CareQuality Commission

Requires improvement 🟠

Coventry and Warwickshire Partnership NHS 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)
RYGHQ	Caludon Centre	Arden Mental Health Assessment Team	CV2 2TE
RYGHQ	Caludon Centre	Health-based Place of Safety	CV2 2TE
RYGCW	Manor Hospital	North Warwickshire Crisis Resolution and Home Treatment Team	CV11 5HX
RYG79	St Michaels Hospital	South Warwickshire Crisis Resolution and Home Treatment Team	CV34 5QW
RYGHQ	Caludon Centre	Coventry Crisis Resolution and Home Treatment Team	CV2 2TE

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Coventry and Warwickshire Partnership NHS 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 Coventry and Warwickshire Partnership NHS Trust and these are brought together to inform our overall judgement of Coventry and Warwickshire Partnership NHS Trust.

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- There was a lack of effective procedures in place relating to medicines management; medicines were consistently stored above their optimum temperature, staff did not transport medicines securely to patients' homes, and staff did not follow a range of policies and procedures.
- Staffing levels in the health-based place of safety were not sufficient to maintain patients' safety when both suites were in use, and systems were not in place to ensure clinical items were safe to use and infection control standards were maintained.
- In the Coventry and North Warwickshire team, staff did not consistently write care plans in collaboration with patients and they did not receive a copy.
- The frequency of supervision was inconsistent across all teams, and was not in line with the trust policy.

However:

- Staff in the crisis teams monitored their caseloads daily and reviewed patients' risks on each visit ensuring risk management plans were in place. Staff were aware of safeguarding procedures and followed the trust lone working policy.

- All teams managed incidents and complaints effectively, and staff received feedback and learning in regular team meetings, which had led to changes being made to make improvements to care given.
- Staff completed holistic assessments, and had considered patients' physical health needs when necessary. Teams worked effectively with each other, and had systems in place to ensure smooth transitions of care took place.
- Patient told us staff were caring and supported them when they were in crisis. Feedback was positive and we saw staff were empathetic and knowledgeable about their patients' individualised care plans.
- Teams were meeting their agreed targets and managers met regularly to discuss team performance. The majority of staff had received an annual appraisal and had received appropriate training to perform their roles well.
- Teams were generally responsive to their patients when required, although the Coventry team felt the demand for their service had increased and they had to rearrange appointments and assessments.

Summary of findings

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

Are services safe?

Requires improvement ●

We rated safe as requires improvement because:

- The health-based place of safety did not increase their staffing levels when both suites were occupied. This meant staff did not have capacity to perform other tasks and ensure they adhered to the trust observation policy safely. This could potentially put patients at risk.
- Staff did not adhere to infection control standards within the kitchen area of the health-based place of safety and chemical cleansers were not stored safely.
- There was a lack of effective procedures in place relating to medicines management in the crisis teams. This meant staff were not always storing, transporting and administering medicines safely.

However:

- Despite the crisis teams' high caseloads, effective systems were in place, which ensured staff monitored and managed them on a daily basis.
- Staff adhered to manufacturer's guidelines and ensured equipment was maintained appropriately.
- Staff assessed and reviewed patient risk on assessment on each visit. Appropriate risk management plans were in place so staff knew how to keep people safe and systems were in place to monitor this.
- Staff had good knowledge of safeguarding procedures, followed the trust lone working policy, and knew how to keep themselves safe.
- Staff reported incidents, and discussed and reviewed them in team meetings. There was evidence of changes being made because of lessons learnt from incidents.

Are services effective?

Requires improvement ●

We rated effective as requires improvement because:

- Apart from the South Warwickshire team, staff did not write care plans for their patients. This meant patients did not have written information to reference regarding their plan of care despite receiving verbal information at the time of their visit.
- Not all staff received regular supervision in line with the trust policy. The Coventry crisis team, the health-based place of safety and the Arden mental health acute team fell short of these standards.

However:

- Staff completed and updated holistic assessments and developed appropriate treatment plans from their findings. Staff undertook physical health tests when required and monitored the physical observations of patients who were taking specific medicines.
- A wide range of experienced and skilled mental health professionals provided help and support to people who were experiencing a mental health crisis.
- The majority of staff had received an up to date annual appraisal, and staff were able to attend monthly team meetings.
- Staff worked effectively with other teams within the trust and other organisations such as social services and GPs. Multi agency meetings with partners were in place for the health-based place of safety and Arden mental health acute team.
- Effective procedures were in place to ensure conditions related to the Mental Health Act were adhered to, and patients' assessed in the health-based place of safety were informed of their rights and assessed within appropriate time frames.

Are services caring?

We rated caring as good because:

- Staff were kind, caring and respectful. Patients felt included in their care and the majority said they felt they had received adequate verbal information, despite the majority not receiving a written copy of their care plan.
- Carers felt listened to and staff sought their views. They were provided with relevant information so they felt involved in the planning of care.
- Staff encouraged feedback and the trust would collate responses received and provide staff with comments made.
- Staff were able to ensure patients privacy and dignity were maintained when they were assessed in the health-based place of safety.

Good ●

Are services responsive to people's needs?

We rated responsive as good because:

- The teams were meeting their agreed targets; crisis teams responded to all referred patients' within four hours, and the Arden mental health acute team responded within 90 minutes to A&E referrals.

Good ●

Summary of findings

- The health-based place of safety completed 77% of Mental Health Act assessments within four hours, and escalated any delays appropriately to senior managers.
- Staff were proactive and flexible and offered a choice of appointments, which allowed patients who were unavailable opportunities to engage with the teams.
- Patients were given a range of information and the teams dealt with any complaints effectively.
- The health-based place of safety offered a secure and comfortable environment that maintained privacy and confidentiality.

However:

- The crisis teams did not always provide an assessment 48 hours of all new referrals, as stated in their operational policy.
- The Coventry crisis team felt the demand on their service had increased and they were not always able to be as responsive as they should be.

Are services well-led?

We rated well-led as requires improvement because:

Requires improvement ●

- Not all staff received regular supervision every two months in line with the trust policy.
- The crisis teams did not work consistently across the trust and there were differences in procedures and systems.
- Overall governance across the service was not robust; the service did not monitor its 48 hour assessment target, and there was a lack of audits within the service to identify supervision rates and medicines management practices.

However:

- The majority of staff were adequately trained and had received an annual appraisal.
- Teams received feedback from complaints and incidents in team meetings, and we saw evidence of changes made because of lessons learnt.
- Teams were meeting their targets, and information on the team's performance was visible to staff.
- Team managers met with their manager every two weeks, which gave them opportunity to share experiences and monitor their performance.
- The Arden mental health acute team was working towards accreditation with the psychiatric liaison accreditation network.

Summary of findings

Information about the service

The crisis resolution and home treatment teams provide services in the community for people with mental health problems who are in crisis.

The teams are based in three 'hubs'. These are at the Caludon centre, serving the Coventry area, St. Michael's hospital in Warwick, serving South Warwickshire, and the Manor hospital in Nuneaton, serving North Warwickshire. They are led by team leaders, and together operate a 24/7 service. At night, the service operates from the Coventry hub, with all calls being rerouted to there.

The health-based place of safety unit is a service for the whole of Warwickshire. It is located at the Caludon centre in Coventry, and is managed by the acute mental health inpatient service. People were brought there by the street

triage service or the police and were detained under section 136 of the Mental Health Act as they had been deemed to require an assessment from mental health services.

The Arden mental health acute team (AMHAT) serves the whole of Coventry and Warwickshire. It is based in the Caludon centre in Coventry, with staff working in the accident and emergency services in acute hospitals in Coventry, Warwick and Nuneaton. It assesses those patients who are ready for discharge from acute hospitals so that those patients can move on to other settings. At the time of our visit, the service manager of the crisis resolution service was managing this service.

Our inspection team

Team Leader: James Mullins, Head of Hospital Inspection (mental health) CQC.

Inspection Manager: Paul Bingham, Inspection Manager, mental health hospitals CQC.

The team that inspected this core service comprised an inspection manager (acute hospitals), an inspector, two mental health nurses and a social worker.

Why we carried out this inspection

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

Coventry and Warwickshire Mental Health Partnership NHS Trust was last inspected in April 2016. At that time, mental health crisis teams and health-based places of safety were rated as good. They did not have any requirement notices.

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, asked a range of other organisations for information and sought feedback from patients and staff at various focus groups.

During the inspection visit, the inspection team:

Summary of findings

- visited the three crisis teams at three hospital sites, the Arden mental health acute team and the health-based place of safety and looked at the quality of the environments and observed how staff were caring for patients
- spoke with six patients who were using the service, observed six home visits and one place of safety assessment
- spoke with three carers
- spoke with the managers for each of the teams
- spoke with 24 other staff members; including doctors, nurses, occupational therapist, social workers, student nurses and support workers
- interviewed the service manager with responsibility for these services
- attended and observed two hand-over meetings, one multi-disciplinary meetings and one team meeting.

- reviewed 25 patient satisfaction questionnaires
- looked at 10 treatment records of patients
- carried out a specific check of the medication management on the three crisis teams
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

Patients and carers were complimentary about the service. People told us staff had been caring and had helped them to recover. One person said the service had enabled them to stay out of hospital and had helped them rebuild their confidence. Most people felt they had enough information to aid their recovery, although they found it frustrating when different people visited them.

Good practice

The Arden mental health acute team had developed a weekly newsletter for staff to impart information about developments within the trust and news relevant to their service.

Areas for improvement

Action the provider MUST take to improve
Action the provider MUST take to improve

- The provider must ensure the kitchen area in the health-based place of safety complies with national infection control standards.

- The provider must ensure domestic materials stored in the health-based place of safety are managed in line with current legislation and guidance.

- The provider must ensure the health-based place of safety is staffed adequately to provide safe care when both suites are occupied.

- The provider must ensure all crisis teams provide a collaboratively produced, personalised written care plan, which patients receive.

- The provider must consistently maintain and monitor medication at their correct temperatures and action any issues.

- The provider must ensure patient's' medication is transported in a locked or secured container.
- The provider must ensure medicines are administered to patients safely, and staff in the crisis teams follow Nursing and Midwifery Council standards for medicine management.
- The provider must ensure a system is in place within the crisis team, to monitor the use of prescription pads and ensure they are safely stored.

- The provider must ensure staff in the crisis teams adhere to the trusts procedure for verbal prescriptions.

Summary of findings

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

- The provider should ensure cleaning records are maintained and available for staff to monitor within the health-based place of safety.

- The provider should ensure all staff receive regular supervision in line with their policy.

- The health-based place of safety should participate in regular audits to monitor the service it provides and identify improvements that could be made.

- The provider should ensure all patients referred to the crisis teams are assessed within 48 hours in line with their policy and should respond to all urgent referrals in a timely manner.

- The provider should ensure systems and procedures are consistent across all three crisis teams.

CareQuality Commission

Coventry and Warwickshire Partnership NHS 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
Arden Mental Health Assessment Team	Caludon Centre
Health-based Place of Safety	Caludon Centre
Coventry Crisis Resolution and Home Treatment Team	Caludon Centre
North Warwickshire Crisis Resolution and Home Treatment Team	Manor Hospital
South Warwickshire Crisis Resolution and Home Treatment Team	St Michaels Hospital

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.

The trust told us that, as this was an area identified for improvement in the last CQC inspection, a three-year training programme for the Mental Health Act has been developed and training commenced in March 2017. We did not have access to staff completion rates at the time of inspection.

A Mental Health Act administrator was responsible for collating, monitoring and supporting staff with all aspects of the Mental Health Act. Staff we spoke with showed a good understanding of their responsibilities under the Mental Health Act.

People who were detained in the health-based place of safety had their rights under the Mental Health Act explained to them.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff showed a good understanding of mental capacity on a case-by-case basis. Staff we observed on visits showed a good awareness of ensuring patients and carers understood and consented to proposed treatments.

Staff we spoke with had an understanding of the guiding principles of the Mental Capacity Act and the majority were up to date with the mandatory trust training required for the Mental Capacity Act.

Staff knew where to find the trust policy on the mental Capacity Act and had opportunities to discuss and make decisions in the patient's best interests if capacity was lacking.

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

Mental health crisis services

Safe and clean environment

- The crisis service saw and assessed the majority of patients in the patients' own homes. Where patients came to team bases for assessment, rooms were clean, safe and well maintained, and ensured privacy and dignity. Rooms had alarms to summon assistance if needed.

- Crisis teams had basic physical health equipment such as blood pressure machines and thermometers, which staff would use to take out to patients' homes. Staff monitored equipment and kept it clean. Patients' attended their GP clinic for more detailed physical examinations.

Safe staffing

- Staff were allocated to the crisis teams according to need based on population and demographics. At the time of inspection, the teams had 72.7 whole time equivalent staff, with four vacancies. Qualified nurses totalled 44 staff, with the four vacancies. Staffing in the Arden mental health acute team consisted of: one band seven manager, one band seven clinical trainer, four band seven senior mental health liaison practitioner, 23 band six nurses and three support workers. Three band six nurses were due to leave; the team manager was advertising their posts. Staff were located in all three hospital sites.

- Team managers told us the majority of vacant shifts were filled by regular staff or regular bank staff. We found there was appropriate use of regular bank staff to fill vacant shifts. No shifts were covered by agency staff.

- Team managers in the crisis teams told us they used bank nurses most days. The Coventry team used a high proportion of bank nurses due to an increased demand for their service within that area. Each crisis team had a pool of experienced bank staff they were able to call on if required to cover sickness or leave.

- The service had a low rate of staff leavers across the period than the trust overall and a lower rate of vacancies and staff sickness.

- Crisis teams do not have waiting lists. In daily handovers, staff allocated pending visits. This meant staff knew who they were visiting and could arrange to see their patients.

- Crisis services used a team caseload approach, which meant all staff had an overview of patients on the caseload. Staff told us caseloads had increased over the last few years due to changes within services including the central booking system and the 'open to all' policy. At the time of inspection caseloads were: Coventry 170, North Warwickshire 130 and South Warwickshire 103. We observed staff discussing patients and managing the team caseload during handovers and clinical reviews.

- All the teams were able to access a psychiatrist when needed.

- As of 31 January 2017, the training compliance for crisis teams and health-based place of safety was 87%, the Arden mental health acute team was 88%. The trust target was 95%. Out of the 15 courses available, there were seven courses where the core service overall was below the target and eight courses where the core service overall met or exceeded the target. Manual handling (people) was the course with the lowest level of compliance, with just 1% of eligible staff trained,The Trusts' Statutory and Mandatory Training Policy identifies that this training is not mandatory for these staff teams.

Assessing and managing risk to patients and staff

- We looked at 23 sets of electronic patient care records in the crisis teams. All but one contained a risk assessment completed at initial assessment. Staff completed a 'working with risk' assessment for all patients, and for patients meeting specific criteria, an enhanced risk assessment for suicide was completed.

- Staff discussed ongoing risk plans for patients daily and staff had a good understanding of interventions required for individual patients. However, patients did not receive a written plan to tell them what to do in a crisis, although they did receive relevant telephone numbers and knew how to contact the team in a crisis.

- Staff used an electronic board to monitor patients' level of visits, any risks identified including warnings, safeguarding issues and current plan of care. This alerted staff to specific concerns to be aware of such as

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to visit in pairs or no lone females to visit. Staff used a RAG (red, amber, green) rated system, which informed them of the patients' level of visits. Red meant daily, amber two or three times a week and green meant weekly. All patients remained on daily visits following their initial assessment until reviewed by the multidisciplinary team. Staff discussed patient's level of risk daily and changed plans and visits accordingly. Staff told us they could respond promptly to patients when their mental health deteriorated.

- Staff were knowledgeable about safeguarding procedures and knew when to make a referral. Staff had made referrals to the multi-agency safeguarding hub within the electronic patient care record, and attended multi-agency risk assessment conferences. A trust safeguarding lead was available within the trust to offer advice and support to staff. Staff accessed three safeguarding training courses (Safeguarding Adults levels 1 and 3 and Safeguarding Children Level 1) and 100% of relevant staff had received the training. We saw safeguarding issues discussed and reflected within team meeting minutes.

- Lone working took place at all three crisis teams. We saw effective protocols in place and staff worked in line with the trust lone working policy. Staff had use of electronic lone working devices but the use of them varied. The shift co-ordinator remained at the staff base and could monitor if staff had not returned on time. Teams had a code word that they used if there were any difficulties during their visits. We saw the code word displayed within the staff base, which staff were aware of. All staff had access to mobile phones.

- We looked at the medicines management within all three crisis teams. We found there were standard stock lists available and there were systems in place to monitor stock levels. Staff monitored the temperatures within the clinic room, or where medicines were stored. However, the temperature had exceeded the maximum of 25 degrees Celsius on many occasions in all three teams. For example, temperatures within the Coventry team from the 9 June 17 to 6 July 17 ranged from 27 to 34 degrees Celsius. This could compromise the effectiveness of some of the stored medicines. The Trust had local guidance in place to reduce the shelf life of medications when the temperature exceeded 25 degrees Celsius that was in line with national recommendations and there was no potential for patient harm. Staff had escalated their concerns to

pharmacy who had given interim advice. Senior managers were aware. The crisis teams did not always use a secure method to transport medicines to patients in the community; staff, on occasions, used their own handbags or carrier bags.

- In two of the three crisis teams, prescription pads (FP10s) were unsecured in a room, which was accessible to non-clinical staff. We alerted staff to this who told us they would lock them away. In two teams, completed or transcribed prescriptions awaiting signatures were accessible to non-clinical staff in open offices. One of the offices was adjacent to a corridor used by a variety of staff and we observed the door open throughout our visit. We handed the prescriptions to staff for safe storage.

- At the South Warwickshire team, staff took out small amounts of stock medications to administer to patients after receiving verbal orders from doctors, these were not followed up by email instructions from the doctor. This meant staff were not adhering to their policy.

- Nurses did not always follow Nursing and Midwifery Council standards for medicine management. Where nurses took medicines out to administer to patients in the community they did not always take out the medication administration record with them. This meant staff did not sign when they gave medication, and could not check against the prescription for route, dose and administration times.

- In the Coventry team, there were 14 sharps disposal containers. The labels on seven of these were not completed which meant there was not an audit of when the box was assembled, where it was used and who by. One box was closed but had not been securely assembled which could place staff at risk of injury.

Track record on safety

- There were no serious case reviews or external reviews relating to the crisis teams in the last twelve months. There had been one serious case review related to a suicide for the Arden Mental Health Acute team.

Reporting incidents and learning from when things go wrong

- Trusts are required to report serious incidents to the Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable). Between 1 February 2016

Are services safe?

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and 31 January 2017, the trust's internal incident reporting system included six incidents for this core service. In the same period there were five incidents reported through STEIS for this core service.

- All staff we spoke with knew what to report and how to report an incident on the trust electronic reporting system.

- Staff received direct feedback when they were the reporter, and the team discussed incidents, actions and recommendations relevant to their service during team meetings. Staff from the Arden mental health acute team gave an example of learning from an incident. The team had implemented a system to ensure they were made aware of assessments completed overnight by the junior doctor. This ensured staff gave appropriate feedback to other relevant people such as GPs.

- Staff received debrief following serious incidents by the team counsellor or psychologist. Confidential staff support facilities were available for all staff if they required them.

Health-based places of safety

Safe and clean environment

- The health-based place of safety was visibly clean, well maintained and safe. Mirrors ensured there were no blind spots in the unit. CCTV cameras were in place and observed in the staff office.

- We identified one potential ligature anchor point in the disabled toilet. However, staff reduced this risk by providing one to one observations and risk assessed each person brought into the unit. A ligature risk assessment was in place and audited regularly. The trust held the audit centrally.

- There was a suitable clinic area, with facilities for monitoring and assessing the patient, including resuscitation equipment. A self-testing defibrillation machine was available in the place of safety. However, staff did not know the defibrillator was self-checking and did not check that its functionality was not impaired. Staff checked the resuscitation bag daily and after use. We found out of date items in the clinic room, including saline, urinalysis sticks, dressings in the first aid kit and the 'spill kit'. We told staff about this on the day of inspection, who removed the items immediately.

- There were two large assessment rooms, both with sofas and chairs. This furniture was in a good state of repair

- The kitchen area where staff prepared food and drinks did not a have a separate hand wash facility for staff to use. The sink available to staff in the kitchen did not meet HBN 00-09 standards for infection control in the built environment standards as it had an overflow, which increases the risk of the spread of infection. The guidance states 'Overflows should not be provided as these are difficult to clean and become contaminated'. The sink also had food debris under a washing up bowl, so was not clean.

- The kitchen remained open throughout our visit and staff told us they did not normally lock it. In an unlocked cupboard, there was a range of chemical cleansers stored. Staff told us they did not have a key to the cupboard. These were potentially accessible to patients if they were unsupervised.

- Staff serviced and maintained equipment in line with the manufacturer's guidelines.

- While the majority of the unit was visibly clean and a schedule of cleaning tasks was in place staff were unable to provide signed records to verify that cleaning was completed each day.

- Staff had access to alarms for use when they needed to summon assistance.

Safe staffing

- Staff who worked in the place of safety were also required to work in bed management and respond to staff shortages. However, it was explained that on a daily basis, the staff are not required to work within or cover both areas at the same time. They are allocated to one of the other. The team consisted of one whole time equivalent (WTE) band seven manager, 10 WTE band six nurses, two WTE band five nurses and 14 WTE health care assistants. Two staff were always available for place of safety assessments, consisting of one qualified and one unqualified nurse.

- There were 3.7 vacancies for qualified staff. Bank staff filled vacant shifts.

- Medical staff attended Mental Health Act assessments at the place of safety when required, although staff told us

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it was difficult to get Section 12 doctors after 3am, which could delay assessments in the night. Staff escalated these incidences to the on call manager. Staff could access psychiatrists with specialities in children and young people and learning disabilities when needed.

- Staff received the appropriate mandatory training in accordance with that provided by the inpatient service.

Assessing and managing risk to patients and staff

- Data received from the trust showed that staff had used physical restraint on a patient three times from December 2016 to May 2017.

- The health-based place of safety policy states that staff provide one to one observations of all patients admitted. However, when two patients occupied both suites, both available staff would be observing the patients'. Staff told us they did not increase staffing levels when both suites were occupied. This meant that staff were not available to perform further tasks if required such as prepare food or provide beverages, without leaving the patient unobserved. We saw this happen whilst on inspection and staff left a patient for a brief period, although no harm came to the patient.

- Individual risk assessments were completed for all patients. These risk assessments identified whether a police officer had to remain with the patient for as long as necessary for example if they required transfer to the acute hospital.

- Staff had not made any safeguarding referrals between 1 December 2016 and 31 May 2017.

- The suite did not store medicines within the clinic room, although we found an out of date bottle of indigestion remedy in a cupboard. Staff disposed of this when we informed them of it.

Track record on safety

- There were no serious case reviews or external reviews relating to this core service in the past 12 months.

Reporting incidents and learning from when things go wrong

- Staff had recorded ten incidents between 1 December 2016 and 31 May 2017. Six were related to assault on staff.

- Staff knew when and what incidents they needed to record and received feedback on outcomes.

Are services effective?

Requires improvement 🟠

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

Our findings

Mental health crisis services

Assessment of needs and planning of care

- We reviewed 23 electronic patient care records in the crisis teams. Staff completed the 'Trusted assessment' form which was the standardised tool used by all teams within the trust. If a patient had been seen in the past by trust services, staff updated the existing assessment form, which meant patients' mental health history was already recorded. We saw completed holistic assessments and appropriate treatment plans developed from the findings. Staff in the Arden mental health acute team also inputted details of their assessment onto the acute hospitals care notes system. Assessments formed part of the discharge plan for the acute hospitals trust and would determine the involvement, if any, from mental health services.

- Apart from the South Warwickshire team, a copy of the care plan in place for a patient was not given to the patient to keep for personal reference. Rather, the patient received verbal information about their plan of care at the time of the visit. The Trust was soon to bring in a format of a care plan which would mean a copy could easily be given to the patient at the time of the visit. Information included changes to medication, next visit time and tasks that needed completing, such as referrals to other teams or agencies. However, patients and carers did not receive any written information on their plan of care to aid their recovery. Team managers in the Coventry and North Warwickshire teams told us they were due to implement crisis care plans in the near future, however no timeframes were in place at the time of inspection.

- All the teams used an electronic patient care notes system. This meant information was secure and other teams around the trust could access it. This was particularly useful when staff wanted to track patients' progress following admission to hospital or when staff required information for initial assessments.

Best practice in treatment and care

- We saw that staff followed National Institute for Health and Care Excellence (NICE) guidelines when prescribing medicines. We reviewed ten medicine charts and found doctors had prescribed anti-psychotic medicines in line with current guidance.

- Teams had access to psychology input and could refer patients for short-term intervention or have input and advice from psychologists. Teams had nurses trained in cognitive behavioural therapy and compassionate focused solution focused therapy. Some teams had staff trained in Mindfulness techniques.

- The crisis teams provided support workers who could assist patients' and carers with employment, benefits and housing needs. They liaised with a range of third sector organisations and could help make appointments and offer transportation when required.

- Staff assessed patients' physical health needs on initial assessment and we saw this documented within the electronic patient care records. Staff documented patients' allergies, smoking status and lifestyle. Following assessment, staff would identify those with pre-existing physical health care conditions, or those who required extra monitoring due to certain medications they were taking, or due to start. Doctors would undertake certain physical health checks, such as blood tests when commencing new medicines.

- The teams used Health of the Nation outcome scales care clustering to determine which treatment pathway patients' would meet their needs.

- The North Warwickshire team completed a training audit every three months to monitor the completeness of staff training. Pharmacy technicians attended the teams every three months to perform medicines audits. Business support managers monitored and audited key performance indicators for all the teams, and provided team managers with actions that required completion to ensure teams' met their targets. Staff in the Arden mental health acute team completed regular case notes audits and fed back actions requiring completion to the relevant colleagues.

Skilled staff to deliver care

- The crisis teams consisted of a range of mental health professionals including nurses, support workers, psychiatrists, psychologists, approved mental health practitioners (AMHPs) and occupational therapists. A new role of clinical support officer provided

Are services effective?

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.

administration and clinical support, who worked with the shift coordinators. The number of each professional varied from team to team, depending on the needs of the area. None of the teams received clinical input from pharmacists. Staff in the Arden mental health acute team consisted of experienced mental health practitioners, psychiatrists, nurses and support workers from specialities such as older adults, crisis services, drug and alcohol and dual diagnosis services.

- Many of the staff were experienced with working with people in crisis and had been in the crisis teams for a number of years.
- Staff received an appropriate induction when joining the trust and the teams provided a local induction for all new starters to ensure they were aware of their policies and protocols.
- Staff working as band three support workers had completed their national vocational qualification up to level three in health and social care.
- Staff told us they received regular supervision from their team managers, every six to eight weeks, which was the trust target. Due to a vacancy for another team manager in the Coventry team, the frequency of supervision had fallen in this team to below this target to every two to three months and the Arden mental health acute team only received supervision every three to six months. However, 96% of staff across the crisis service and 90% within the Arden mental health acute team had received an appraisal within the last 12 months. The trust's target rate for appraisal compliance was 95%. Band six nurses in the Arden mental health acute team could attend peer supervision on a monthly basis.
- Staff attended monthly team meetings. We attended one at the North Warwickshire team, and saw complaints, incidents and new developments across the service discussed. Staff were able to give input into the agenda and at times guests were invited to present and talk about their service.
- The trust reported that 100% of eligible staff were revalidated as of 31 January 2017. No nurses were overdue for revalidation.
- Psychiatrists who were expert in treating older age patients' had provided training to the crisis teams to upskill staff who were unfamiliar with looking after people with illnesses such as dementia. Team managers were supportive of staff who wished to acquire further

skills such as non-medical prescribing or phlebotomy training. All crisis teams had access to non- medical prescribers and support workers provided anxiety management to patients'.
- Team managers had addressed poor performance from staff within the teams in the past, although no one was undergoing this process at the time of inspection.

Multidisciplinary and inter-agency team work

- Staff in the crisis teams attended multidisciplinary team meetings throughout the week. We observed a multidisciplinary team meeting in the Coventry team. Staff discussed patients' current presentation, any risks and safeguarding concerns, actions required and discharge plans. Staff updated the electronic caseload board to reflect the revised care plan and any actions not completed were allocated to staff to complete.
- The crisis teams had regular, detailed handovers, which occurred twice daily to enable staff to share and pass on information. We observed two handovers and saw they were task orientated and identified risks.
- Staff in the crisis teams only discharged patients following allocation of a care coordinator from the community teams or on completion of their treatment plan. Staff liaised with colleagues in other teams within the trust, such as community and inpatient services. We saw staff discussing patients with other colleagues whilst on inspection and this was evident within the electronic patient care record. Staff dialled into the daily bed management conference call and discussed any patients' waiting for admission or discharge from hospital.
- Staff had developed good working relationships with external agencies such as GPs, social services and third sector organisations such as MIND and the Recovery partnership. Staff attended joint assessments with other providers such as drug and alcohol teams when required. All team managers told us they had built up good relationships with their GPs, however since the introduction of the trust central booking system, they did not have the same insight into the patient's needs at the time of referral and it limited the information they gained regarding the referred patient. Approved mental health practitioners employed by the social services worked within the crisis teams.
- The team manager of the Arden mental health acute team attended monthly meetings with staff from the

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Requires improvement 🟠

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acute hospital sites in Coventry, Warwick and Nuneaton, where they provided a service. This had helped build up relationships, and issues were discussed to improve the service and any frustrations between the partners.

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

- There were no Mental Health Act Reviewer visits between 1 April 2016 and 31 March 2017 relating to this core service.
- The trust told us that, as this was an area identified for improvement in the last CQC inspection, a three-year training programme for the Mental Health Act has been developed and training commenced in March 2017, but no up to date figures were available.
- The trusts Mental Health Act administrator was responsible for collating and monitoring information to make sure patient's rights were protected.
- The crisis teams visited patients on section 17 leave from the ward. Staff were aware of their responsibilities under the Mental Health Act and patients restrictions under section 17.

Good practice in applying the Mental Capacity Act

- As of 31 January 2017 the overall compliance for this core service for Mental Capacity Act 2005 training was 93%. This was below the trust target of 95%. Two teams scored above the trust target, and three were below.
- The trust provided information around the Deprivation of Liberty Safeguards applications they have made between 1 April 2016 and 31 March 2017. None of these related to this core service.
- Staff we spoke with had an understanding of the guiding principles of the Mental Capacity Act.
- Part of the inclusion criteria for referral to the crisis team was that patients were deemed to have capacity. During medical reviews, staff always assessed capacity as a standard part of the process. Staff understood that patients should be supported to make decisions independently before they were assumed to lack the mental capacity to make those decisions.
- Staff had opportunity to discuss capacity within handover and make decisions in the patient's best interests, if capacity was lacking.
- There was a trust policy on the Mental Capacity Act including Deprivation of Liberty Safeguards, which staff

were aware of and could refer to on the trust intranet. Staff could also discuss any Mental Capacity Act matters with medical staff, approved mental health practitioners and the trust lead.

Health-based places of safety

Assessment of needs and planning of care

- We looked at four electronic patient care records. Staff completed a risk assessment and the place of safety assessment form. All were appropriately completed.

Best practice in treatment and care

- All people brought to the place of safety for assessment underwent a physical health check by the hospitals duty doctor before commencing the Mental Health Act assessment. This would determine if the person detained was medically fit for interview.
- Staff told us they did not participate in audits. Multi-agency evaluations took place involving the place of safety and were reported to and monitored by the Multi-agency monitoring group

Skilled staff to deliver care

- Staffing consisted of a band six nurse and a health care assistant for each shift. When police officers brought a person to the place of safety under a section 136, staff contacted the approved mental health practitioner who organised two section 12 approved psychiatrists to complete the Mental Health Act assessment.
- Staff told us they did not receive regular supervision but they participated in an annual appraisal.

Multidisciplinary and inter-agency team work

- The service had monthly multi-agency meetings with the police, ambulance and social services. The manager of the service told us these were very helpful in improving relations, understanding and communication. They said relations with the police and ambulance were very good.

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

- Staff completed a specific place of safety assessment form on the trust electronic patient care record. Information included time of detention under section 136 and the time the assessment concluded. This was in

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line with the Mental Health Act Code of Practice. The trust used this information to determine how often the place of safety was used and to gather data on the assessment outcomes.

- Staff had received the trust mandatory training in the Mental Health Act, however this included limited information on section 135 or 136. Staff could access specific training and advice in relation to section 135 and 136 from the trust Mental Health Act team.

- People detained under section 136 received their rights under the Mental Health Act in verbal and written form when they arrived at the place of safety. We observed this and saw it recorded in the electronic patient care record.

Good practice in applying the Mental Capacity Act

- Staff we spoke with had an understanding of the Mental Capacity Act, but were unable to talk confidently of the guiding principles. Staff relied on the psychiatrists and approved mental health practitioner to undertake Mental Capacity Act Assessments.

Are services caring?

Good ●

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

Our findings

Mental health crisis services

Kindness, dignity, respect and support

- We observed staff were respectful and caring during their interactions with patients and carers. Staff offered practical and emotional support and were able to signpost to other agencies when required.
- Patients and carers were positive about staff. This was evident in direct feedback from patients and carers and from surveys of patients and carers.
- Staff showed knowledge and understanding of their patients' individual needs during handovers and multidisciplinary team meetings. The allocation of a lead professional following assessment ensured staff could maintain continuity of care and patients and carers did not have to repeat themselves to different staff.
- Staff were clear on confidentiality and were able to discuss examples of when it should be maintained and where it had to be breached because of the nature of the disclosures. They were also clear on issues of confidentiality between patients and other family members.

The involvement of people in the care they receive

- We observed six interactions between patients and staff. Staff involved patients in their care, and discussed options and gave information regarding their care plan. However, apart from the South Warwickshire team, patients did not receive a written copy of their care plan. However, it was clear from patient and carer comments and from our observations during visits that staff gave patients opportunity to discuss their treatment.
- We observed the involvement of carers in the crisis team, and saw staff give information to them and sought their views on the provision of providing care within the home environment. However, we did not see that staff had offered carers assessments. One carer we spoke with thought a carer's assessment would have been useful.
- An advocacy service was available to patients when they required it.
- The crisis service gave patients questionnaires to fill in and return following discharge from the team. We reviewed some of the results from all three teams. These were very positive, with the majority of responses showing a high level of satisfaction with services. Negative feedback included not seeing consistent staff members, and staff being late for appointments.

Health-based places of safety

Kindness, dignity, respect and support

- We observed one interaction between staff and a person brought to the place of safety. Staff were respectful and kind, and explained the reasons for their detention and the procedure. Staff offered food and beverage and ensured the person was comfortable.
- Staff told us they ensured people's privacy and dignity was maintained. The discreet entrance at the back of the suite enhanced this, and people did not have to walk through any public areas of the hospital.

The involvement of people in the care they receive

- Advocacy service and interpreters were available for patients to access from the place of safety. Staff noted that advocacy services would be exceptional as the aim was to have people moved to a more appropriate setting in less than six hours.
- Staff did not request feedback from people with experience of using the place of safety. This meant staff missed opportunities to gauge the effectiveness of their service and make improvements if needed.

Are services responsive to people's needs?

Good ●

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

Our findings

Mental health crisis services

Access and discharge

- The target response time for the crisis teams from referral to initial contact was four hours. Data supplied by the trust showed 99% of patients received a telephone call within four hours of referral.

- The target response time for Arden mental health team from A&E referral to assessment was 90 minutes. Data supplied from the trust showed the team had achieved this target 90% of the time. The trust target was 90%. They were exceeding their targets in relation to target times for assessments within the clinical decision unit and other wards.

- The crisis resolution operational policy states that people referred to the service will receive an assessment within 48 hours. Some delays in face-to-face assessments were evident when we looked through the notes in the Coventry and North Warwickshire team, although we saw staff had attempted to make appointments, and taken patients requests for assessments outside the 48-hour period into consideration. We also observed a telephone call in the Coventry team with a GP, whereby staff were unable to see a person urgently that day so advised the patient to attend A&E. Team managers told us capacity within the teams differed due to the amount of referrals each team received. From January 2017 to June 2017, the Coventry team had received 1602 referrals, South Warwickshire 1058 and North Warwickshire 956. We requested information from the trust to show how often they met their 48-hour target but they told us they did not monitor this, as it was not a key performance indicator.

- Staff told us not all referrals made to the team required crisis team input. However, staff did not refuse referrals and took patients' onto their caseload following assessment until the most appropriate team was able to take over or they were ready for discharge into primary care services. Staff across all three teams told us of delays of discharge patients to the trust community-integrated practice units (IPU) because of a lack of care coordinators in the IPUs. This affected their ability to provide a responsive service, as the teams were required to provide input to patients until discharge. When we inspected, 56 patients' from the crisis teams were waiting for transfer to the 3-8 IPU team. One patient from the Coventry team had been waiting since March 2017. The service manager for the teams had raised this issue to the community team's senior managers.

- The crisis teams provided a shift coordinator during the day who could respond to incoming calls. Staff working within the Coventry team said the amount of calls coming into the service was often overwhelming. This affected their ability to deal with tasks correctly, staff filled assessment slots inappropriately, which meant the team were not always responsive to urgent referrals. Coventry staff reported they did not feel there were enough resources to meet the increasing demand on the service. This resulted in patients having to wait for an assessment, and the night shift often had to complete them. The Coventry team had developed a new post of clinical support officer who was able to work with the shift coordinator and take calls from patients' and carers' who rang into the team to help. Senior staff told us they wanted to monitor the volume of calls and streamline the shift coordinator role although plans were not in place when we inspected.

- In the North and South Warwickshire team, staffing numbers were sufficient to ensure the service was able to contact, assess, and treat all people referred to it promptly. Team managers told us staff prioritised urgent referrals and moved appointments around to accommodate when required. Staff rescheduled any cancelled appointments as soon as possible.

- The teams were accessible 24 hours every day. All patients we spoke with told us they received contact numbers to speak with a member of the team straight away.

- The operational policy of the crisis service gave criteria for who was offered a service. It did not exclude people, but made it clear that, after initial assessment, it was less likely to offer intensive support to those with issues such as mild anxiety and relationship problems or a primary diagnosis of alcohol or other substance misuse. The service would refer such patients to appropriate services. Staff made it clear they supported patients until the team had identified an appropriate service. Our observations of reviews and handovers confirmed this. The operational policy for the Arden mental health acute team had clear criteria for who would be offered a service.

Are services responsive to people's needs?

Good ●

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

- Staff in the crisis teams were proactive and flexible with patients who were harder to engage. Staff told us that they provided patients' with a time slot for home visits rather than an exact time to allow for flexibility with patient visits. Patients' could request changes to their visiting times and staff would accommodate this. We saw patients offered a choice of appointments and of patients opting for evening appointments.
- Staff in the crisis teams followed the trust Did Not Attend policy for patients who did not engage with arranged appointments. We saw this reflected in the electronic patient care record and handovers.
- Staff in the crisis team facilitated early discharge from hospital and acted as gatekeeper to all potential admissions. Staff attempted to treat patients' in the least restrictive environment, and could visit up to twice a day. Staff told us they visited at least daily for all patients waiting for in-patient beds. At the time of inspection, six people were waiting for admission to hospital, one with medical recommendations under the Mental Health Act.

The facilities promote recovery, comfort, dignity and confidentiality

- The teams saw most patients at home, although they could choose to see staff at their team base site. Staff saw patients' who attended appointments with the crisis teams in comfortable, soundproofed interview rooms, to assist privacy and dignity.
- Staff from the Arden mental health acute team saw patients on the acute hospital trust premises. Staff had use of rooms that provided privacy and confidentiality.
- The South Warwickshire team gave patients' a folder entitled 'My Care Plan'. This contained details of useful contacts including PALS, general useful information about the service, and details of how to get help. The Coventry and North Warwickshire teams had information leaflets about the team available, however, no staff we spoke with were aware of them, therefore they did not give them out to patients'. Leaflets regarding medicines, treatments and other organisations were available and staff gave them to patients' when required.

Meeting the needs of all people who use the service

- Most visits were home visits. There was disabled access for patients if required where patients came to hospital premises.

- Information leaflets were available. These were available in different languages in teams where there were a range of users for whom English was not their first language.
- Interpreters and signers were accessible when required.

Listening to and learning from concerns and complaints

- Between 1 February 2016 and 31 March 2017 14% of all complaints made about trust services related to this core service, making this the core service the third highest number of complaints for the trust. In the same period, this core service received 22 compliments. No complaints had been referred to the Ombudsman.
- The team with the most compliments was Crisis North Warwickshire with 11. Eight of these were in May 2016.
- The trust reported that the three most common themes for complaints were communication, patient care and values/behaviour of staff, but it did not give details of themes by core service.
- Patients we spoke to knew how to complain, although apart from the South Warwickshire team, patients did not routinely receive Patient Advice and Liaison service (PALS) leaflets.
- All staff we spoke with knew how to handle complaints and team managers told us they initially tried to resolve complaints at a local level.
- The trust cascaded actions and recommendations identified through team meetings, one to ones and email. This was evident in minutes we reviewed of previous meetings and saw this discussed in a team meeting we observed.

Health-based places of safety

Access and discharge

- Data supplied by the trust showed the place of safety had admitted 468 people from April 2016 to March 2017. This equates to an average of nine assessments per week. Of these, 77% of assessments were completed within four hours. The longest wait in the place of safety was 33 hours. This was due to staff waiting for a child and adolescent mental health bed. The unit admitted intoxicated people who lacked capacity. Staff would postpone assessments until it was appropriate for them to be completed.

Are services responsive to people's needs?

Good ●

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

- The unit offers a 24-hour service, seven days a week. On those occasions when both suites were in use or an under 18 patient was admitted, the service were unable to admit further patients.
- The service did not accept further referrals to the other suite when an under 18 was admitted. From April 2016 to March 2017, 41 patients who were under 18 years old had been admitted.
- Data from January 2017 to June 2017 sent by the trust showed that staff had redirected ten people to A&E, due to the place of safety being unable to accept them.
- The service did not exclude anyone detained under a Section 136 or a 135, unless they were particularly agitated and aggressive. In these cases, police used a more secure place of safety such as the police station, although staff told us this was a rare occurrence.

The facilities promote recovery, comfort, dignity and confidentiality

- The environment was secure and comfortable. The two suites were easily observable and maintained confidentiality. Rooms contained a large settee, two comfortable chairs and a TV. Windows were opaque which enhanced privacy and a clock was visible within the unit. Staff provided snacks, beverages, blankets and washing facilities, although the unit did not have a shower.
- A fully equipped clinic room ensured people received a physical health assessment and staff could take care of any existing physical health needs.
- The unit displayed information on how to complain, about independent mental health advocacy services and how to avoid abuse.

Meeting the needs of all people who use the service

- Staff could produce information in other languages if needed and they had access to interpreters and signers.
- A disabled toilet was available and the environment was large enough to manipulate a wheelchair around safely.

Listening to and learning from concerns and complaints

- The health–based place of safety had not received any complaints between 1 December 2016 and 31 May 17.

Are services well-led?

Requires improvement ●

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

Our findings

Mental health crisis services

Vision and values

- The trust values were: Compassion in action, respect for everyone, working together, and seeking excellence. Staff were aware of the values of the trust and how these values related to their work. We saw this reflected within staff appraisals and staff had provided examples of when they had met the values within their work.
- Staff were complimentary of their immediate managers and service managers and some had met members of the board who had visited the team. However, apart from the CEO, the majority of staff were unaware of other members of the board.

Good governance

- Staff were adequately trained, and managers promoted the need to attend mandatory training.
- Staff received annual appraisals and regular supervision; although the frequency of supervision had reduced in the Coventry team and was less than the trust target of six to eight weeks in the Arden mental health acute team.
- Appropriate numbers of staff were available and staff told us that direct patient care was their priority.
- All incidents and complaints were analysed and reviewed and investigations took place when necessary. Team managers would disseminate shared learning with staff in team meetings.
- Procedures relating to safeguarding were widely followed and staff knew how to raise an alert.
- There were limited audits that meant the service missed opportunities to monitor good practice and identify the areas that required improvement such as medicines management, supervision and lack of care planning across all the service.
- Staff were aware of the procedures related to the Mental Capacity Act and Mental Health Act and that they could seek guidance from senior staff and the trust leads.
- The service used key performance indictors to monitor the performance of the teams. These included gatekeeping, seven day follow up, GP letters following assessment, contact to patient within four hours following referral and appraisals. We reviewed data

whilst on inspection which showed all teams were meeting their key performance indicators. Data regarding the team's performance was accessible to staff and was on display within teams offices.
- The Arden mental health acute team had a weekly admission avoidance target agreed with each acute site. Generally, the team met these targets, except when admission to a mental health bed was required, and beds were unavailable. This meant staff had to admit patients to an acute hospital bed whilst waiting for a mental health bed.
- The same service manager oversaw the crisis teams, although there was a lack of consistency across the teams. An example being differences in care planning and the way teams managed and allocated staff to new assessments. We were told some of these discrepancies were due to differences on the demands for each team, although it was acknowledged that systems such as the shift coordinators role and duties could be improved upon, and tasks more defined to improve efficiency.
- Team managers told us they had sufficient authority to make decisions and administration support monitored and reported on the team's performance.
- The teams had submitted items to the risk register in the past, although nothing was on it at the time of inspection.

Leadership, morale and staff engagement

- As of 31 January 2017, there was one case of a suspended staff member within this core service over the previous 12 months, an investigation is ongoing.
- Sickness for all teams was lower than the national average and staff turnover was low.
- No teams reported any current bullying or harassment cases.
- Staff we spoke with were aware of the whistle-blowing process, however had not needed to use it. Staff told us if they had concerns, they would raise them with their team manager or service manager. They were complimentary about their immediate managers and felt they were open and supportive.
- Staff told us they enjoyed working in the crisis teams, although morale had been low in some teams. This was due to the increasing demand on their service and the constant re-organising of visits and re-allocation of

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.

work. Some staff felt there were not enough resources to meet the demand of their service. This put pressure on staff and some considered it hampered their ability to provide a high quality service.

- Staff we spoke with in the Arden mental health acute team had high morale and job satisfaction and a sense of empowerment. They enjoyed the variety and scope of the work and the opportunities for development.
- Staff had access to leadership training if they wanted it, and band six nurses had attended this in the past.
- We observed teams working well with each other and mutual respect was evident. Staff sought guidance and support from other disciplines within the team when they needed it.
- The service manager for the crisis teams and Arden mental health acute team met with team managers twice a month. Agenda items included sickness, supervision and appraisals, training, staffing and vacancies, complaints and compliments, patient feedback and any actions, and learning alerts.
- Staff in the Coventry crisis team could attend a monthly staff forum. This gave staff the opportunity to discuss any matters relating to the team or practice confidentially, which would then be fed back to the team managers, and discussed more widely in the team meeting. Staff were encouraged to share new ideas to improve the service. An example being the inclusion of a 'follow up template' on the electronic care records system.
- The team had developed a weekly newsletter following feedback from the team that they did not always receive information on team developments or issues relating to the trust.

Commitment to quality improvement and innovation

- The North Warwickshire team were participating in two research projects – Achieving quality and effectiveness in managing dementia in a crisis team and Outcomes of patients using day hospitals versus crisis teams.
- The Arden mental health acute team had applied to become a member of the Psychiatric Liaison Accreditation Network. The Psychiatric Liaison Accreditation Network (PLAN) works with services to assure and improve the quality of psychiatric liaison in hospital settings.

Health-based places of safety

Vision and values

- Staff were aware of the values of the trust and how these values related to their work.

Good governance

- Data was collected that supported the monitoring of the performance of the health based places of safety
- The service worked with the police and other agencies to develop and maintain good relationships and protocols for the use of the place of safety.
- Staff told us they did not receive regular supervision although had the opportunity to discuss issues in an informal way.

Leadership, morale and staff engagement

- Staff were aware of the whistle blowing process and said morale was generally good, although felt they needed more staff when they were busy.

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
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must ensure the health-based place of safety is staffed adequately to provide safe care when both suites are occupied. This was a breach of Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must ensure all crisis teams provide a collaboratively produced, personalised written care plan, which patients receive. This was a breach of Regulation 9 (3) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure the kitchen area in the place of safety complies with national infection control standards. The provider must consistently maintain and monitor medication at their correct temperatures and action any issues.

Requirement notices

The provider must amend its guidance and ensure that medicines transported under staff's personal control is transported in a tamper evident and preferably secured container

The provider must ensure medicines are administered to patients safely, and staff follow Nursing and Midwifery Council standards for medicine management.

The provider must ensure a system is in place to monitor the use of prescription pads and ensure they are safely stored.

The provider must ensure staff adhere to the trusts procedure for verbal prescriptions.

This was a breach of Regulation 12 (2) (g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Assessment or medical treatment for persons detained under the Mental Health Act 1983	The provider must ensure domestic materials stored in the place of safety are managed in line with current legislation and guidance.
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	This was a breach of Regulation 15 (1)(a)