Requires improvement

Cornwall Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Date of inspection visit: 13 - 16 April 2015
Date of publication: 09/09/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ866	Bodmin Hospital	Home Treatment Team - east	Boundary Road Bodmin North Cornwall PL31 2QT
RJ863	Longreach House	Home Treatment Team – west	Longreach House Camborne Redruth Community Hospital

Summary of findings

RJ863	Longreach House	Place of Safety (136 suite)	Longreach House, Camborne Redruth Hospital

This report describes our judgement of the quality of care provided within this core service by Cornwall 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 Cornwall Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cornwall 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?	**Good** 
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 gave an overall rating for the crisis service and place of safety of **requires improvement** because:

- There was a lack of physical health assessments in the home treatment teams (HTTs).
- There were crisis plans missing from some care plans in both HTTs.
- There was limited integrated multidisciplinary work in the HTTs.
- There was no permanent management in the HTT west team, since the retirement of the previous manager.
- There were sometimes delays in transfer from the place of safety / section 136 suite caused by difficulties in finding a placement.
- There was limited evidence of monitoring, auditing and evaluation of the services being delivered in both the place of safety suite and HTT teams.

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:

- Staffing on both the acute wards in Redruth had been increased by one health care assistant on every shift in order to provide safe staffing levels as needed in the place of safety suite. Within the home treatment teams there were appropriate staffing levels in a stable staff team.
- Risk assessments were of a good standard.
- Staff had a good awareness of safeguarding policy and processes and had received training.
- The place of safety suite was spacious, well maintained, fit for purpose and in line with Royal College of Psychiatrists' guidance (2013).
- Patients who had used the service said that they felt safe there

However:

- There was no rapid access to a psychiatrist in the HTTs.
- Compliance with statutory and mandatory training was mixed with compliance being better in the East team as opposed to the West.

Are services effective?

Requires improvement 

We rated effective as **requires improvement** because:

- Within the Home Treatment Teams (HTTs), the majority of care plans did not include sufficient details to ensure the safety of patients, for example in relation to crisis/relapse plans.
- We saw some up-to-date physical health care plans, for example in relation to lithium or clozapine medication, but many others were either absent or out of date.
- There was a lack of multidisciplinary input within the HTT, which had no psychology input and of greater concern was the lack of dedicated medical input to the HTT teams.

However:

- Within the place of safety service there had been an increase in the number of people brought into the unit by the police and a consequent reduction in those being taken to the police station.

Are services caring?

Good 

We rated caring as **good** because:

Summary of findings

- We observed positive one-to-one interaction between patients and staff. Carers and patients mostly spoke highly of staff. Staff demonstrated a good understanding of their patients.
- Within the place of safety service patients told us they felt cared for.
- HTT staff had developed relationships with food banks and had food boxes available in the office to take out if patients did not have food.
- Staff in the place of safety unit bought clothes in a local shop for anyone who needed them.

However:

- The majority of care plans did not contain people's own words.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Within the HTTs patients and staff highlighted the lack of access to dedicated sessions from other members of the multi-disciplinary team and its possible effect on team responsiveness and access to appropriate treatment.
- There were only three staff on duty overnight for the whole county, and staff could find this very pressurised.
- Quite frequently there were no available beds in the trust for acute admissions. This would have a significant impact on the work of the HTTs and place of safety.

However;

- The place of safety service now responded to people of all ages and provided telephone advice to police officers.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- There were limited governance arrangements, particularly in the west team, where all those in management roles were in acting positions.
- HTT west had no permanent management in post at band 7. At the time of the inspection, the service line director had been in this post for six weeks, the clinical lead had been covering a vacancy for HTT west for six weeks. The team leader of the east team had started in post quite recently and then had started, in addition, acting into the west team leader post.
- There was no multi-agency performance review or audit in the place of safety unit.

However;

Summary of findings

- Staff knew how to use the trust's whistle-blowing process. Staff told us that they felt able to raise with the trust any concerns they might have about patient care or treatment.

Summary of findings

Information about the service

- The Home Treatment Teams (HTT) service was split into two teams covering the east and west of Cornwall. It was managed as part of acute inpatient services. Both teams were located on the same sites as acute inpatient wards in Bodmin and Redruth and acted as gatekeepers for admission into these wards. The clinical model was based on each consultant having their own geographical area and looking after patients across the pathway from acute inpatient admission, input from the HTT and community mental health team care. The service had approved mental health professionals integrated into the team. The service operated 24 hours a day. The day shift was 8am to 8pm and provided crisis services and early discharge for working age adults and older people with functional mental ill-health. Overnight the much smaller HTT worked with all ages and patient groups across Cornwall, particularly on the provision of Mental Health Act assessments, and provided telephone advice to other health professionals.
- The Longreach place of safety suite (136 suite) was the sole suite for Cornwall, located alongside two acute admission wards (Carbis and Perran) in Redruth. The suite was managed as part of the acute inpatient service. The suite was staffed when necessary by staff from the two wards and could accommodate up to two patients.

Our inspection team

Chair: Michael Hutt**,** Independent Consultant

Head of Inspection: Pauline Carpenter, Head of Hospital Inspection, CQC

Team Leader: Serena Allen, Inspection Manager, CQC

The team that inspected this core service included two CQC inspectors, two Mental Health Act reviewers and two specialist advisers with backgrounds in social work.

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 two home treatment teams (HTTs) at their bases and the place of safety (136 suite), and looked at the quality of the environment.
- Observed 13 HTT patient interactions on inpatient wards or in people's own homes.
- Spoke with 11 patients who used the HTT services about their care and experiences.

Summary of findings

- Observed two assessments on inpatient wards for referral to the HTT.
- Spoke to two patients on the inpatient wards who had been brought into the place of safety by the police under section 136 of the Mental Health Act.
- Spoke with the managers or acting managers for each of the services and senior managers within the organisation.
- Spoke with 17 staff working in the home treatment teams.
- Discussed the place of safety with a senior member of Devon and Cornwall Police.
- Spoke to the trust's manager of approved mental health professionals (AMHPs).
- Spoke to one bed coordinator.
- Attended a nursing handover.
- Looked at 20 care and treatment records.
- Carried out a specific check of medication management in the home treatment teams.
- Looked at a range of records and documents relating to the running of the service.
- Reviewed minutes of the section 136 meeting, and the special section 136 Isles of Scilly meeting.

What people who use the provider's services say

- We spoke to eleven people who were using the Home Treatment Teams and most spoke positively about the service. They described the staff as caring, pleasant, respectful and responsive, and said that staff involved them in decisions about their care. One patient told us that the team had helped her considerably including increasing her confidence. They also said they knew how to make direct contact or how to make a complaint if they wished. Some said they had seen a number of people, in one case four different members of staff in one week, but that they did not mind. They told us that sometimes staff would be in a hurry.
- Carers we interviewed said that they had been able to make contact with the service when they needed to.
- Two people who had used the place of safety said that they had little recollection of their time in the unit, but had no complaints. One concern about police actions was passed onto the police. Another person who had come into the suite said it was a safe haven and that the staff were kind and helpful.

Good practice

- Staff in the HTTs and inpatients wards were able to provide telephone advice to police officers considering a section 136 intervention.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that physical health assessments, crisis plans and care plans reflect patients' needs and contain specific plans to manage or mitigate any risks. Care plans must ensure they meet the patient's individual needs and ensure their welfare and safety.

Action the provider SHOULD take to improve

- The provider should evaluate, monitor or audit the assessment process within the place of safety suite, including length of stay, delays, and admission into an acute ward.
- The provider should work with its multi-agency partners, including the police, ambulance service and commissioners, to review how it assesses and monitors the service it delivers in the place of safety suite.

Cornwall 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
Home treatment team – east	Bodmin Hospital
Home treatment team – west	Longreach House, Redruth
Place of safety / section 136 suite	Longreach House, Redruth

Mental Health Act responsibilities

Adherence to the Mental Health Act

- There were no detained patients on the caseloads of the Home Treatment Teams (HTTs).
- In relation to MHA assessments we examined the admission pathway for one particular patient who had been admitted on section 4 of the MHA during the night several days earlier, with the plan that she would be assessed the following morning for a section 2. The reason for the section 4 was fully documented in the Approved Mental Health Practitioner report. However this patient was not seen by a consultant psychiatrist until the third day for a range of reasons, and therefore remained on section 4 for a longer period of time than is considered good practice.
- Although there was generally good adherence to the MHA, there were two significant issues which affected this degree of adherence. There were a number of instances of there being no second doctor on the rota to attend MHA assessments out-of-hours. In addition we were told that AMHPs could sometimes find it difficult to complete an application for admission because no bed could be identified, sometimes for a lengthy period of time.
- Between October 2012 and September 2013 the East Home Treatment Team carried out 281 MHA assessments. Of these approximately 45% were admitted for acute inpatient care while a further 12% were taken directly onto the HTT caseload. More recent figures were not available.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff reported that they had undertaken Mental Capacity Act e-learning and we saw records to show that this was the case. We found evidence to show that MCA procedures were followed.

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

Summary of findings

Please see above summaries.

Our findings

Safe staffing Home Treatment Teams

- Both teams had good staffing levels. The teams comprised mental health nurses, support, time and recovery workers, senior practitioners and social workers.
- There were some forthcoming vacancies; however plans were in place to address these as they occurred. The vacancies were to be covered by band 5 staff members acting into a band 6 post and then the vacant band 5 post would be covered by a bank member of staff on a short term contract.
- We were told and saw evidence that when staff were sick, the shortfall was covered by bank staff who were usually other community based staff from within the trust. There was no use of locum or agency staff to cover shortfalls in staffing.
- There was no rapid access to a psychiatrist. The HTTs did not have dedicated sessions from a consultant working with them (a Royal College of Psychiatrists' standard).The arrangement was that patients were allocated to their geographical consultant. This caused delays in treatment and prescribing in some cases. Although we were told that the consultants were supportive and responsive to requests for help, the absence of dedicated sessions meant that there was little medical leadership or proactive involvement in innovation, service development or review.
- Staff received induction and mandatory training, although we saw evidence to suggest that compliance with statutory and mandatory training was better in the east team.. For the west team, there were 38 statutory and mandatory subjects to be covered. Seven core subjects were 100% completed, nine core subjects were 90% to 99% completed and six core subjects were 80% to 89% completed. An example of percentages completed as per subject was care planning. Out of 18 staff needing to complete this, 94% had. In relation to risk incident reporting, out of 22 staff needing to complete this, 64% had done so. There was a range of safeguarding training available which included PREVENT (preventing radicalisation) and domestic violence. Out of 18 staff needing to complete domestic violence safeguarding, 33% had done so, and for PREVENT 24% had completed. Much of the training appeared to be e-learning.

Assessing and managing risk to patients and staff

- We saw evidence in the notes and observed face-to-face assessments to show that staff undertook a risk assessment of every patient at initial assessment and updated this regularly. We observed support, time and recovery workers identifying a risk issue and taking it back to the team.
- In some cases we saw that crisis plans were not being formulated. Where they had been in place, most were of a generic nature and were not person-centred. For example: "On-going assessment and formulation while under the care of the HTT – to be completed by the transfer of care to his care coordinator." This statement was of a 'cut and paste' nature and there was no evidence to show that the prompt had been acted upon, reviewed and a crisis plan completed in a person-centred way. This was the case in three care records of the seven we reviewed.
- We observed interactions to show that staff responded promptly to sudden deterioration in people's health and initiated contact and treatment accordingly.
- Staff were trained in safeguarding and knew how to make a safeguarding alert and did this when appropriate. We found evidence in care records and observed staff in handovers sharing information about safeguarding concerns.
- We observed on the day of our visit good personal safety protocols including lone working practice. Staff had access to each other's diaries. Staff used 'safe words' to alert colleagues to moments of risk and danger.
- There were no concerns found during our visit in relation to medicines management practice. This was in part due to the fact that neither team had any people on medications that required dispensing on a prolonged or

Good

Are services safe?

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

frequent basis. Where this was the case all records were compliant. There was no identified clinic area and medicines would be stored in a locked cupboard in the office area. The west HTT kept their medications within a locked safe within a cupboard and we considered this to be appropriate and safe practice

Reporting incidents and learning from when things go wrong

- We saw evidence to show that staff fully understood safeguarding procedures, reported incidents where necessary, and knew how to use the electronic system in order to do so.
- Staff told us that in the event of a serious incident they were de-briefed and supported. The west team also had access to regular group supervision that was facilitated by a psychologist where such issues would be discussed. However, a minority of staff said that the team's processes for de-briefing could be improved.
- Learning from incidents was limited and a minority of staff told us they heard about an incident but did not hear about the outcomes or about lessons to be learnt from it. Currently, due to staff changes there were limited team meetings and limited scope to learn and share with all members of the HTTs. Managers were aware of and attempting to address this issue.

Health Based Place of Safety 136

- Staff had access to electronic records for care plans and risk assessments. They also carried out a risk assessment within the unit.

Safe Staffing for Health Based Place of Safety 136

- There had been a significant increase in staffing on the wards so that staff could be released as necessary to the place of safety/136 suite. Each of the two wards had increased their staffing by one health care assistant on every shift. Staff would work in the unit for up to two hours and then swap with other ward member of staff rather than stay in the unit for a prolonged period of time.

Safe and Clean Environment for Health Based Place of Safety 136

- The environment was spacious and well-maintained, with good lines of sight and CCTV cameras which were linked to the unit office. There were minimal ligature points. For example the bedroom door hinges posed a potential risk, but the risk was mitigated by the CCTV cameras and staff observations. The staff had immediate access to ligature cutters and resuscitation equipment.
- Police had a separate entrance to the unit so that patients did not have to come in via the main ward entrance.
- Any medication brought in by a patient was placed in a locked cupboard within the place of safety suite.

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.

Summary of findings

Please see above summaries

Our findings

Assessment of needs and planning of care

- Assessments of inpatients who were referred for home treatment team care were being completed in a timely manner. We observed such assessments by home treatment staff and found them to be comprehensive, taking around an hour to complete.
- Care plans were developed with contributions from people who use services and they would generally be given a copy of their care plan. All four care plans which were carefully reviewed contained review dates.
- Care records contained up to date information. We observed that once needs were identified, there was no evidence to show that detailed treatment plans were being completed. For example we observed in the west team two records out of the six we reviewed where patients had been identified as at risk of suicide or self-harm, but the care plans did not address how staff should respond to this risk in any detail.
- There were no crisis plans present in some of the records we reviewed and where they were present most of the time they were standardised and not individualised. We were told that crisis plans should be formulated prior to the person who used services experiencing a crisis, and that the allocated care coordinator was responsible for ensuring this plan was in place.
- We were also told that measures were being taken to address this and that HTT staff were completing crisis plans once transfer from community mental health teams (CMHTs) to HTT had taken place. However, on visits to people who used services' homes we saw four care plans that contained crisis/contingency plans that had been agreed with those involved. It is NICE guidance that people using mental health services who may be at risk of crisis are offered a crisis plan.
- All information needed to deliver care was stored securely and available to staff when they needed it. The trust operated an electronic records system available to inpatient and community staff.

Best practice in treatment and care

- We observed only one person on the east team who required assistance from the HTT to take their medication. We did not observe any prescribing guidance in either team as there were no people needing any medications to be provided by the HTT staff. All prescribing was done by the patients Responsible Clinician.
- If someone had already been referred to a psychologist they would continue to receive psychological therapies from that psychologist. The HTTs did not have a psychologist attached to their teams, but could refer to other services, for example for dialectical behaviour therapy.
- Both east and west teams had social work staff who were also approved mental health professionals (AMHPs) allocated to them on a full time basis. Issues surrounding employment, housing and benefits would be addressed by the HTT staff or by their care co-ordinator in the community mental health team.
- There was some evidence that staff were aware of the importance of addressing physical health needs, but this was poorly recorded. We were told that upon transfer to the HTT someone's physical health details would be requested from their GP. We saw evidence to show that this was not always the case. Where this information was present, quite often it was out of date. Outside of this process, staff had not, on most occasions, addressed the physical health needs of people and there were no physical health investigations being undertaken and or documented. The exception to this was the team's role in monitoring the possible effects of clozapine which appeared to be consistent and thorough. In addition we witnessed some monitoring of physical health on home visits. The teams also had access to two health care assistants/ technicians who were trained to carry out ECGs and phlebotomy in people's homes.
- The team leader had initiated clinical audit within both teams. However, this did not involve other clinical staff. This was because the team leader was new in post and was establishing systems around audit and outcomes.

Skilled staff to deliver care

- The substantive HTT team staff were nurses and Social Workers. Both teams lacked access to the full range of mental health disciplines required to care for the people

Are services effective?

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using their service. There was no direct input from occupational therapy, psychologists, and medical staff. People who were receiving psychological or occupational therapy did so as a result of having already been referred by an inpatient ward or their GP. HTT staff could request and refer for these additional services but staff and patients told us that they had experienced delays in doing so. Medical cover was provided by the geographical consultant for the person using services. However, both staff and patients said that this also caused delays in treatment and access to outpatient appointments. For example, one person told us that they had to wait for three weeks for a prescription change.

- We reviewed records that showed that staff were receiving managerial supervision. The west team were receiving group supervision facilitated by a psychologist. Staff in both HTTs described receiving much support from their teams and managers. The team manager had recently developed a supervision spreadsheet.
- We were told that the night shift could be particularly stressful with demands for the small team to find beds, find appropriate adults, and respond to urgent and non-urgent concerns from a wide range of people.
- Staff in the east had regular staff meetings and the minutes from these were shared with the west team. However we were told that there had been no team meetings in the west team since August 2014 as a result of the retirement of the previous manager and the temporary management arrangements.
- We reviewed records to show that staff in the east team were receiving specialist training including cognitive behavioural therapy and solution focused training. Staff in the west team said that they did not have access to training outside of mandatory requirements.
- There were no issues with staff performance currently and the team manager was able to describe how they would respond to performance issues.

Multi-disciplinary and inter-agency team work

- Team meetings took place regularly in the east team but only included HTT staff who were nurses, support, time and recovery (STR) workers and AMHPs. The involvement of other disciplines such as medical and psychology staff was on an as needed basis and was infrequent.
- We observed a staff handover meeting in the west team. Staff were professional and shared information around people's care and treatment.
- Staff told us that they received the right information most of the time when people were transferred between teams and we observed through care records that this was the case.
- There were good working links, including effective handovers, with primary care, social services, and other teams external to the organisation.

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

- We examined the admission pathway for one particular patient who had been admitted under section 4 of the MHA during the night several days earlier, with plans for her to be assessed the following morning for a section 2. The reason for the section 4 was fully documented in the AMHP report. There had been no second doctor available to complete section 2 paperwork and it was judged that it would be safer to admit her rather than delay until the following day. Once admitted this patient was seen by a junior doctor approximately 36 hours later but was not seen by a consultant psychiatrist until the third day and therefore remained on section 4 for a longer than was considered good practice. The reasons for the delay in her further assessment appeared to be that her own consultant was on leave and another consultant was unexpectedly absent.
- We also saw some MHA assessment figures up to September 2013. Of the total number of people assessed just under 45% were admitted to an acute ward and a further 12% were taken straight onto the HTTs caseload. More recent figures were not available to us.

Health Based Place of Safety 136

- The team worked with commissioners to agree increased staffing. This increase in staffing and new shared guidelines had enabled the unit to receive a higher proportion of people detained under section 136 of the Mental Health Act so that fewer people were being taken to police stations. Figures supplied by Devon and Cornwall police indicate an average of nine section 136 detentions per month during December 2014 to February 2015 to Cornwall police stations. Earlier months in 2014 had an average of around 20

Are services effective?

Requires improvement

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detentions. The police attributed this downward trend to closer partnership working and confirmed that the trend had continued, although specific figures were not available at the time of our visit.

- Police officers were usually able to leave the unit within an hour of their arrival.
- A specific policy for managing patients from the Isles of Scilly had been developed.
- The staff had developed a leaflet about section 136 rights and also gave anyone admitted to the place of safety suite a comprehensive verbal briefing.
- Staff conducted a physical health check on admission and if someone required physical health intervention they would be transferred to accident and emergency by police car or ambulance.

Good

Are services caring?

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

Summary of findings

Please see above summaries

Our findings

Kindness, dignity, respect and support

- We observed staff interactions with people who used services that were respectful, caring and supportive. We observed people who were experiencing distress and staff responded to this appropriately, by being kind and patient. Staff conducted themselves in a professional manner and were kind and respectful at all times.
- We spoke to a number of people who were using these services. Of those who were using the Home Treatment Teams most spoke positively about the service and said that staff involved them in decisions about their care. One patient told us the team had helped her significantly with her mobility and this had increased her confidence. They also said they knew how to make direct contact or how to make a complaint if they wished. Some said they had seen a number of people, in one case four different members of staff in one week, but that they did not mind. They told us that sometimes staff would be in a hurry.
- People who used the services of the HTTs spoke very highly of the staff and the support they received in both teams.
- Staff in both the east and west teams were familiar with the people for whom they were caring and were able to demonstrate their knowledge of people's individual needs.
- We observed staff involving carers in discussions and recognising their expertise. They also considered carers' needs in making appointments. This was confirmed by one carer, who added that he had been able to access staff quickly when he needed to.
- HTT staff had developed relationships with food banks and had food boxes available in the office to take out if patients did not have food.
- Staff adhered to confidentiality principles in relation to personal information and the electronic systems available to them supported this.
- Carers we interviewed said that they had been able to make contact with the service when they needed to.

The involvement of people in the care that they receive

- There was evidence to show that people had been involved in the formulation of their own care plans and people who used services told us that this was the case. People told us that they had copies of their care plans. There were however few entries using people's own words.
- We saw examples of how people's families were involved and supported in their relative's care and treatment.

Health Based Place of Safety 136

- The patients we spoke to said that they felt cared for within the suite. Staff could provide food and hot or cold drinks from the ward, and patients could have a shower if they wished. Staff would also buy clothes for a patient if necessary, using petty cash. There was a radio in both the rooms.
- Two people who had used the place of safety said that they had little recollection of their time in the unit, but had no complaints. One person had a complaint about the police intervention and this has been passed onto the police. Another person who had come into the suite said it was a safe haven and that the staff were kind and helpful.
- There would be at least one member of staff allocated to each individual in the suite. If there was a child or young person there would always be two members of staff.
- It was not possible for family members or carers to stay in the suite with their relative, but patients were able to use the telephone to contact others if they wished.
- The multi-agency section 136 working group gathered feedback about patient experiences and used that in training programmes.

Are services responsive to people's needs?

Good

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

Summary of findings

Please see above summaries

Our findings

Access and discharge

- The target for time from referral to telephone discussion with referrer was 20 minutes, and from triage to assessment was within 24 hours, or if urgent the expectations were for a quicker response.
- The case loads of the two teams varied significantly at different times. On the days of our visits the caseload of the east team was 30 and the west team was 13. However, these figures did not take into account the teams' various other roles, including liaison and assessments.
- We were told that as a result of the absence of medical input to the teams timely outpatient appointments could be difficult to arrange.
- We were told by AMHPs who take on night duty shifts and by their manager, that the night duty team from 8.30pm to 8am were under pressure, as there would normally be three staff on duty for the whole county. One member of staff would be an AMHP and would co-ordinate and attend any MHA assessments leaving two staff to field phone calls and other requests for urgent assessments.
- There were two bed co-ordinators, based at Longreach House in Redruth, but covering the whole acute inpatient service line including HTT, between the hours of 8am and 6pm. These members of staff held information about bed availability in the trust and the rest of the south west . Their responsibilities included organising transfers to and from Cornwall, and co-coordinating a weekly review for all Cornwall patients in out of area placements. This information was recorded on a spread sheet. The bed co-ordinators would always try to find a bed in the trust first before going elsewhere. However we heard from AMHPs that they expected, following a MHA assessment, to have to find a bed elsewhere and were surprised if there was a bed available within the trust. At the time of our inspection, there were 14 patients out of area attributed to the acute inpatient service line.
- We were told that there was often a shortage of beds for acute admissions in the trust and that patients needing admission were sometimes transferred out of the area. On the day of our visit the bed co-ordinator reported that there were six or seven people needing admission, with no placement yet identified, but that this was unusually high. Normally there would be two or three. There were 14 patients out of area for the acute inpatient service at the time.
- Staff in both the east and the west teams were skilled in crisis intervention and had a range of training outside of their statutory and mandatory agenda to assess people competently and quickly.
- Staff told us that they responded to a number of telephone calls from people who used services regularly throughout the day and night. Although there was a delay in taking a call during our visit, we observed one telephone call between a member of staff and a distressed person that was managed sensitively and professionally.
- We tracked the care pathway for someone in crisis and found the team were responsive, and escalated the situation appropriately to other agencies, including the police for a welfare and safety check.
- We saw examples of how both teams responded to people who did not keep scheduled appointments. Both teams were proactive in following up missed appointments.
- We observed examples of both teams negotiating alternative times for appointments, employing a flexible approach to care.
- We did not find any evidence to show that appointments were cancelled or running late by the HTT staff in either team.

Meeting the needs of all people who use the service

- The team had access to information leaflets on some mental health problems, for example managing depression.
- We were told that there were members of the traveller community and Polish community who have used the service. Recently a Polish national had been assessed with the help of a Polish interpreter.

Are services responsive to people's needs?

Good

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

Listening to and learning from concerns and complaints

- Staff were able to discuss their understanding of the trust complaints systems and knew how to handle complaints appropriately.
- At the time of admission to the service patients were normally given a copy of the PALS leaflet which explained how to make a comment or complaint. Some people who used the service confirmed that they had been given a leaflet and one told us she was making a complaint about one of the inpatient wards.

Health Based Place of Safety 136

- The place of safety service had made a number of changes to their processes in line with the Mental Health Crisis Care Concordat. The unit was responsive to people of all ages and would receive and assess children and young people as well as adults. We saw evidence of several young people having been brought into the suite in recent weeks. The only exclusions would be those who were potentially violent. Before 1 April 2015 the unit sometimes turned people away because there were not enough staff or the person had been drinking. However, in line with the Crisis Care Concordat, from 1 April the unit had been more inclusive and aimed not to turn anyone away unless they were violent. The change in criteria was confirmed by the Devon and Cornwall Police. Before taking action under section 136 of the Mental Health Act the police would sometimes consult ward staff or the home treatment team for telephone advice. The police telephoned the suite when they were on their way with someone for a MHA assessment.
- A section 136 information leaflet had been developed, including information on the right to access legal advice, as outlined in the MHA Code of Practice. Verbal information was also given to all patients.
- There were quite frequent difficulties in accessing local acute admission beds, so that those assessed in the place of safety as needing admission under the MHA or informally might at times have to wait for a lengthy period of time before arrangements for their admission were finalised. When Longreach House was closed there were over 40 acute admissions a month placed out of the county, but this had dropped to eight in January and five in February of this year The trust did not collate details of any delays, but we were told that delays could happen at times and that these could have a impact on the work of AMHPs. If AMHPs had significant problems in accessing a Section 12 doctor or ambulance or in finding a bed, they would complete an incident form.
- The unit had two rooms and could therefore admit two adults or two young people at the same time. The unit did not allow there to be one adult and one young person in the suite at the same time.

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.

Summary of findings

Please see above summaries

Our findings

Good governance

- We noted that the services had more work to do in relation to governance. The newly appointed team leader in the east team was also acting into the west team leader role and had begun to introduce governance such as quality audits around care plans, staff meetings and training records. This information was more readily available in the east than in the west due to this temporary arrangement.
- We saw evidence in records that safeguarding and clinical incidents were being reported through trust and local authority systems.
- There was some involvement of AMHPs in audit. However, we did not find any evidence to show that other non-managerial clinical staff were involved in clinical audit, or that there was regular auditing of care plans or risk assessments
- We found evidence to show that safeguarding, MHA and MCA procedures were followed. We were told about and observed through the clinical notes evidence of a member of staff in the west team having addressed a safeguarding issue outside of the county.
- The team manager had sufficient authority and administrative support. Both teams also had dedicated administrative support.
- Staff had the ability to submit items to the service line's risk register. However this was done via the team manager.

Leadership, morale and staff engagement

- Sickness and absence rates were low within both teams.
- We were not told of, and no staff reported to us, any instances of bullying or harassment.
- Staff knew how to use the trust's whistle-blowing process. Staff told us that they felt able to raise with the trust any concerns they might have about patient care or treatment.
- Morale in the east team was higher than in the west . The west team had recently lost their previous manager to retirement and were adjusting to the new managerial arrangements. The west team were without a substantive team leader while the east team leader was helping to cover the vacancy in the west . It was clear that the team leader was a strong advocate for the crisis and home treatment teams. However, the geographical and operational demands on the team leader meant that she was unable to provide regular and consistent cover to the west team. This arrangement has been in place for several weeks. The trust had endeavoured to recruit to the vacant post but had been unsuccessful.
- There were opportunities for leadership development. The west team leader had recently vacated the post and the opportunity for west team members to act into the position was offered.
- There was a good sense of team working and mutual support within the east team. However this was less evident in the west team as a result of management and leadership changes, and a period of change and uncertainty.
- We were told that there was to be a redesign of the service but that staff did not feel fully engaged in these discussions.
- Staff told us that they were open and transparent and explained to people who used services if and when something went wrong. People who used services told us that they had good relationships with the staff in both teams and trusted staff to share with them when problems occurred or things went wrong with their care and treatment.

Commitment to quality improvement and innovation

- Staff did not always feel involved in service development and told us this could affect their level of satisfaction with their job. For example, staff told us that the single point of access service was discontinued without any explanation or consultation with staff.

Health Based Place of Safety 136

- There was evidence of a cohesive multi-agency commitment to the section 136 process and the new policy and guidance. There were both peninsula and local criminal justice and health liaison meetings and a section 136 multi-agency meeting, chaired by a commissioner, which focused on the implementation of the Crisis Care Concordat, problem-solving and evaluation.

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.

- There were two people who had used mental health services who were members of this local group.
- Currently there were no shared data collection or performance indicators, but we were told that these would be developed.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services We found that the provider had not carried out assessments that reflected patients' needs or ensured safety of the patients. This included lack of crisis plans and lack of physical health assessment.