Good

Oxford Health 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)
RNU30	Littlemore Hospital	Ashurst ward. Littlemore Mental Health Centre.	OX4 4XN
RNU03	Warneford Hospital	Vaughan Thomas ward	OX3 7JX
RNU09	Buckingham Health and Wellbeing Campus	White Leaf Centre, Aylesbury.	HP20 1EG

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

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Summary of findings

Overall summary

We rated Oxford Health NHS Foundation Trust's health-based places of safety as **good** because:

- The places of safety were clean and well maintained (with the exception of Ashurst), with good sight lines. There was adequate staffing from the wards and staff followed a clear operational protocol. Staff had received training and were well supported. They carried out brief risk assessments and physical health checks and had access to emergency equipment if needed. Incidents were reported and the multi-agency problems in practice meeting reviewed them and identified lessons to be learnt.
- The places of safety had a clear and comprehensive standard operational procedure which was based on the multi-agency agreement. All the places of safety accepted all ages and the only exclusion criterion was potential violence. Staff received annual training in de-escalation and the prevention and management of violence. There were good working relationships with the police and ambulance service at the senior level. However, we heard from some frontline staff that there were occasional disagreements between nursing staff and police officers about the time at which officers could leave.
- Staff treated patients who were brought into the suite with kindness and respect. They were offered food and a hot or cold drink. All the units, except Ashurst, had showers and patients could be provided with toiletries. In two of the units we visited it was possible to listen to the radio or music, or to read a book or magazine.
- The rate of inpatient admission after assessment in places of safety was very low. However, the numbers of people taken to police custody had dropped considerably in recent months, following the introduction of the street triage services.
- Each of the places of safety was managed by the team manager of the ward to which it was attached, supported by modern matrons and senior managers. There was a commitment and clear leadership at all levels to take this challenging work forward. The trust had signed up to the multi-agency agreement with Thames Valley police and also to Oxfordshire and Buckinghamshire Crisis Care Concordats. The trust also actively participated in the problems in practice meetings. The reviews of incidents in these meetings were fed back to front-line staff. Most staff said that they felt supported by their managers.
- There was some local auditing on one of the places of safety.

However,

- There were some occasional episodes of the beds in the places of safety being used for other purposes, including seclusion of inpatients or emergency accommodation for someone awaiting admission.
- There could be quite lengthy delays within the places of safety both before Mental Health Act assessment and after, if the person was to be admitted. The average length of time in the suite was over eight hours, but this could be considerably longer if no admission bed could be located.
- Although there was a great deal of information collected for the problems in practice meetings, there was little evidence of collation of these data for further analysis.

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:

- The places of safety were clean and mostly well maintained, with good sight lines.
- There was adequate staffing from the wards and staff followed a clear protocol. Staff appeared to be well trained and supported.
- Staff carried out brief risk assessments and physical health checks and had access to emergency equipment if needed.

However

- There had been twelve serious or potentially serious incidents over the previous twelve months. These were reported and the multi-agency problems in practice meetings reviewed incidents and identified lessons to be learnt for all organisations involved.

Are services effective?

Good

We rated effective as good because:

- The places of safety had a clear and comprehensive standard operational procedure which was based on the multi-agency agreement. There were times when a place of safety was not available and on these occasions there was an escalation process to senior management to address it.
- All the places of safety accepted all ages and the only exclusion criterion was potential violence.
- Staff received regular training in de-escalation and the prevention and management of violence.
- There were good working relationships with the police and ambulance service at the senior level.

However

- There were occasional disagreements between frontline nursing staff and police officers about, for example, the time at which officers could leave. This is not unexpected in the course of such challenging work. On these occasions there was analysis of these episodes at the problems in practice meetings and learning from them.

Are services caring?

Good

We rated caring as good because:

Summary of findings

- Staff treated patients who were brought into the suite with kindness and respect. They were offered food and a hot or cold drink. In some units spare clothes were available.
- In all units patients could go to sleep, although the lights were not always dimmable. Some of the units had showers and staff provided toiletries. In two of the units we visited it was possible to listen to the radio or to music. Staff could also give patients books or magazines to read.

Are services responsive to people's needs?

Requires improvement 

We rated responsive as requires improvement because:

- There were some quite lengthy delays within the places of safety both before Mental Health Act assessment and after if the person was to be admitted, whether informally or detained. The average length of time in the suite was over eight hours, but this could be considerably longer if no admission bed could be located.
- There was evidence that one place of safety had been used as an emergency bed for an informal inpatient on two recent occasions, without evidence of their consent.
- We were told by Thames Valley Police that between September 2014 and August 2015 there had been a number of occasions when someone could not be taken to the health-based place of safety in Oxford and in Buckinghamshire due to the place of safety being unavailable.
- The rate of admission (through Mental Health Act detention or informally) after Mental Health Act assessment in the places of safety had remained low, even though the street triage services were signposting the police and people elsewhere.

However,

- We heard reports that the street triage services were highly valued by the mental health service and the police.
- We found that the numbers of people taken to police custody had dropped considerably in recent months.
- There were separate entrances to two of the three places of safety, but not to Amber place of safety which was used much less frequently.

Are services well-led?

Good 

We rated well-led as good because:

- Each of the places of safety was managed by the team manager of the ward to which it was attached, supported by modern matrons and senior managers.

Summary of findings

- There was commitment and leadership at all levels to take this challenging work forward. The trust had signed up to the multi-agency agreement with Thames Valley Police and also to Oxfordshire and Buckinghamshire Crisis Care Concordats.
- The trust also actively participated in the problems in practice meetings. The reviews of incidents in these meetings were fed back to front-line staff. Most staff said that they felt supported by their managers.
- There was some local auditing on one of the places of safety.

However

- Although there was a great deal of information collected for the problems in practice meetings, there was little evidence of collation of these data for further analysis.

Summary of findings

Information about the service

Health-based places of safety are small staffed units on the site of a mental health service. They provide for people who have been found by the police in a public place and who are deemed to need a mental health assessment (section 136 of the Mental Health Act). Section 135 may also be used by the police with a warrant to bring someone in from a private location.

Oxford Health NHS Foundation Trust provides health-based places of safety at three locations. At Littlemore Hospital in Oxford the place of safety is attached to Ashurst ward, which is a psychiatric intensive care unit for men. This place of safety was described as being the first in line for the county. If the Ashurst place of safety was occupied or unavailable the second place of safety for Oxfordshire was attached to Vaughan Thomas ward (an acute ward for men) at Warneford Hospital. This place of safety opened in August 2014. Both of these places of safety served Oxfordshire.

There were three places of safety based at the White Leaf Centre in Aylesbury, they were attached to:

- Sapphire, an acute ward for men
- Ruby, an acute ward for women
- Amber, a mixed ward for older people.

However only two of these would be used at any one time. During the week of our inspection only the place of safety on Amber ward was open. The other two wards were closed to visitors on infection control grounds. Amber was an older people's ward and as a result the place of safety there would normally only take older or physically ill/frail people. These places of safety served Buckinghamshire.

All the trust's places of safety were able to receive patients of all ages, including children and young people.

There had been no previous CQC inspection of place of safety services.

Our inspection team

The inspection team was led by:

Chair: Professor Jonathan Warren, Director of Nursing, East London Foundation Trust

Head of Inspection: Natasha Sloman, Head of Inspection for Mental Health, Learning Disabilities

and Substance Misuse, Care Quality Commission

Team Leader: Serena Allen, Inspection Manager, Care Quality Commission

The team which inspected health-based places of safety comprised six people: a CQC inspector, two Mental Health Act (MHA) reviewers, a consultant psychiatrist, a nurse, and a CQC policy advisor.

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?

Summary of findings

Before the inspection we requested and reviewed information about the health-based places of safety provided by the trust.

During the inspection visit, the inspection team:

- visited three health-based places of safety at three hospital sites to review the quality of the environment and to observe how patients were cared for by staff
- spoke with five inpatients who had been admitted through the places of safety
- spoke with one person who was in the place of safety at the time of our inspection on section 136 of the Mental Health Act and also observed the patient being placed in the 136 suite
- spoke with the managers of the wards where the places of safety were located
- spoke with 15 other staff members; including doctors, nurses and approved mental health professionals
- interviewed a number of senior staff in all three settings
- received information from an inspector in Thames Valley Police
- reviewed 16 care records
- reviewed incidents relating to places of safety
- looked at a range of policies, procedures, audits and other information
- reviewed the minutes of some problems in practice meetings
- reviewed the 2015 inter-agency partnership agreement between Thames Valley Police and Health and Social Care Agencies
- reviewed the Oxfordshire and Buckinghamshire Crisis Care Concordats and action plans.

What people who use the provider's services say

We spoke to six patients who had been brought into a place of safety, one of whom was brought into Ashurst at the time of our visit. Three patients said they could remember very little about their stay and had found it quite confusing. One said that nobody talked to her initially and it was only when another member of staff came in to the suite and talked to her and reassured her that she calmed down. Most patients said that the staff had been kind and helpful and had given them something to eat and drink. One person said he would have liked to listen to the radio, and three said they were frustrated that they were not able to smoke.

Good practice

In Vaughan Thomas ward we heard from the deputy manager about an innovative way of providing training on section 136 throughout the team, using presentations, role play and pocket sized information leaflets. Staff on Vaughan Thomas area were also trained in dual diagnosis and to recognise the signs of alcohol withdrawal.

We were told about a planned training event in December 2015 for health staff and police officers to share experiences and learn together.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should be consistent and comprehensive in its reporting of delays before and after Mental Health Act assessment in its places of safety.
- The provider should ensure that any disagreements between nursing staff and police officers are reported and reviewed and that joint action plans are developed which build on the existing programme of shared events and training.

Oxford Health 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
Place of safety. Ashurst ward. Littlemore Mental Health Centre.	Littlemore Hospital
Place of safety. Vaughan Thomas ward	Warneford Hospital
Place of safety. White Leaf Centre, Aylesbury.	Buckingham Health and Wellbeing Campus.

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.

There appeared to be good adherence to the Mental Health Act and the Code of Practice. Mental Health Act documents were all in order. There was evidence in records and through our observations that patients on section 136 or 135 were given an explanatory leaflet and had their rights explained. This was recorded on a specific form. However one patient told us that nobody explained his rights, while others said they were too confused to remember.

Training in the Mental Health Act was provided at the beginning of someone's employment and some staff said it was repeated annually. Some staff said they had been given updates on the new Code of Practice or on section 136, while others were not sure. Policies had not yet been updated with the 2015 Code of Practice (CoP). The new CoP was on the trust's intranet.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training in the Mental Capacity Act as part of their mandatory training and knew where to go for further advice if necessary. There was no evidence of formal capacity assessments being undertaken by staff in the places of safety. However, capacity and consent was addressed in the Mental Health Act assessment conducted by medical staff and the approved mental health professional.

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 places of safety were clean and safe for patients and staff. There were closed circuit television cameras in each place of safety.
- The Ashurst place of safety appeared uninviting, and not in a very good condition. The lighting could not be dimmed. There were significant marks (possibly from kicking) low down on the entrance/exit door. There was no shower. The Ashurst place of safety had blind spots, but these were mitigated by a mirror on the ceiling and by the policy that anyone in the suite was on continuous within-eyesight observation. The other places of safety were well maintained and light.
- Furniture on all sites was of a design which should not cause injury and was comfortable and well maintained. Bedding was generally of the non-rip style. There was air conditioning or ventilation and a comfortable room temperature. A clock could be viewed, although the clock in Amber was not secured to the wall. There was no direct access to outside space from any of the places of safety, and it appeared that potential ligature points had been minimised.
- Emergency resuscitation equipment was available from the attached wards. The lights in the Vaughan Thomas place of safety were dimmable, so that someone could sleep while still being observed.
- In all three areas visited the places of safety could be sealed off and managed safely.

Safe staffing

- Staffing for the three units visited was provided by the attached wards from the ward establishment. Each ward staffing establishment had been increased to facilitate staff being released to staff the place of safety. We heard from managers and front-line staff that staff would move from other wards if there were shortages which could have an impact on the places of safety. As a result the places of safety would almost never be closed for that reason. However, we were told that if the staffing level was judged at ward level to be unsafe, this could lead to the place of safety being closed. This would be escalated to senior managers.
- Although there were three places of safety attached to wards at the White Leaf Centre in Aylesbury only two of these would be open at any one time.
- The police notified the ward by telephone when they were bringing someone in. This meant that the nurse would be able to prepare the room and check records for any available information. The patient would be welcomed by a registered nurse and health care assistant. The police would stay to handover information about the patient and would leave after approximately 30 minutes to an hour, depending on the nurse's assessment of safety and risk.
- If the patient remained calm, the continuing care and observations would be provided by a health care assistant until the arrival of the approved mental health professional and medical staff to carry out a Mental Health Act assessment. Information and observations from this initial time in the section 136 suite would be shared with those carrying out the Mental Health Act assessment. Staff would normally rotate each hour.

Assessing and managing risk to patients and staff

- There was no template for risk assessment in the places of safety. However, there was a brief risk assessment carried out on admission by the registered nurse. We saw that these assessments had been completed.
- Baseline physical assessments were conducted by nursing staff on admission. We observed one newly admitted patient, who had complained of an infection, having a number of physical health checks done. Junior medical staff became involved if there were physical health issues which needed attention, or emergency prescribing.
- Staff working in the place of safety had alarms to alert colleagues to any concerns.
- Staff had access to electronic records on patients referred to the place of safety.

Good

Are services safe?

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

- The policy was that the police officers would not leave if the person was not calm. However, staff told us of several incidents when the police insisted that they should leave when the person had yet to calm down. On one occasion at Ashurst Ward, the police kicked at the external door from inside the place of safety. The nurse had not facilitated them leaving as she had not deemed it safe for them to do so.

Track record on safety

- We reviewed a spreadsheet of incidents relating to section 136 over a period from October 2014 to June 2015. There were 23 recorded incidents, although eight of these were not associated with the use of section 136. The remaining 15 reports covered clinical incidents, a medication error, communication problems with the police and ambulance service, and two separate incidents on Sapphire ward. In these incidents two patients (one of whom was a woman) who were in the place of safety appear to have gained unsupervised access to the attached ward, leading to possible risk to themselves and others.
- There had been 12 incidents which had been given a risk rating of moderate or high in the previous 12 months. Information about these incidents was fed into the problems in practice meetings, which were multi-agency meetings, well attended mostly by relatively senior staff. We saw evidence in minutes of discussions about incidents and heard from staff that the learning from local incidents was discussed in team meetings.
- There was one incident where a firearm was found on a patient after the police had left the unit. The police said that they had already searched him. This incident was followed up by an investigation and joint learning for police and health staff. A metal detector has now been supplied to aid searches.
- Another incident involved a washbasin being ripped off the wall and used by the patient to break a window and escape. This was investigated as a serious untoward incident and learning was shared between agencies.

Reporting incidents and learning from when things go wrong

- There were monthly multi-agency problems in practice meetings in Oxfordshire and Buckinghamshire which discussed many shared issues between the police and the trust, including sections 135 and 136. Any significant incidents were reported to the meeting and investigated. Staff told us that findings from investigations were fed back to them in team meetings. One staff nurse told us she had attended the problems in practice meeting to discuss an incident she had been involved in and found it helpful.
- We heard from one staff nurse that communications with the police 'could be better', particularly over how long staff would like them to stay, and that it would be useful to have joint working sessions. We understand from senior managers that a one day workshop for police and health staff has been planned for November/ December 2015.
- Staff told us that some incidents, for example, lengthy waits for assessment or delays in finding a bed for admission, were not routinely reported. However, we were also told that anything outside of the multiagency protocol would be reported as an incident. Some staff said that they knew that they could report an incident while others appeared not to be aware of this.

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

- In almost all cases someone brought into the place of safety received a Mental Health Act assessment with two doctors and an approved mental health professional. It is not a requirement that someone on section 136 receives a full Mental Health Act assessment. They could have a mental health assessment from one doctor and an approved mental health professional (paragraphs 16.25-16.27 of the Code of Practice.) However, staff told us that that rarely happened.
- All reports were directly entered or scanned into the trust's electronic records system.

Best practice in treatment and care

- The places of safety had a standard operational procedure (SOP) which clearly set out the many steps from initial telephone notification of someone being brought in to the place of safety to the person's discharge from it. We observed this procedure being followed with sensitivity and kindness with a new admission to the Ashurst place of safety. The nurse kept the patient informed of what would happen and expected timescales. This SOP was set out on a poster in the Vaughan Thomas place of safety office, and appeared to comply with the Code of Practice.
- The trust had a place of safety booking form which was used from the time of arrival. It contained information about the patient, information from the police about the incident, time of arrival and departure of the police officers, searches, explanations of their rights, and initial nursing assessment, and details of the Mental Health Act assessment.

Skilled staff to deliver care

- Staff told us that they received annual training in the prevention and management of violence and aggression including verbal de-escalation, and search procedures. They also had informal, on-the-job and shadowing training in section 136. In Vaughan Thomas ward we heard from the deputy manager about an innovative way of providing training on section 136 throughout the team, using presentations, role play and pocket sized information leaflets. Staff on Vaughan Thomas area were also trained in dual diagnosis and to recognise the signs of alcohol withdrawal. Some staff were trained to use the Clinical Institute Withdrawal Assessment of Alcohol Scale.
- Occasionally there would be a need to restrain someone in the section 136 suite. This could be seated restraint, but would sometimes be on the floor. Very rarely this would entail very brief prone restraint. Staff told us that such incidents were always reported within the ward restraint records.
- We were told about a planned training event in December 2015 for frontline health staff and police officers to share experiences of section 136 and places of safety and learn together.

Multi-disciplinary and inter-agency team work

- Both counties had problems in practice meetings, attended by Mental Health Act office staff, street triage manager, 136 suite staff, specialist registrars, police, and the out-of-hours approved mental health professional team. We heard from senior managers that generally there were good working relationships at the senior level. However, there had been some incidents of significant disagreement between the police and staff in the place of safety about whether the police officers could leave, resulting in at least one incident being reported. We were told by the ward manager on Ashurst there had been an incident in which the police officers wished to leave and were kicking at the door. The multi-agency partnership agreement states that police officers should normally not be expected to stay in the place of safety for longer than 30 minutes. We also heard that police had sometimes arrived at White Leaf Centre without prior notification. Although staff generally felt supported by police officers, one member of staff told us that they sometimes felt intimidated by police presence.

Adherence to the Mental Health Act and the Code of Practice

- There appeared to be good adherence to the Mental Health Act and the Code of Practice. Mental Health Act documents were all in order. There was evidence in records and through our observations that patients on section 136 or 135 were given an explanatory leaflet and had their rights explained. This was recorded on a specific form.

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.

- Training in the Mental Health Act was provided as part of the induction programme. Staff said this was repeated annually. Some staff said they had been given updates on the new Code of Practice or on section 136, while others were not sure. Policies had not yet been updated with the 2015 Code of Practice (CoP). The new CoP was on the trust's intranet.

Good practice in applying the Mental Capacity Act

- Staff received training in the Mental Capacity Act and knew where to go for further advice if necessary. Capacity and consent was addressed in the Mental Health Act assessment conducted by medical staff and the approved mental health professional.

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 kind and respectful interactions between staff and patients.
- Patients in the places of safety would be placed on observations (within eyesight) with recording of behaviour and mental state every 15 minutes.
- One patient told us that he had been given a blanket and pillow so that he could go to sleep, but not given a sheet or pillow case. Another patient said that he had felt safe there and that the staff were respectful, polite and caring.
- One person, currently in the place of safety on section 136 said that the staff were totally professional and that he had been treated well. Another told us that the first few members of staff who looked after her did not talk to her or provide any reassurance. However another member of staff who came later was kind and friendly.
- Patients brought into the suite were given an opportunity to make a phone call, using the unit phone if necessary. Families were not allowed to come into the suite but could deliver clothing or other requested items.
- Staff told us that a male member of staff would never be left to look after a woman in the 136 suite.
- Anyone admitted to any of the places of safety would be offered food and a hot or cold drink. We observed a patient being offered coffee and a sandwich. The unit had spare clothing if needed.
- In Vaughan Thomas place of safety the area had recently been painted. There was a shower for patient use. Patients in Vaughan Thomas and in Amber were able to listen to the radio or music and they had access to books or magazines. However, one patient who had come through the suite said that he was not asked if he would like to listen to the radio. He was also told by the police that he would be able to smoke when he got there and was frustrated when he discovered that he could not.
- On Vaughan Thomas male patients awaiting admission after their assessment were encouraged to go onto the ward for meals or to go into the garden. However, this was not possible for women as it was a male ward.
- Approved mental health professionals confirmed that staff in the places of safety treated patients with kindness and courtesy and one patient in the Vaughan Thomas place of safety confirmed that it was a clean and well-decorated environment where he felt safe.

The involvement of people in the care they receive

- Mental Health Act assessments took into account, as far as possible, patients' perspectives and information received from nearest relatives.
- Patients were provided with information on mental health, housing and were signposted to local services and helplines. They were also advised on how to complain if they wished.
- On Vaughan Thomas place of safety there was a clear and helpful information leaflet "Welcome to the Warneford 136 suite" which encouraged patients to ask questions and contribute to their assessment. On Amber ward it appeared that patients were not given information about the use of CCTV cameras.

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

- We reviewed 16 care records. There were some delays in organising an assessment and sometimes delays in finding a bed for those who were to be admitted.
- There was an escalation process to senior management if there was no place of safety available to receive someone on a section 136.
- Between August 2014 and July 2015 there were 538 people brought into one of the health-based places of safety. Of these, 157 (30%) were admitted on a section of the Mental Health Act or informally, and the rest were discharged.
- In July 2015 the following figures were recorded in the minutes of the Oxfordshire problems in practice meeting. Four people were detained on section 135, one person detained on section 136 and taken to A&E, and 26 people detained on section 136 to a health-based place of safety. Of these 31 people, 10 were detained on section 2, three on section 3, none admitted informally, and 18 discharged.
- In Buckinghamshire the following figures were recorded in problems in practice meeting minutes. In September 2014 there had been 28 people detained on section 136 and brought to a health-based place of safety, one taken to a police station, and two taken to A&E. Following assessment, two were detained on section 2 or 3 of the Mental Health Act. In July 2015 there were 13 brought to a health-based place of safety, and none to either a police station or A&E. Following assessment, three were detained on a section of the Mental Health Act.
- There were also some differences in figures provided by the police and those provided by the trust on the numbers of people taken into police custody on section 136, although any instances of police custody were reported to the multi-agency problems in practice meetings. The reasons for police custody were not recorded in the problems in practice minutes, but we were told by managers and front-line staff that the only reason for using police custody was because of the risk of violence and the numbers were now very low. This was in accordance with the Code of Practice, paragraph 16.38. . The police told us that over a rolling 12 months period there had been a 67% reduction in the use of police custody.
- In Oxfordshire we were told by trust managers and a senior police officer that the street triage service (which operated from 18.00 to 04.00) had significantly reduced the number of patients being brought in on section 136. This was because the service was able to intervene, signpost and arrange an alternative outcome at an early stage. This service had started in July 2014. The street triage team had access to the trust's electronic records at the police station.
- In Buckinghamshire the street triage service operated from 17.00 to 04.30 and started in June 2015. We were told it had also reduced the number of patients being brought in on section 136. For example there had been 30 patients detained on section 136 per month around one year ago and in July 2015 the figure was 13. There had been a rolling 12 month reduction of 75%. As in Oxford, the street triage team had access to the trust's electronic records at the police station. Senior police confirmed that there had been a rolling year decrease in section 136s of 14% in Oxfordshire and 22% in Buckinghamshire.
- Although the local policy was that patients should be brought to the place of safety by ambulance, we were told by one patient that he had come in by police car. The patient who came in on the day of our visit was brought in by ambulance.
- The local target time for the start of Mental Health Act assessment was two hours, but this was not achieved on every occasion. Approved mental health professionals told us that the majority of assessments were completed within four hours. This included during the night, but sometimes could take up to 12 hours. There could be delays before assessment and after assessment if there were difficulties in finding a bed. A member of medical staff who responded to section 136 during the day told us that he can attend quickly during office hours. The average length of stay in the place of safety was approximately six hours. When it took longer than four hours we were told an incident form was completed and reasons would be recorded, although we did not see any of these records.

Are services responsive to people's needs?

Requires improvement

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

- In Oxford we were given information on four current inpatients who had been subject to section 136 recently. Two of these patients had remained in the place of safety overnight as there were no beds available at the time. A third patient stayed in the place of safety from 20.00 on a Sunday evening until 15.30 the following day for the same reason.
- We examined 11 section 136 booking forms in Buckinghamshire, and noted the time of detention by the police, the time of arrival at the place of safety and the time of the outcome of the Mental Health Act assessment. Of these 11 patients, two were admitted informally, and the outcome and timing of one was not recorded. The remaining eight were discharged. The time between arrival at the place of safety and the completion of the Mental Health Act assessment varied from two and a half hours to twelve and a half hours. Seven of the 10 patients spent more than six hours in the place of safety.
- The duty manager took on the responsibility of finding a bed if the outcome of assessment was admission. The aim would be to find a bed within 24 hours.

The facilities promote recovery, comfort, dignity and confidentiality

- With the exception of Amber ward, there were separate entrances into the places of safety we visited. The entrance to the place of safety on Ashurst ward was visible from the main area of the ward, potentially allowing those being brought in to be seen from the ward. This could breach confidentiality. The main place of safety room was not visible from the ward.

Meeting the needs of all people who use the service

- All ages were accepted in all the trust's places of safety. We were told that in recent months the youngest patient to use the service had been 15 and the oldest 85. The only exclusion criterion was significant risk of violence. If a patient was physically unwell they would be taken to accident and emergency first and then brought to the place of safety after any treatment.
- We had mixed reports about the involvement of the child and adolescent mental health service (CAMHS) with any young person admitted to the place of safety. We were told that a CAMHS consultant would always be involved in the Mental Health Act assessment but that only occasionally would other members of the CAMHS team attend.
- The places of safety across the trust were sometimes used for other purposes. They had been used for seclusion for ward inpatients at times. However we were told that it had very rarely happened that an alternative place of safety was not available. This appeared to contradict information on instances of unavailability from the police.
- On Vaughan Thomas we found that two informal inpatients who had recently come through the place of safety had not come in on section 136 but had been assessed elsewhere and stayed for some time in the suite while waiting for a bed. There was no record that these patients had consented to this.
- Although Vaughan Thomas and Amber places of safety had access to a radio or music this was not the case on Ashurst. There was no radio or television even though some patients could spend a long time in the unit.
- We were also told about a new scheme in Aylesbury for 33 people who presented frequently to A&E, street triage or places of safety. In this scheme independent organisations use an assertive outreach model to provide support, housing advice, financial and welfare benefits information, and advice on drugs and alcohol. The team anticipate that this will have an impact on section 136 referrals, but it was too early to have any figures.

Listening to and learning from concerns and complaints

- Vaughan Thomas place of safety had recently developed a feedback form for patients who had been through the section 136 suite. This asked them about their experience, whether they were treated with dignity and respect and what could be improved upon. As this was a very recent development we were not able to see any completed questionnaires.
- The trust patient information leaflet "Welcome to the Warneford 136 Suite" had a section on concerns, comments and complaints and gave advice on speaking to a member of nursing staff or contacting the Patient Advice and Liaison Service.

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 said they felt committed to this work and most said that they enjoyed it.

Good governance

- There was an overarching high level partnership agreement with other agencies, which contained a degree of operational guidance and was informed by the Mental Health Act, The Code of Practice, Police and Criminal Evidence Act (PACE), and Royal College of Psychiatrists' guidance. The Standard Operating Procedure put this agreement into practice within the places of safety. Team leaders and their managers attended problems in practice meetings and fed back lessons learned to their teams.

Leadership, morale and staff engagement

- Most staff told us that they felt listened to, and felt able to raise concerns. Fourteen of the 15 members of staff we spoke to said that they received regular supervision and that morale was reasonable.
- Most staff said they enjoyed their job and felt supported by their managers, although two said that support from managers could be variable, and sometimes managers did not understand the pressures they experienced in the place of safety. They told us that their managers were generally good at cascading information.

Commitment to quality improvement and innovation

- We were given a copy of the Oxfordshire Declaration on its Mental Health Crisis Care Concordat (CCC), signed by 13 organisations, and found many references to initiatives linked to this in problems in practice meetings. We were also given a copy of the Buckinghamshire Crisis Care Concordat action plan, which was comprehensive and clear. However, we heard from the police that CCC meetings had been less well attended recently.
- The deputy manager on Vaughan Thomas in Oxford carried out some auditing of booking forms to check for accuracy and completeness. As a result there had been some gradual improvement in the completion of these forms.
- The two street triage services were working closely with places of safety and were a key part of the trust's crisis services.
- At the time of our inspection there appeared not to be any comprehensive and multi-agency collection and analysis of significant data, including time of police detention, arrival at place of safety, Mental Health Act assessment, involvement of street triage, outcome and any delay in finding a bed. The absence of this collation and analysis prevented further understanding of any patterns or trends. This was one of the actions in Buckinghamshire CCC action plan from June 2015.