of their team.
- The teams offered practical support for patients with employment, housing and benefits. The teams had strong links with employment organisations, citizens advice bureau, benefits offices and housing schemes in order to support patients.
- Patients were offered opportunities to attend 'The Recovery College' which had a range of recovery focussed educational courses, voluntary employment, accessing benefits, employment opportunities and building self-confidence.
- The teams carried out clinical audits to monitor the effectiveness of the service provided. The managers showed us the trust wide audits in records audits that included care planning, risk assessments and person-centred-planning, medicines audits and health and safety. The findings were used to identify and address changes needed to improve outcomes for patients.

Are services effective?

Requires improvement

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

Skilled staff to deliver care

- All of the teams had experienced and appropriately qualified staff. The teams were mostly made up of band six and seven nurses. The teams included nurse prescribers and staff that were approved mental health professionals.
- We saw evidence from records that all staff including bank and agency received appropriate induction which involved shadowing experienced staff before they could work on their own. Staff told us that they received an appropriate induction.
- Staff in the Home treatment team and Crisis and resolution team did not receive supervision regularly. We saw the records that some staff had received supervision only twice in the last 12 months. Staff told us that they did not get regular supervision. The managers told us that they were in the process of implementing robust supervision processes. Staff in the referral and assessment service and psychiatric liaison teams received regular supervision.
- Staff could review their practice and identify training and continuing development needs in these sessions.
- Annual appraisals were taking place. The average percentage of non-medical staff that received an appraisal in the last 12 months was 95% across all teams. Staff told us that they received appraisals. We reviewed some the appraisals at Penn hospital and found that they were detailed, with specific and measurable objectives and timescales.
- Staff in the home treatment team told us that team meetings did not take place regularly. Records showed that in the year 2015 only three staff meetings had been conducted. The other teams had regular staff team meetings to discuss operational and clinical issues.
- Staff told us they had undertaken training relevant to their role. Staff had received STORM training which centred on suicide prevention. Staff had received training in cognitive behavioural therapy (CBT) and solution focussed therapy. The teams told us that they had reflective practice sessions with the psychologist to discuss areas practice specific to their roles.

Multi-disciplinary and inter-agency team work

- The teams consisted of doctors, nurses, social workers, occupational therapists, psychologists and support workers. The teams did not have direct input from a pharmacist into clinical care. Patients told us that there were able to see a wide range of professionals depending on their needs.
- All teams had regular and effective multi-disciplinary team meetings taking place. These meetings involved doctors, psychologists, nurses, social workers, occupational therapists, support workers and housing officers. We attended three multi-disciplinary team meetings and looked at records that showed discussions held addressed the identified needs of the patients.
- We attended two handover meetings in Referral and assessment service and Crisis and resolution home treatment teams and found them to be effective. Staff discussed each patient in depth about any changes in treatment plan and risk, patients' presentation, progress and details of family support. Staff demonstrated an understanding of their patients' needs and how they were to be supported.
- The teams had a good working relationship with inpatient wards, street triage, psychiatric liaison team and the A&E department. They shared information effectively about patients likely to move between services. The teams received handover information in the morning regarding any patients that they had been in contact with out of hours services. The teams gave the out of hours teams any information on patients that were high risk and likely to be in crisis. Patients transferred between teams had clear discharge plans in place.
- The teams had good working links with the external organisations. They had effective partnership working with GPs, acute hospitals, independent organisations, local authorities, police, housing associations and the citizens advice bureau. There were multi-agency groups in Wolverhampton and Sandwell to discuss and monitor the use of section 136. The teams invited external professionals where appropriate to review the risk assessments and crisis plans within the care programme approach process and to facilitate safe discharge. Patients and their families told us that other professionals who were involved in their care and treatment attended their meetings.

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

Are services effective?

Requires improvement

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

- Training records indicated that staff had not received training in Mental Health Act (MHA) and the Code of Practice. Staff corroborated this.
- Staff in charge of the 136 suites did not receive any special training for section 136 of MHA specific to the role although the MHA Code of Practice requires this.
- The policy on the use of section 136 and the136 suite had not been updated since the revised MHA Code of Practice was introduced in 2015.
- Staff at both places of safety reported explaining to patients their rights under the MHA. Nursing staff knew about the rights of patients detained under section 136, such as their right to refuse medication. Records of admission to 136 suites contained basic information such as dates, times and personal details on the Mental Health monitoring form. The form used by the trust also recorded whether staff had told the patient about their rights and carried out risk assessments. However, there were no more detailed records until the completion of the approved mental health professional (AMHP) report. Therefore, we could not tell whether staff were following the guiding principles of the MHA Code of Practice.
- Staff knew how to contact the Mental Health Act team for advice when needed. This meant staff could get support and legal advice on the use of the MHA when needed.
- Staff were aware of how to access and support patients to engage with independent mental health advocacy when needed. Information on independent mental health advocacy services was readily available to support patients.
- The teams had not conducted any recent audits to ensure that the MHA was being applied correctly.

Good practice in applying the Mental Capacity Act

- Training records showed that staff had received training in the Mental Capacity Act. We were told that Mental Capacity Act training was part of safeguarding training. Staff demonstrated a good understanding of Mental Capacity Act and could apply the five statutory principles.
- Staff were aware of the policy on Mental Capacity Act and knew the lead person to contact about Mental Capacity Act to get advice.
- The teams did not document information on how capacity to consent or refuse treatment had been sought.
- All documents we viewed did not have any information on where patients lacked the capacity to consent. Staff were able to explain how patients would be supported to make decisions where appropriate. They were able to tell us how procedures were followed so that decisions were made in patients' best interest.
- Staff spoken with demonstrated that they understood what type of actions could be viewed as restraint and knew situations when it was the right thing to do.
- The teams did not have arrangements in place to monitor adherence to the Mental Capacity Act to ensure that it was being applied correctly.

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 good interactions between staff and patients. This included home-visits and clinical review meetings. Staff spoke to patients in a way that was respectful, considerate clear and simple. They offered patients reassurance and showed positive willingness to support them.
- Patients and their families were positive about the attitudes of staff and the care that they received. Our observations and discussions with patients and their families confirmed that they had been treated with respect and dignity. We were told that staff were polite, kind and compassionate.
- Staff showed that they understood the individual needs of patients and could describe how they supported patients with different needs. Patients told us that staff had a good understanding of their needs. Patients felt they were supported in a way they were pleased with.
- Staff showed a good understanding of how to maintain confidentiality when they held discussions about people's care.

The involvement of people in the care they receive

- Patients told us that staff discussed their care and treatment with them.
- The teams involved patients to participate in the care programme approach and clinical reviews.
- We observed four clinical reviews and patients were given time to express their views. The clinical team explained choices available to patients' care and were encouraged to make their own decision. Their views were taken into account.
- We went on four home visits with staff members; two of the patients told us that they did not have copies of their care plans and had signed them, whereas the other two had.
- Patients told us that they were encouraged and given advice on how to take their medicines independently.
- The teams involved patients' carers in the assessment and discussion of care and treatment where appropriate. Patients were encouraged to involve relatives and friends in care and treatment discussions if they wished. Families and carers were provided with support where it was appropriate. The teams carried out formal carers' assessments.
- Voice Ability provided advice, support and advocacy services in Sandwell. Most staff we spoke to knew how to access advocacy services. However, in Wolverhampton staff were not able to find advocacy leaflets and were not clearly aware of how to access advocacy services when needed.
- The teams conducted regular patient surveys to gather their views. Patients in Wolverhampton were also given questionnaires after their clinical reviews to give feedback on their care and treatment. The results were analysed every three months to formulate trends and themes to enable staff to make changes to the service where needed.
- The teams took into account patients' advance decisions. These were recorded where it was appropriate.

Are services responsive to people's needs?

Good

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

Our findings

Access, discharge and bed management

- All new referrals were gatekept by the referral and assessment service (RAS) in Wolverhampton. In Sandwell they were received through crisis and resolution home treatment team (CRHTT). Referrals came from GPs, families, self-referrals and other health care workers.
- Following a triage referrals were prioritised using a screening tool according to risk and identified needs. The referrals in Sandwell were classified as; section136 seen in one to two hours, immediate risk seen in four hours, urgent seen in 24 hours, routine seen in seven days and non-urgent seen in 28 days. In Wolverhampton routine referrals were seen within four weeks, urgent referrals were seen between six and 48 hours and emergency referrals were seen within six hours. The team met all of the response times.
- The referral pathways were robust, outlining clear lines of responsibility, time frames and actions to be taken.
- The RAS worked with patients for up to two weeks before transfer to HTT, any other appropriate team or discharge. The CRHTT and HTT worked with patients for up to six weeks however, patients could stay longer than that if required.
- None of the teams had patients on waiting list. The teams discussed, monitored and responded to patients' needs in a way that took account of the level of risk presented by patients. Response was prioritised according to risk presented.
- The teams responded on time and effectively when patients required crisis and routine care. The teams worked 24hours every day. The teams operated with night staff that worked from 10pm to 8am and were responsible for responding to all out of hours calls. Where the team could not visit patients in their homes, they asked them to be seen at the teams' bases. They also worked collaboratively with the street triage team that could respond to patients' home at night if a patient could not visit the base.
- The psychiatric liaison team assessed patients in mental health crisis arriving in the A&E or on the wards in the acute general hospital between 8am and 10pm seven days a week. The psychiatric liaison team assessed all of the patients in A&E within one hour and in other wards within four hours. This is within their target. We saw that the team responded on time when a bleep was raised by A&E staff. Their target to respond to a bleep is 30 minutes. Staff from A&E told us that the team always responded on time. Patients seen and assessed were referred back to their GP, admitted to the general wards, admitted to a mental health ward, taken on to the caseload of the home treatment team or referred to the community mental health team. Between 10pm and 8am the referral and assessment service would respond to patients arriving in A&E in Wolverhampton and the CRHTT in Sandwell.
- The health based places of safety section 136 suite received admissions from police officers and the street triage team. All Mental Health Act assessments took place within 72 hours and most within three hours of arriving at the place of safety. Staff reported that they could arrange for doctors with expertise in Child and Adolescent Mental Health Services (CAMHS), learning disabilities and autistic spectrum disorders to take part in assessments if the individual needs of the patient required such input. Staff and police officers told us that since street triage team was in place, the health based places of safety were rarely used.
- Patients were rarely moved to police custody because of the 136 suites being occupied.
- The home treatment teams were the gatekeepers for working age adult beds. If a bed was not available in Sandwell, they would access the crisis beds at 'P3' working in partnership with a voluntary organisation. This facility was not only used for patients requiring beds but also for those who could benefit from respite.
- The teams had clear criteria that ensured all patients that required treatment were responded to and signposted to the appropriate service. The out of hours services could see all patients in crisis and refer them to the appropriate teams during working hours. Out of hours, they also covered for all mental health community teams.
- The teams took active steps to communicate with patients that were not willing to engage with their services. The teams offered patients opportunities to be seen where they felt most comfortable such as at home, the team base or at the GP surgery. These patients were discussed in team meetings and strategies were put in place on how to best engage them. For example, the doctors may stay later after hours to visit or see some patients that would like to be seen in the evenings. The

Are services responsive to people's needs?

Good

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

team also discussed patients who did not attend appointments and proactive steps to re-engage with these patients such as cold calling, repeated phone calls and follow up discussions with the referrer.
- Staff set up appointments in a way that showed responsiveness to patients who had the highest needs. The teams used a needs priority system to book appointments. This was discussed in handovers and allocated to staff accordingly. Appointments were discussed with patients to check the best suitable times for them.
- Appointments were rarely cancelled and where there were cancellations, patients were seen at the earliest possible opportunity. Patients told us that they were always seen on time and any cancellations were explained to them and seen at the next available appointment.
- The teams maintained their appointment times and when they were running late patients were informed. Patients told us that staff were reliable and arrived on time to their appointments.

The facilities promote recovery, comfort, dignity and confidentiality

- People detained in the places of safety had access to a toilet and washing facilities. Food and drink was available. At Penn hospital, there was also access to a television set. There was comfortable furniture at both hospitals, but if someone wanted to sleep, they would have to lie on the sofa.
- The teams had enough therapy rooms to conduct one to one or group sessions. However, one of the interview rooms at Penn hospital was cold and small.
- All interview rooms were appropriately designed and located for the purposes of clinical interviews.
- The teams did not have information leaflets specific to their teams on how the services were run. We were told that they were being changed as a result of service changes. The teams provided patients with accessible information on common mental health issues, medications, treatments, local services, patients' rights, advocacy services and how to complain.

Meeting the needs of all people who use the service

- All of the environments that had full disabled access.
- The teams had information leaflets in different languages. This meant that non-English speaking patients were able to get information in the languages they understood. Staff told us that leaflets in other languages could be made available through their intranet translation services when needed. Staff demonstrated to us how they typed information in English on the intranet translation and chose the language in which they wanted the document to be translated into.
- The teams had access to interpreters when needed. Staff could to tell us how they could access interpreting services.

Listening to and learning from concerns and complaints

- The units displayed information on how to make a complaint. Patients could raise concerns with staff anytime. Staff told us they tried to resolve patients' and families' concerns informally at the earliest opportunity. Patients told us that they could raise any concerns and complaints freely.
- Patients knew how to raise concerns and make a complaint. Patients told us they felt they would be able to raise concerns should they have one and were confident that staff would listen to them.
- Staff were aware of the formal complaints process and knew how to support patients and their families when needed. We observed that staff responded appropriately to concerns raised by relatives and carers of patients and received feedback.
- Our discussion with staff and records observed showed that any learning from complaints was shared with the staff team through the handovers and staff meetings

Are services well-led?

Requires improvement

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

Our findings

Vision and values

- The teams had the vision and values of the trust displayed. Staff agreed and were familiar with the trust's values. They told us that these values relate well to the team's objectives.
- Staff demonstrated a good understanding of their team objectives and how they linked in to the trust's values and objectives.
- Staff knew who their senior managers were and told us that they visited the teams.

Good governance

- The managers felt they were given the independence to manage the teams and had administration staff to support the teams. They also said that, where they had concerns, they could raise them. Where appropriate the concerns could be placed on the trust's risk register.
- The governance systems and methods to assess and monitor performance around quality, safety and risk were not robust and effective enough to ensure that quality and safety was maintained at all times. The inspection team identified areas where improvements were needed. The areas that were not monitored appropriately were care plans, risk assessments, ligature risk, staff supervision, medicines management, physical health needs, records management and Mental Health Act training.
- Managers provided data on performance to the trust consistently. All information provided was analysed at team and directorate level to come up with themes and this was measured against set targets. The teams captured data on performance such as referral time response, waiting list, discharges, appointments and patient clusters. The performance indicators were discussed at monthly business meetings. The information was used as a way of improving performance in some areas identified.

Leadership, morale and staff engagement

- The sickness rate in the 12 month period for home treatment team and referral and assessment service was one percent, for Crisis and resolution home treatment team was 14% and for psychiatric liaison team in Sandwell was 16% and 6% for Wolverhampton.
- At the time of our inspection there were no grievances being pursued within the teams, and there were no allegations of bullying or harassment.
- Staff told us that they were aware of the trust's whistleblowing policy and that they felt free to raise concerns.
- Staff told us that they were supported by their line managers and were encouraged to access clinical and professional development courses. They told us that managers were accessible to staff, approachable, had an open culture and willing to listen. Two members of staff from the home treatment team told us that they do not feel supported by their manager as they were given more work of bed management on top of their caseload.
- Our observations and discussion with staff confirmed that the teams were cohesive with good staff morale. They all spoke positively about their roles and demonstrated their dedication to providing high quality patient care. Staff told us that they felt anxious about changes to be made to the teams. They told us that they were updated and consultations were about to take place.
- Staff were open and transparent and explained to patients if and when something went wrong. Incidents were discussed with patients and their families. Patients told us that they were informed and given feedback about things that had gone wrong.
- Staff told us the board informed them about developments through emails and intranet and sought their opinion through the annual staff survey.

Commitment to quality improvement and innovation

- The teams did not participate in any quality improvement programmes such as home treatment accreditation scheme and psychiatric liaison accreditation network from the Royal College of Psychiatrists or involved in any research.

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 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated activities) Regulations 2014 Person-centred care The care and treatment of patients must be appropriate, meet their needs and reflect their preferences. Patients in Crisis and resolution home treatment team did not have care plans that were holistic or recovery orientated. Health checks were not carried out and physical health needs were not monitored. This was a breach of Regulation 9(3) (a)

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 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (Regulated activities) Regulations 2014 Dignity and respect Patients must be treated with respect and dignity. The management of potential risk from ligature points in the 136 suite did not respect patients' privacy and dignity. This was a breach of Regulation 10(2) (a)

This section is primarily information for the provider

Requirement notices

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 (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated activities) Regulations 2014** Safe care and treatment Care and treatment must be provided in a safe way for patients. Environmental risk assessments to include ligature risk had not been carried for flats used as crisis beds at 'P3. Risk assessments were not always completed for patients and regularly reviewed and updated. The trust did not have appropriate arrangements for the safe management of medicines at Quayside House. There was no access to emergency equipment at Quayside. This was a breach of Regulation 12(2)(b)(d)(f)(g)

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 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated activities) Regulations 2014** Good Governance Systems or processes must be established and operated effectively to ensure compliance. Records were not well organised, lacked detail and different team members could access patients' records when needed. The governance systems and processes were not effective enough to monitor all areas of quality and safety. This was a breach of Regulation 17(2)(c)