Requires improvement

Birmingham and Solihull Mental Health NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Date of inspection visit: 27th-30th March 2017
Date of publication: 01/08/2017

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXTD3	Birmingham & Solihull Mental Health Foundation Trust	Rapid, Assessment, Interface and Discharge (RAID)	B15 2TH
RXTD3	Oleaster Centre	South Crisis Resolution Home Treatment Team	B15 2SY
RXTD3	Oleaster Centre	Health-Based Place of Safety	B15 2SY
RXTD3	Oleaster Centre	Psychiatric Decisions Unit	B15 2SY
RXT54	Northcroft	North Crisis Resolution Home Treatment Team	B23 6DW

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

Summary of findings

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 Birmingham & Solihull Mental Health NHS Foundation Trust and these are brought together to inform our overall judgement of Birmingham & Solihull Mental Health NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Overall summary

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

- Night time staffing of the crisis resolution home treatment team and RAID teams often fell below planned staffing levels.
- Medicines management practice was not robust across all teams. We found that there were gaps in medicines reconciliation, transportation in community teams and documenting of patients' allergy status.
- We found that staff at the health based place of safety did not consistently monitor the quality and completeness of monitoring forms completed by staff.
- We found that patients and staff did not always have access to alarm points, and alarm systems at trust locations had not been effectively checked to ensure they worked.

However:

- Patients reported that staff were caring, polite and respectful and we saw this demonstrated in our observations.
- Staff reported that teams worked well, were supportive and worked hard to deliver patient care.

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:

- Night time staffing of the crisis resolution home treatment team and RAID teams often fell below planned staffing levels.
- We found that patients and staff did not always have access to alarm points, and alarm systems at trust locations had not been effectively checked to ensure they worked.
- Staff did not consistently demonstrate safe lone working practices and information to support lone working practices was not regularly reviewed or updated.
- Medicines management practice was not robust across all teams. We found that there were gaps in medicines reconciliation, transportation in community teams and documenting of patients' allergy status.
- Crisis resolution home treatment teams reported delays in accessing inpatient beds when patients needed one.

However:

- Care records contained completed risk assessments that were regularly reviewed and updated.
- Community bases where staff saw patients were clean, tidy and well maintained.
- Staff recorded incidents on the trust's electronic system that provided staff with feedback and learning from incidents across the trust. Staff knew how to report incidents and gave examples of the types of occurrences reported.

Are services effective?

Good

We rated effective as Good because:

- Staff undertook a comprehensive assessment of patient's needs.
- Crisis resolution home treatment teams provided a range of physical interventions for patients including blood tests and an electrocardiogram service.
- Staff participated in regular clinical audit activities.
- Crisis services and health-based places of safety employed suitably qualified and experienced staff to deliver patient care. Staff accessed training, supervisory practices and appraisals.
- Teams reported good multi-disciplinary and inter-agency working; meeting regularly to discuss and plan patient

Summary of findings

care.Staff at the health based place of safety did not consistently complete Section 135/136 place of safety monitoring forms. The trust had not audited monitoring forms for quality and completeness.

However:

- Staff at the health based place of safety did not consistently complete Section 135/136 place of safety monitoring forms. The trust had not audited monitoring forms for quality and completeness.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Patient records did not consistently demonstrate that staff provided patients with copies of their treatment plans or that staff had discussions with patients about sharing information.
- Patients felt that their contact with staff was sometimes hurried and reported frequent changes of staff delivering their treatment.

However:

- We observed good patient and staff interactions. Staff listened, were sensitive to needs and used language that patients could understand.
- Patients and carers reported that staff were polite, respectful and caring.
- Patients reported that staff provided details about how to contact services at all times for help and support.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Information for people who did not speak English as a first language was displayed in English. This meant that people who did not speak English as a first language may have difficulty in accessing services that they required.
- The average length of a patient stay at the psychiatric decisions unit was greater than the trust's target and many patients experienced stays of 24 hours or greater.

However:

- Crisis resolution home treatment teams prevented admission to hospital by providing patients with short-term care and treatment in their homes. Teams acted as effective gate keepers for the trust's inpatient admission beds.

Summary of findings

- Crisis resolution home treatment services operated 24 hours a day, seven days a week and applied no direct exclusion criteria. Teams assessed the needs of all patients referred within 24 hours of receiving a referral.

Are services well-led?

Good 

We rated well-led as Good because:

- Staff were aware of the organisation's values and objectives. They reported that senior managers were visible around the trust and recalled examples of them visiting trust locations.
- Staff reported that teams worked well, were supportive and worked hard to deliver patient care.
- The trust was the only mental health organisation participating as part of NHS England's Test Beds. The project was developing technology to help patients stay well and monitor their conditions themselves at home.

However:

- Local governance systems had not ensured that patient care was consistently delivered safely and effectively.
- Staff spoke about the pressures of providing a 24 hour service and the impact of staffing shortfalls on patient care and workplace stress.

Summary of findings

Information about the service

The trust provides crisis services and health based places of safety across Birmingham and Solihull through crisis resolution home treatment teams (CRHT), rapid assessment interface and discharge (RAID) mental health teams and urgent care services. Urgent care services include the health-based place of safety, psychiatric decisions unit, bed management, street triage, and British Transport Police.

Crisis Resolution Home Treatment Teams

The trust provides crisis resolution home treatment services from six teams. The teams are Solihull Team, North Team, South-West Team, South-East Team, Zinnia Team and Handsworth & Ladywood Team. At night, the service is provided centrally from the Oleaster Centre.

Rapid Assessment Interface and Discharge Teams

The trust provides rapid assessment interface and discharge teams from City Hospital, Good Hope Hospital, Heartlands Hospital and University Hospital Birmingham. The service is also provided from Solihull Hospital but only between 7am and 9pm.

Health-Based Place of Safety

The trust provides a health-based place of safety at the Oleaster Centre with capacity for two patients. It is staffed by one senior nurse and one nursing assistant at all times who also act to provide a bed management service for the trust.

Psychiatric Decisions Unit

The trust provides a psychiatric decisions unit at the Oleaster centre with capacity for up to eight patients. The unit has its own staff team. The unit offers a place for patients to receive an extended assessment and decision making service for up to 12-hours as an alternative to remaining in an A&E department or being taken into custody.

Our inspection team

Our inspection team was led by:

Chair: Mick Tutt. Non-Executive: Director Solent NHS Trust

Head of Hospital Inspections, CQC: James MullinsInspection manager: Kenrick Jackson

The team that inspected the core service comprised of one CQC inspector and three specialist advisors. The specialist advisors included 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.

The Care Quality Commission last inspected the trust in May 2014, including an inspection of community based crisis services. The rating applied to community based crisis services was 'Good' and the overall rating for the trust was 'Good'.

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?

Summary of findings

- 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 other organisations for information and sought feedback from patient through focus groups and comment cards.

During the inspection visit, the inspection team:

- Visited two crisis resolution home treatment teams, and one rapid, assessment, interface and discharge team. We spoke with the managers of these services.
- Visited the psychiatric decisions unit and health based place of safety, both at the Oleaster Centre. We spoke with the manager of the psychiatric decisions unit and a senior nurse at the health-based place of safety.
- Received eight completed CQC comment cards from patients that had experience of using crisis services and health-based places of safety.
- Made one unannounced night time visit to crisis services and health-based places of safety based at the Oleaster Centre and City Hospital.•Conducted telephone interviews with eight patients that had experience of using crisis resolution home treatment services.
- Conducted telephone interviews two carers that had experience of using rapid, assessment, interface and discharge teams.
- Looked at 18 patient care records and 15 prescription charts.
- Looked 11 Section 135/136 place of safety monitoring forms.
- Spoke with 13 other staff members; including doctors, nurses, occupational therapists, and nursing assistants.
- Attended and observed one handover meeting and one multi-disciplinary meeting.
- Attended and observed three community visits and three patient reviews.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with eight patients and two carers that had experience of crisis services and health based places of safety. We received eight completed CQC comment cards specific to this core service.

Patients and carers were happy with the way that staff approached them; describing them as respectful, caring, and responsive. Patients recalled that staff provided contact numbers for crisis resolution home treatment services, in and out of hours.

Patients reported concerns about the way in which teams delivered services, their involvement in the care planning process, and the involvement and support provided to family member or carers.

Three of the completed CQC comment cards were negative and related to the quality of care and attitudes of staff at one team in the trust.

The trust provided data from patient feedback obtained through the 'Friends and Family Test'. The trust scored lower than the England average for four of the six months between July and December 2016 for recommending the trust as a place to receive care.

Good practice

- The trust provided staff with additional safeguarding training that was appropriate to the communities they served, for example, female genital mutilations.
- The trust's electronic incident recording system included 'It Takes 3', a serious of short films sharing learning from incidents across the trust with staff.
- The trust was the only mental health organisation participating as part of NHS England's Test Beds. The project was developing technology to help patients stay well and monitor their conditions themselves at home.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that a process is in place to record relevant details in a prescription stock control system to aid reconciliation and audit trailing.
- The trust must ensure allergy status of patients is completed on all prescription charts in a timely manner.
- The trust must ensure that staff have access to appropriately lockable cases to transport medications between crisis resolution home treatment bases and patient's homes.
- The trust must ensure that staff at the health based place of safety have access to personal alarms and patients have access to alarm points when using trust facilities.
- The trust must ensure that all alarm triggers used at the psychiatric decisions unit are effectively checked and maintained.
- The trust must ensure that effective processes are in place to monitor the quality of recorded information for all patients assessed in the health based place of safety.

Action the provider SHOULD take to improve

- Staff should ensure that care records demonstrate patient involvement and the sharing of treatment plans with patients.
- Staff should ensure that care records demonstrate how and with who patient information can be shared with during a treatment episode.
- The trust should ensure that patient facilities at the health based place of safety and psychiatric decisions unit promote comfort and are well maintained.
- The trust should monitor the night time staffing levels of crisis services and health-based places of safety and take action to ensure that the number of staff on duty consistently meets required levels.
- Staff should ensure that they follow agreed lone working practices.
- The trust should ensure that staff's emergency contact details and regularly reviewed and updated to support lone working practices.
- The trust should ensure that night time staffing at the crisis resolution home treatment service and RAID teams consistently meets agreed levels.
- Staff should ensure that care plans demonstrate the individual needs of patients and patient involvement in the planning of care.
- Staff should ensure that care records demonstrate that staff undertake a physical health examination of patients accessing crisis services.
- The trust should ensure that staff accessible resources used to plan and monitor patient treatment is up-to-date.
- Staff should ensure that all patients know how to complain.
- The trust should ensure that patient information is accessible in a range of formats that reflects the diversity of the communities that their services serve.
- The trust should ensure completion rates of all individual mandatory training courses meets the trust's target of 85%.
- The trust should ensure that the length of patient stays at the psychiatric decisions unit do not exceed 12 hours.

Birmingham and Solihull Mental Health NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Rapid, Assessment, Interface and Discharge (RAID)	Birmingham & Solihull Mental Health Foundation Trust
South Crisis Resolution Home Treatment Team	Oleaster Centre
Health-Based Place of Safety	Oleaster Centre
Psychiatric Decisions Unit	Oleaster Centre
North Crisis Resolution Home Treatment Team	Northcroft

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.

Staff received training in the Mental Health Act. Figures for January2017 indicated that 97% of crisis services and health-based places of safety staff had completed this training.

Staff accessed administrative support and legal advice on the implementation of the Mental Health Act from the trust's centrally located lead team.

We reviewed 11 Section 135/136 place of safety monitoring forms. We found an overall lack of consistency in the completion of monitoring forms with only two demonstrating full completion. We found omissions in the

recording of patients receiving their right under the Mental Health Act, the time of arrival to the place of safety and the calculation of the total time from arrival to release or section.

The trust had not audited the quality or completeness of information recorded on Section 135/136 monitoring forms, reporting that this was scheduled to take place in September 2017.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Figures for January 2017 indicated that 99% crisis services and health-based places of safety staff had completed this training.

Staff we spoke with displayed understanding of the Mental Capacity Act and its guiding principles. Staff could explain the presumption of mental capacity and acting in a patient's best interests where the patient lacks capacity. Staff assessed and recorded a patient's capacity to consent to treatment where concerns were identified.

The trust provided a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards and staff knew how to access it.

From December 15 to November 16, trust data showed that this core service had made no Deprivation of Liberty Safeguards applications.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

Crisis resolution home treatment teams

- The north and south east/west crisis resolution home treatment teams held offices within trust locations. Both teams had access to appropriate facilities including, staffed patient waiting areas, lockable clinic rooms, and designated assessment rooms with alarm points.
- Records demonstrated regular cleaning and we found all areas to be clean, tidy and well maintained.
- There was access to hand-sanitising stations at each location and posters advising staff and patients of correct hand washing and infection control techniques.
- Fire extinguishers and portable appliance testing (PAT) stickers were visible and in date.

Rapid, Assessment, Interface and Discharge (RAID)

- RAID services assessed patients in the accident and emergency departments, clinical decision units or inpatient wards at acute hospitals in Birmingham and Solihull. RAID staff at University Hospital Birmingham had access to two designated offices, one of which was in the accident and emergency department. A five-minute walk separated the offices.
- Fire extinguisher and portable electrical equipment checks were in date in both areas.•We saw that staff could access hand washing facilities and cleaning gels at both locations. Infection control information and posters were visible around the hospital.
- RAID staff at University Hospital Birmingham did not have access to a dedicated area adapted for mental health assessments. Staff told us that they often interviewed patients in curtained cubicle areas because it was difficult to obtain a room in the accident and emergency department. We saw that these areas frequently contained ligature risks.
- Cubicles had fixed point alarm calls for summoning emergency assistance. The RAID service we visited had access to three personal alarm triggers that were compatible with their acute hospital alarm system. We saw that two of these alarms were damaged and staff would not be able to trigger them quickly in an emergency. The service manager told us that they had reported this to the acute hospital and no incidents had occurred because of damaged alarm triggers.
- The trust was not responsible for the cleaning and maintenance of premises used by RAID services. However, we found that areas used by RAID staff were clean and well maintained.

Health-based place of safety

- We inspected the health-based place of safety (also known as the section 136 suite) located in the Oleaster Centre. The suite had a dedicated parking area for emergency vehicles with a discrete entrance providing direct access for patients. Other visitors accessed the suite through doors directly off the Oleaster Centre's main reception. Access and exit were secured, staff carried swipe cards to move freely.
- The suite included a staff office, locked kitchen area, toilet, locked clinic room, and two patient areas. Shower facilities were located just outside of the suite and staff escorted patients to provide access. Shower facilities did not have an alarm point, this meant that staff and patients could not summon assistance in an emergency.
- Records demonstrated that staff regularly cleaned the health-based place of safety. However, one of the shower areas was in need of maintenance. We found that it smelt strongly of damp and stained sealant at the base of the shower was visible.
- Doors to patient areas were 'anti-barricade', which meant that they opened both ways, and had an observation panel for use by staff. The health-based place of safety has strong, heavy, durable furnishings. External windows to the health-based place of safety were obscured to protect occupant's privacy.
- The health-based place of safety had a locked clinic containing an emergency bag, emergency drugs, ligature cutters and oxygen. Records demonstrated that staff checked emergency equipment daily.
- The health-based place of safety had been designed with anti-ligature fittings; however, the trust had identified some environmental ligature risks in patient areas. We saw that staff were aware of these and observed patients to prevent harm occurring.

Requires improvement

Are services safe?

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

- Staff at the health-based place of safety did not have access to personal alarms. Staff told us that the three alarms allocated had been misplaced over time.
- Fire extinguishers and portable appliance testing (PAT) stickers were visible and in date.

Psychiatric decisions unit

- We inspected the psychiatric decisions unit which was also located in the Oleaster Centre. Access to the unit was secured; staff released doors with a swipe card. Exit from the unit was activated by a button located next to the doors, which was accessible to everyone. The unit included a staff office, locked clinic room, and two patient lounges. Lounge areas to the psychiatric decisions unit had windows onto a courtyard area and were not visible to passers-by.
- The lounges provided single sex accommodation for up to eight patients, four in each lounge. The unit had strong, heavy, durable furnishings. Toilet facilities were located immediately outside of the unit. Shower facilities were shared with the health-based place of safety. Patients wishing to use shower facilities required staff escort to access. We found the accommodation arrangements on the unit to be in line with mixed sex guidance.
- The psychiatric decisions unit had locked clinics containing an emergency bag, emergency drugs, ligature cutters and oxygen. Records demonstrated that staff checked emergency equipment daily. However, we found bandages in a first-aid kit that had expired for use in August 2014.
- The psychiatric decisions unit had been designed with anti-ligature fittings. However, the trust had identified some environmental ligature risks in patient areas. We saw that staff were aware of these and observed patients to prevent harm occurring.
- Staff at the psychiatric decisions unit carried personal alarms that triggered the Oleaster Centre's alarm system. During the inspection we found that one personal alarm failed to trigger the system, it was not until a second alarm was triggered that assistance arrived. This meant that staff could not effectively summon assistance in an emergency.
- Records demonstrated regular cleaning and we found all areas to be clean, tidy and well maintained.
- There was access to hand-sanitising stations at each location and posters advising staff and patients of correct hand washing and infection control techniques.
- Fire extinguishers and portable appliance testing (PAT) stickers were visible and in date.

Safe staffing

Crisis Resolution Home Treatment:

- Staffing establishments varied across crisis resolution home treatment teams:
- North crisis resolution home treatment team was staffed by one whole time equivalent team manager; nine whole time equivalent band 6 nurses; two whole time equivalent band 5 nurses and four band 3 nursing assistants. The team held one vacancy at band 5.
- South east/west crisis resolution home treatment teams operated under one whole time equivalent team manager; 14 whole time equivalent band 6 nurses; one band 6 occupational therapist; one band 4 nursing assistant and three band 3 nursing assistants. The team held two vacancies at band 6.
- Staff worked shifts during the day to provide cover from 08:00am until 9:00pm.
- The multidisciplinary team also included consultant psychiatrists and specialist registrar doctors that responded as part of the service. Staff we spoke with reported no delays in accessing a doctor.
- Team managers reported that the trust had established staffing requirements for the crisis teams that were measured by population need and demographics of the catchment areas.
- Crisis resolution home treatment teams did not use agency staff. Teams used bank staff that either worked within crisis resolution home treatment or were familiar with the service. Where shifts remained unfilled, managers had the option to move staff between sites. Team managers most commonly allocated bank shifts to staffing the service overnight. During an unannounced visit, we saw that two night shifts allocated to bank staff had remained unfilled leaving one nurse to provide a crisis resolution home treatment service across the trust. In the period from December 2015 to November 2016, the trust reported 30 occasions when night time staffing of the crisis resolution home treatment services fell below the establishment level of three nurses.
- Team managers reported that there was no maximum caseload numbers for crisis resolution home treatment teams. At the time of inspection, north team was providing a service to 45 patients and south east/west team to 104 patients. Team managers reported the

ability to book additional staff to meet the demands of the service. Managers reviewed caseloads on a daily basis during handovers that were attended by all staff on duty.

- Trust data from December 2015 to November 2016 reported a range of sickness rates from 0% to 20% across the crisis resolution home treatment teams. The Solihull team recorded the greatest range of sickness rates from 3.5% to 20%, and the south east team the lowest range from 0% to 4.7%. The staff turnover rate for the same period was 7%.
- The trust provided staff with mandatory training and had a target completion rate of 85%. Overall, the crisis and health-based places of safety core service met this target with a completion rate of 90%. However, four areas of training fell below the 75% target. These were safeguarding adults level two, intermediate life support and approaches to violence through effective recognition and training for staff; both the five day course and a one-day staff refresher.

Rapid, Assessment, Interface and Discharge (RAID)

- Staffing establishments varied across RAID teams. RAID University Hospital Birmingham was staffed by one whole time equivalent team manager, seven whole time equivalent band 6 nurses and one whole time equivalent band 5 nurse. The team held two vacancies at band 6 which had been recruited to.
- Nurses worked a shift pattern to provide a service 24 hours a day. The manager reported that night shifts were most commonly affected by shortages and on occasions, staff were required to work alone. In the period January 2017 to March 2017, the trust recorded 19 incidents where night shifts at Univsersity Hospital Birmingham had been staffed by one RAID team member.
- The RAID University Hospital Birmingham service manager reported that staffing levels for the service had been agreed with the acute hospital when the service started. RAID services did not use agency staff. The services used bank staff that either worked within RAID services or were familiar with the service. Where shifts remained unfilled, managers had the option to move staff between sites
- The service also included four psychiatrists providing 2.7 whole time equivalent hours to the service. Psychiatrists functioned as part of the service during office hours, Monday to Friday. One doctor provided out-of-hours cover with responsibility only for the UHB site. Staff we spoke with reported no delays in accessing a doctor.
- At the time of the inspection, RAID University Hospital Birmingham held a caseload of 44 patients. Caseloads were reviewed daily in a morning meeting that all staff on duty attended. We observed a meeting and found it to be thorough, well organised and included elements of staff education.
- Trust data from December 2015 to November 2016 reported a range of sickness rates from 0% to 23% for rapid, assessment, interface and discharge teams. The City Hospital team recorded the greatest range of sickness rates from 0% to 23%, and the Solihull Hospital team the lowest range from 0% to 1.2%. The staff turnover rate for the same period was 10%.
- The trust provided staff with mandatory training and had a target completion rate of 85%. Overall, the crisis and health-based places of safety core service met this target with a completion rate of 90%. However, four areas of training fell below the 75% target. These were safeguarding adults level two, intermediate life support and approaches to violence through effective recognition and training for staff; both the five day course and a one-day staff refresher.

Health-based place of safety:

- The health-based place of safety was staffed by one senior nurse (Band 7) and one nursing assistant at all times. Staff worked a shift pattern to staff the service 24 hours a day. Additional staffing was available on request from a number of wards based at the Oleaster Centre.
- The trust did not provide details of sickness rates, vacancy rates and staff turnover for the health-based places of safety for the period December 2015 to November 2016.
- Staff reported that they experienced no difficulties or delays in accessing medical staff for Mental Health Act assessments. During the inspection, we saw that an appropriately qualified doctor arrived promptly to assess a patient at the health-based place of safety.
- The trust provided staff with mandatory training and had a target completion rate of 85%.Overall, the crisis and health-based places of safety core service met this target with a completion rate of 90%. However, four areas of training fell below the 75% target. These were

safeguarding adults level two, intermediate life support and approaches to violence through effective recognition and training for staff; both the five day course and a one-day staff refresher.

Psychiatric decisions unit:

- The psychiatric decisions unit (PDU) had a staff team of one whole time equivalent team manager, four whole time equivalent band 6 nurses and four band 3 nursing assistants. Staff worked a shift pattern to provide a service 24 hours a day.
- The trust did not provide details of sickness rates, vacancy rates and staff turnover for psychiatric decisions unit for the period December 2015 to November 2016.
- The PDU had one 0.9 whole time equivalent consultant psychiatrist who attended the unit daily. The unit had no rostered medical cover at night. However, the on-call doctor at the Oleaster Centre provided cover for physical health, prescribing medication or in the event of an emergency. Staff reported that this arrangement did not create any difficulties.
- The trust provided staff with mandatory training and had a target completion rate of 85%. Overall, the crisis and health-based places of safety core service met this target with a completion rate of 90%. However, four areas of training fell below the 75% target. These were safeguarding adults level two, intermediate life support and approaches to violence through effective recognition and training for staff; both the five day course and a one-day staff refresher.

Assessing and managing risk to patients and staff

Crisis resolution home treatment teams:

- We reviewed 12 care records from the crisis resolution home treatment teams. All contained a two-part risk assessment from the trust's electronic record system that staff had completed with patients at admission. The first part was a screening tool and the second allowed staff to make a more detailed assessment of risk. We saw examples of staff communicating specific or high level risks using alerts on electronic records. In nine of the care records, we saw that staff had updated risk assessments at weekly clinical reviews or in response to specific incidents.
- We saw that staff had created crisis plans in 11 of the 12 records reviewed. Plans identified which services to contact in a crisis and how to contact them. Staff reported that patients could contribute advance decisions with regards to how crisis presentations or deterioration in mental state should be managed.
- Staff described how they would respond quickly and appropriately to sudden deterioration in a patient's mental health presentation. Staff reported that they would act on concerns raised by patients, family members, carers or other health professionals during visits or raised by telephone.
- Crisis services and health based places of safety did not operate a waiting list. Staff assessed patients referred to crisis resolution home treatment teams within 24 hours and for those entering the service, the aim was for treatment to commence immediately. Crisis resolution home treatment teams managed patients waiting to access an inpatient bed. Staff reported that waiting to access inpatient beds was routine, particularly for informal patients who were not detained under the Mental Health Act. In the period December 2015 to November 2016, the trust recorded 110 incidents of delayed admissions to inpatient beds.
- Lone working took place at crisis resolution home treatment teams. Although, new assessments and medical reviews were always conducted in pairs between one doctor and one nurse, risk assessments were carried out to determine whether it was safe for staff to attend appointments on their own. The trust provided staff with mobile phones that were enabled to be used as personal alarms with global positioning system tracking. We saw other systems to record and monitor the movements of staff including signing in/out books and buddy systems. However, during inspection we saw that staff did not always adhere to these practices when visiting patients in the community. Teams held personal contact details of staff for use in an emergency but could not provide evidence that these were regularly reviewed or updated.
- Medicines management practices varied at the crisis resolution home treatment teams that we visited. We saw that staff stored medication securely and that there were systems in place to check and monitor clinic fridge temperatures. Prescriptions, for use by staff out of hours, were stored in a locked cabinet when not in use. However, there was no record of these prescription numbers to aid reconciliation and audit trailing. Staff reported that they used information from referral forms or contacted GP's directly to ensure that existing

prescribed medications were recorded correctly. However, we saw no clear record of medicine reconciliation on prescription charts. We also found that patient's allergy status was not complete on six of eleven prescription charts reviewed. Staff did not use lockable cases to transport medications between crisis resolution home treatment bases and patients homes. Staff believed that lockable cases risked drawing unwanted attention when working in the community and used plastic containers with a temporary seal as an alternative. However, the trust policy directed staff to ensure that medication was transported in secure locked containers.

- The trust provided staff with safeguarding training of both adults and children. Qualified staff accessed safeguarding training to level three children and level two adults; unqualified staff accessed training to level two children and level one for adults. Records showed that only 70% of staff working in crisis services and health based places of safety had completed level two adults safeguarding. Some staff had accessed additional safeguarding training that was appropriate to the communities they served. Staff we spoke with showed a good understanding of when and how to make a safeguarding referral. Staff accessed safeguarding policies online, knew how to contact local safeguarding leads and the trust's safeguarding team. Staff raised incidents reports when they made safeguarding referrals and described working in partnership with local social care agencies where safeguarding concerns had been identified.

Rapid, Assessment, Interface and Discharge (RAID):

- We reviewed four care records from RAID University Hospital Birmingham. All contained a two-part risk assessment from the trust's electronic record system that staff had completed with patients at admission. The first part was a screening tool and the second allowed staff to make a more detailed assessment of risk. We saw examples of staff communicating specific or high level risks using alerts on electronic records. We saw that staff updated the risk assessments of inpatients at the acute hospital.
- We saw that staff had created crisis management plans in three of the four records reviewed. Plans identified care interventions and destinations on discharge. Staff reported that patients could contribute advance decisions about how care should be managed.
- The trust provided staff with safeguarding training of both adults and children. Qualified staff accessed safeguarding training to level three children and level two adults; unqualified staff accessed training to level two children and level one adult. Records showed that only 70% of staff working in crisis services and health based places of safety had completed level two adults safeguarding.
- Staff described how they would respond quickly and appropriately to sudden deterioration in a patient's mental health presentation. Staff reported that they would act on concerns raised by patients, family members, carers or other health professionals during assessments in accident and emergency departments. Staff responded to deterioration or changes in the mental state of inpatients at acute hospitals based on observation and the reports of staff on inpatient wards.
- RAID University Hospital Birmingham did not operate a waiting list. Staff received referrals through a secure electronic emails system and allocated assessments throughout the day. Staff prioritised referrals from the accident and emergency, followed by clinical decisions unit and finally, from inpatient wards.
- RAID University Hospital Birmingham staff did not prescribe or dispense medications. Instead staff consulted with and made recommendations to the responsible clinician of the patients inpatient care. Staff contacted other professionals to confirm the medicines that patients reported to them, including GP's and staff from substance misuse services.

Health-based place of safety:

- We looked at the electronic records for five patients assessed at the health-based place of safety. We found that in all cases, staff had updated the electronic patient record, including risk assessment and an entry in the patient's progress record.
- The trust provided staff with safeguarding training of both adults and children. Qualified staff accessed safeguarding training to level three children and level two adults; unqualified staff accessed training to level two children and level one adult. Records showed that only 70% of staff working in crisis services and health based places of safety had completed level two adults safeguarding

Requires improvement

Are services safe?

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

- Staff could view the care records of any patient known to the trust. This meant that they could view any existing crisis plans or advanced decisions made by patients presenting at the health based place of safety.
- We saw that staff observed patients for the duration of their detention at the health-based place of safety. This meant that they were able to respond quickly and appropriately to a sudden deterioration in a patient's mental health presentation.
- Staff assessed the need for police support within the health-based place of safety with a risk assessment tool detailed in the multi-agency protocol. We interviewed the police liaison officer who was in attendance at the health-based place of safety. They reported that staff only asked police officers to remain at the place of safety when a medium or high patient risk was identified and never because of a lack of staff resources.
- Medicines were not stored at the health-based place of safety. When a patient was prescribed medication staff accessed it from the psychiatric decisions unit, located in the same building. Staff reported that medication was rarely prescribed for patients attending there.

Psychiatric decisions unit:

- We reviewed two care records; each contained a two-part risk assessment from the trust's electronic record system that staff had completed with patients. The first part was a screening tool and the second allowed staff to make a more detailed assessment of risk. Staff at the psychiatric decisions unit reviewed and updated risk assessments of patients referred from rapid, assessment, interface and discharge teams.
- Staff could view the care records of any patient known to the trust. This meant that they could view any existing crisis plans or advanced decisions made by patients presenting at the health-based place of safety.
- We saw that staff observed patients for the duration of their stay at the psychiatric decisions unit. This meant that they were able to respond quickly and appropriately to a sudden deterioration in a patient's mental health presentation.
- The trust provided staff with safeguarding training of both adults and children. Qualified staff accessed safeguarding training to level three children and level two adults; unqualified staff accessed training to level two children and level one adult. Records showed that only 70% of staff working in crisis services and health based places of safety had completed level two adults safeguarding. Staff we spoke with showed a good understanding of when and how to make a safeguarding referral. Staff accessed safeguarding policies online, knew how to contact local safeguarding leads and the trust's safeguarding team. Staff raised incidents reports when they made safeguarding referrals and described working in partnership with local social care agencies where safeguarding concerns had been identified.
- We saw that staff had not checked the temperature of a fridge located in the units office on a daily basis. Staff used this fridge to store food and drink items supplied for patient use. We also saw that staff had not checked the clinic room temperature on a daily basis, however this room had been identified and reported as too hot for medication storage. Omissions were identified on the four days prior to visiting the unit. Staff were using an alternative secure room for the storage of medication. We saw that staff undertook regular temperature checks in this area.
- We saw that staff stored medicines securely in a locked cupboard that was only accessible to appropriately qualified staff.

Track record on safety

Crisis resolution home treatment teams

- In the period November 2015 to October 2016, crisis resolution home treatment teams reported 22 serious incidents requiring investigation. The most common type of incident meeting the criteria for reporting was patient self-inflicted harm. One report involved the death of a patient.
- Staff provided examples of changes to practice within crisis services as a result of serious incident investigations. This included changes in the way that staff handed over information between day and night shifts in the crisis resolution home treatment teams. The current system of using secure emails had replaced a telephone handover to teams.

Rapid, Assessment, Interface and Discharge (RAID):

- In the period November 2015 to October 2016 RAID services reported one serious incident requiring investigation. This related to disruptive, aggressive or violent behaviour.
- Staff provided examples of changes to practice within crisis services as a result of serious incident investigations. This included changes to the

assessment, review and discharge of patients presenting to RAID with dual diagnosis presentations. Dual diagnosis is the term used to describe patients with mental health and substance misuse challenges.

Health-based place of safety

- In the period November 2015 to October 2016 the health based place of safety reported no serious incidents requiring investigation.

Psychiatric decisions unit

- In the period November 2015 to October 2016 the psychiatric decisions unit reported no serious incidents requiring investigation.

Reporting incidents and learning from when things go wrong

Crisis resolution home treatment teams:

- Staff from crisis resolution home treatment teams knew how to report and gave examples of the types of incidents to be reported. This included safeguarding reports, medication errors, occurrences of aggression and occurrences of patient self-injury or accidents. Staff recorded incidents on an electronic reporting system and documented it in treatment records.
- The trust's electronic reporting system provided managers with a dashboard that allowed them to manage and view incidents reported by their teams. The dashboard categorised incidents and detailed the number of days since the last incident in a category had occurred.
- Staff we spoke with described their approach to duty of candour. They reported being open and transparent with patients and explained when things go wrong.
- The trust's electronic reporting system provided email feedback to staff reporting incidents that did not meet the serious threshold. Staff could also view incidents that had occurred across the trust and access the trust's risk register. The system included It Takes 3; a series of short films sharing learning from incidents across the trust.
- Staff reported that they met to discuss feedback from incidents at handovers, multidisciplinary meetings and supervision. We also saw examples of staff meetings, where learning from incidents was discussed and recorded. If absent, staff could access the minutes of team meetings on their return.
- Staff reported receiving de-brief and support following a serious incident. Some described it as an informal process in teams that was not recorded; others reported meeting more formally and recording outcomes on incident forms or in supervision records. Managers we spoke with showed awareness of the trust's employee wellbeing service that they could refer staff to for additional support.

Rapid, Assessment, Interface and Discharge (RAID):

- Staff from RAID teams knew how to report and gave examples of the types of incidents to be reported. This included safeguarding reports, medication errors, occurrences of aggression and occurrences of patient self-injury or accidents. Staff recorded incidents on an electronic reporting system and documented it in treatment records.
- The manager of the RAID service also had access to University Hospital Birmingham's electronic reporting system and where needed recorded incidents here. For example; if staff discharged a patient against the recommendation of RAID.
- The trust's electronic reporting system provided managers with a dashboard that allowed them to manage and view incidents reported by their teams. The dashboard categorised incidents and detailed the number of days since the last incident in a category had occurred.
- Staff we spoke with described their approach to duty of candour. They reported being open and transparent with patients and explained when things go wrong.
- Staff reported that they met to discuss feedback from incidents at handovers, multidisciplinary meetings and supervision.
- Staff reported receiving de-brief and support following a serious incident. Some described it as an informal process in teams that was not recorded; others reported meeting more formally and recording outcomes on incident forms or in supervision records. Managers we spoke with showed awareness of the trust's employee wellbeing service that they could refer staff to for additional support.

Health-based place of safety:

- The trust's electronic reporting system provided managers with a dashboard that allowed them to

manage and view incidents reported by their teams. The dashboard categorised incidents and detailed the number of days since the last incident in a category had occurred.

- The trust's electronic reporting system provided email feedback to staff reporting incidents that did not meet the serious threshold. Staff could also view incidents that had occurred across the trust and access the trust's risk register. The system included It Takes 3, a series of short films sharing learning from incidents across the trust.

Psychiatric decisions unit:

- Staff we spoke with on the PDU knew how to report and the types of incidents to be reported. Staff recorded incidents on an electronic reporting system and documented it in treatment records.
- The trust's electronic reporting system provided managers with a dashboard that allowed them to manage and view incidents reported by their teams. The dashboard categorised incidents and detailed the number of days since the last incident in a category had occurred.
- The trust's electronic reporting system provided email feedback to staff reporting incidents that did not meet the serious threshold. Staff could also view incidents that had occurred across the trust and access the trust's risk register. The system included It Takes 3; a series of short films sharing learning from incidents across the trust.
- Staff reported that they met to discuss feedback from incidents at handovers, multidisciplinary meetings and supervision. Staff also regularly met as a group where learning from incidents was discussed and recorded. If absent, staff could access the minutes of team meetings on their return.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

Crisis resolution home treatment teams:

- Staff from crisis resolution home treatment completed the trusts assessment summary document for new patients. We looked at 12 care records and all contained a complete assessment summary document as part of the trust's electronic patient record. Assessment summaries were holistic and included social circumstances, family history and substance misuse.
- Staff from crisis resolution home treatment completed crisis care plans with new patients or added to the plans of existing trust patients. Plans were present in 11 of the 12 records that we reviewed. Interventions focused on managing the presenting crisis, safety, and discharge from crisis services. Plans lacked individuality and patient involvement; we found the 'my mental health recovery' section was often incomplete. Interventions lacked detail and appeared similar across the plans reviewed.
- All staff accessed and recorded information using the trust's electronic care records system. Community staff accessed the system remotely where they had an internet connection, using laptops provided by the trust. Staff could view patient records from all services within the trust. This helped staff to provide safe and consistent care.
- Staff ensured assessments of patients detained in the health based place of safety began as soon as possible after their arrival. The police or ambulance staff notified health-based place of safety staff of a patients expected arrival, who then contacted the relevant professionals to carry out the Mental Health Act assessments. This helped ensure that timely assessments and avoid delays for the patient.

Rapid, Assessment, Interface and Discharge (RAID):

- Staff from RAID completed the trusts assessment summary document for new patients or updated documents of existing trust patients. We looked at four care records and all contained a complete assessment summary document as part of the trust's electronic patient record.
- Staff from RAID completed crisis care plans with new patients or added to the plans of existing trust patients. Plans were present in three of the four records reviewed. Although interventions focused on managing the presenting crisis, safety, and discharge from crisis services; crisis care plans lacked individuality.
- All staff accessed and recorded using the trust's electronic care records system. We saw that this was accessible to RAID staff working from acute hospital bases. Staff could view patient records from all services within the trust. This helped staff to provide safe and consistent care.

Health-based place of safety:

- Staff updated the electronic patient record of patients assessed at the health based place of safety, including risk assessment and an entry in the patient's progress record. We reviewed five patient records and found details of comprehensive assessments undertaken by an appropriately qualified doctor.
- Care plans were not formulated by staff at the health-based places of safety
- All staff accessed and recorded using the trust's electronic care records system. Staff could view patient records from all services within the trust. This helped staff to provide safe and consistent care.

Psychiatric decisions unit:

- Staff from the psychiatric decisions unit reviewed and where necessary updated the trusts assessment summary document for patients referred from Rapid, Assessment, Interface and Discharge (RAID) teams. We looked at two care records and both contained a complete assessment summary document as part of the trust's electronic patient record.
- Staff from the psychiatric decisions unit reviewed and where necessary updated the crisis care plans of patients referred to the unit. Plans were present in both of the records reviewed. Interventions focussed on discharge from crisis services, contact telephone numbers and medications.
- All staff accessed and recorded using the trust's electronic care records system. Staff could view patient records from all services within the trust. This helped staff to provide safe and consistent care.

Best practice in treatment and care

Crisis resolution home treatment teams:

Are services effective?

Good

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

- We saw evidence of staff using National Institute of Health and Care Excellence (NICE) guidance relevant to their practice for prescribing medication. This included guidance on the management of personality disorders and alcohol-use disorders.
- The crisis services did not have psychologists as part of their staff teams. When staff identified a need for psychological therapies, staff recommended this as part of a patient's referral to community mental health teams or to the trust's primary care psychological therapies service.
- Staff provided patients with information about agencies that could support them with employment, housing and benefits needs.
- Crisis resolution and home treatment teams provided a range of physical interventions for patients including blood tests, monitoring patients following electroconvulsive therapy and a trust electrocardiogram service for patients commencing anti-psychotics. Care records showed that staff undertook monitoring of patients physical health where a need had been identified.
- Staff used the health of the nation outcomes scale to measure the health and social functioning of people with mental illness. Staff used other ratings and outcome measures including the mini-mental state examination and the clinical institute withdrawal assessment for alcohol.
- Staff participated in regular clinical audits of the quality and completeness of patient care records. Staff shared outcomes at handovers or during managerial supervision. Teams also reported specific clinical audit activities covering a range of clinical areas including hand hygiene and referral outcomes.

Rapid, Assessment, Interface and Discharge (RAID):

- Although RAID services did not prescribe or dispense medication, staff described using National Institute of Health and Care Excellence (NICE) guidance relevant to their practice for prescribing of medication in order to offer guidance to accident and emergency staff on prescribing for alcohol-use disorders and mental illness.
- RAID staff at University Hospital Birmingham did not have psychologists as part of their staff teams. When staff identified a need for psychological therapies they recommended this as part of a patient's referral to community mental health teams or the trust's primary care psychological therapies service.
- Staff provided patients with information about agencies that could support them with employment, housing and benefits needs. Information leaflets provided by RAID contained a range of helpful telephone numbers and websites.
- Staff reported that patients accessing RAID had recorded physical health checks completed by the referring agency, for example; accident and emergency. However, the four care records reviewed demonstrated that referring staff had not recorded patient's physical health checks prior to transferring care to the RAID team.
- Staff used the health of the nation outcomes scale to measure the health and social functioning of people with mental illness. Staff used other rating and outcome measures including the mini-mental state examination and the clinical institute withdrawal assessment for alcohol.
- Staff participated in regular clinical audits of the quality and completeness of patient care records. Staff shared outcomes at handovers or during managerial supervision. Teams also reported specific clinical audit activities covering a range of clinical areas including safeguarding and referral to assessment response times.

Health-based place of safety:

- The health-based place of safety did not have psychologists as part of their staff teams.
- Staff reported that patients accessing the health-based place of safety often had recorded physical health checks completed by the referring agency, for example; accident and emergency or street triage service. Staff at the health-based place of safety had access to physical health monitoring equipment to undertake any additional physical health checks or respond to deterioration in a patient's physical health.
- Staff at the health-based place of safety had not audited the quality or completeness of information recorded on Section 135/136 monitoring forms. The trust reported that this was planned to take place in September 2017 as part of the urgent care audit schedule.

Psychiatric decisions unit:

- Staff reported following National Institute of Health and Care Excellence (NICE) and Nursing & Midwifery Council guidance relevant to their practice when assessing, planning and delivering patient care.

Are services effective?

Good

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

- Staff provided patients with information about agencies that could support them with employment, housing, and benefits needs. Information leaflets provided the psychiatric decisions unit contained a range of helpful telephone numbers and websites
- We reviewed two care records, both of which demonstrated that staff had recorded patients' physical observations, including blood pressure and pulse, on arrival to the unit.
- Staff reported that they used rating and outcome measures, including the clinical institute withdrawal assessment for alcohol, with patients on the unit.
- Staff participated in regular clinical audits of the quality and completeness of patient care records. Staff shared outcomes at handovers or during managerial supervision.

Skilled staff to deliver care

Crisis resolution home treatment teams:

- Crisis services consisted of doctors, nurses, support workers and administrative staff. One of the crisis resolution home treatment teams that we visited had an occupational therapist on the team. We saw examples of nurses holding enhanced roles on teams, including prescribing and approved mental health professional.
- We saw that staff had the necessary qualifications and experience to carry out their roles. The majority of nursing positions in crisis resolution home treatment teams were at Band 6, which reflected the level of experience expected for the role.
- Staff received a trust induction on commencing their roles, this included training and awareness of trust policies and procedures. We also saw examples of induction practices specific to teams, including buddying arrangements.
- Staff had access to clinical and managerial supervision and regular access to support in handovers and multidisciplinary team meetings. Staff reported receiving managerial supervision every six to eight weeks which was in line with local policy. We saw that supervision sessions were recorded on an employee self-service electronic record which staff used to confirm information recorded and schedule a future meeting. The trust reported that it was developing an electronic system to record clinical supervision activity and planned for this system to go live in April 2017.
- The trust reported that as of November 2016 the overall appraisal rate for crisis resolution home treatment staff was 90%.
- Staff were able to access specialist training for their roles. Staff we spoke with provided examples of bespoke training that they could access such as phlebotomy, approved mental health professional training, management and leadership courses.
- Team managers addressed poor staff performance promptly and effectively in one-to-one management supervision. Team managers demonstrated when and how to escalate concerns higher in the organisation; for example to human resources or occupational health.

Rapid, Assessment, Interface and Discharge (RAID):

- The multidisciplinary RAID team at University Hospital Birmingham consisted of doctors, nurses, support workers and administrative staff.
- We saw that staff had the necessary qualifications and experience to carry out their roles. The majority of nursing positions at RAID University Hospital Birmingham were at Band 6 which reflected the level of experience expected for the role.
- Staff received a trust induction on commencing their roles, this included training and awareness of trust policies and procedures. Staff joining the RAID team at University Hospital Birmingham were given the opportunity to work a period as supernumerary upon commencement of employment.
- Staff had access to clinical and managerial supervision, and regular access to support in handovers and multidisciplinary team meetings. Staff reported receiving managerial supervision every six to eight weeks which was in line with local policy. We saw that supervision sessions were recorded on an employee self-service electronic record which staff used to confirm information recorded and schedule a future meeting. The trust reported that it was developing an electronic system to record clinical supervision activity and planned for this system to go live in April 2017.
- The trust reported that as of November 2016, the overall appraisal rate for RAID teams was 88%.
- Staff were able to access specialist training for their roles. Staff we spoke with provided examples of conferences in psychiatric liaison and leadership courses.

Are services effective?

Good

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

- Team managers addressed poor staff performance promptly and effectively in one-to-one management supervision. Team managers demonstrated when and how to escalate concerns higher in the organisation; for example to human resources or occupational health.

Health-based places of safety:

- Health-based places of safety multidisciplinary team consisted of doctors, nurses, support workers and administrative staff. Approved mental health professionals were employed and co-ordinated by the local council via the section 75 agreement and attended the suite as required.
- The health-based place of safety was always staffed by a senior Band 7 nurse which reflected the level of experience expected for the role.
- Staff received a trust induction on commencing their roles, this included training and awareness of trust policies and procedures.
- The trust reported that as of November 2016 the overall appraisal rate for crisis services and health-based places of safety staff was 89%.

Psychiatric decisions unit:

- The psychiatric decisions unit multidisciplinary team consisted of doctors, nurses and support workers. Staff held the necessary qualifications and experience to carry out their roles.
- Staff received a trust induction on commencing their roles, this included training and awareness of trust policies and procedures.
- Staff had access to clinical and managerial supervision, and regular access to support in handovers and multidisciplinary team meetings. Staff reported receiving managerial supervision every six to eight weeks, which was in line with local policy. The trust reported that it was developing an electronic system to record clinical supervision activity and planned for this system to go live in April 2017.
- The trust reported that as of November 2016 the overall appraisal rate for crisis services and health-based places of safety staff was 89%.
- The team manager addressed poor staff performance promptly and effectively in one-to-one management supervision and demonstrated when and how to escalate concerns higher in the organisation; for example to human resources or occupational health.

Multi-disciplinary and inter-agency team work

Crisis resolution home treatment teams:

- Crisis resolution home treatment teams held weekly multi-disciplinary team meetings for each psychiatrist attached to the team. Staff provided examples of where representatives from the local community mental health team and acute admission ward attended these meetings.
- Crisis resolution home treatment teams held two handovers; one during the day and another at the end of the shift. We observed one crisis resolution home treatment team handover; all staff on duty attended and discussed all active patients, new referrals and diary tasks.
- Staff reported having good communication links with other teams within the trust, including inpatient services, community mental health teams and other specialist services. However, teams reported difficulties in contacting and working with the SMS services. This was as a result of these services no longer being provided by the trust and the subsequent disjoint with working practices of the new provider organisation.
- Crisis resolution home treatment teams worked closely with community mental health teams to prevent delays in discharge. Crisis resolution home treatment referred new patients to community mental health teams at admission and monitored the referral's progress regularly. Staff undertook regular joint visits where patients where already under the care of a community mental health team.
- The trust operated a multi-agency protocol for patients detained under Section 135/Section 136 of the Mental Health Act. We saw that a multi-agency monitoring group met regularly to discuss data, feedback and significant events from the health-based place of safety.

Rapid, Assessment, Interface and Discharge (RAID):

- Staff at RAID held daily multi-disciplinary team meetings to discuss new referrals, existing patients open to the service and allocate tasks for the day. We observed one meeting and found it to be well organised and thorough.
- Handover systems were in place at the teams we visited to ensure that staff communicated tasks and information between each shift. RAID staff worked 12 hour shifts so handovers took place at the start and end of the shift to reflect this.

Are services effective?

Good

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

- Staff reported having good communication links with other teams within the trust, including inpatient services, community mental health teams and other specialist services.
- Staff reported good working links external health and social care providers. Staff identified good working links with acute hospital staff, safeguarding and emergency duty teams and substance misuse services.

Health-based places of safety:

- Handover systems were in place at the health based place of safety to ensure that staff communicated tasks and information between each shift.
- We saw evidence of effective links with external teams and agencies. During the inspection we spoke with police and paramedics accompanying patients to the health-based place of safety. The police constable described the place of safety as a good facility that provided a consistent 24 hour service. The paramedics told us that protocols to transport patients to the place of safety worked well, a police officer had accompanied the patient in the ambulance that day. During the inspection we saw a paramedic providing a verbal handover to an approved mental health practitioner and an appropriately qualified doctor.
- Staff at the health-based place of safety reported that they had worked hard to develop good working links within the organisation with community teams, inpatient wards and crisis services. We saw evidence of handover to other teams when patients were being transferred from the health-based places of safety.

Psychiatric decisions unit:

- Handover systems were in place at the PDU to ensure that staff communicated tasks and information between each shift.
- PDU staff reported having good communication links with other teams within the trust; including crisis resolution home treatment and in particular, the rapid, assessment, interface and discharge team based at University Hospital Birmingham.
- Staff reported good working links external health and social care providers. This included housing services, local authority and substance misuse services.
- The trust was not commissioned to provide mental health services to patients aged 18 to 25 years. However, these patients were seen at psychiatric decisions unit (PDU). Staff from the responsible provider did attend at the PDU to assess patients and co-ordinate treatment plans. Staff at the PDU reported that they had worked hard to develop a good working relationship with this provider.

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

Crisis resolution home treatment teams:

- The trust provided training in the Mental Health Act (MHA). Figures for January2017 indicated that 97% of crisis resolution and home treatment staff had completed training in the MHA. This course was mandatory for staff and repeated every three years.
- Staff we spoke with to demonstrated a good understanding of the Mental Health Act (MHA), the Code of Practice and the guiding principles. Staff knew where to seek advice on the Mental Health Act if they needed it.
- Staff accessed administrative support and legal advice on the implementation of the Mental Health Act from the trust's centrally located lead team.
- Staff that we spoke with were not aware of any regular audits undertaken locally to ensure that the Mental Health Act was being applied correctly to patient care.
- Crisis resolution home treatment teams stored completed medical recommendation forms for admission under the Mental Health Act when an admission bed was not immediately available. Staff recalled occasions when medical recommendations had expired prior to an admission bed being found, a period of 14 days. However, the trust did not record the number of times that medical recommendations expired because of waits to access inpatient beds.
- Staff reported that crisis resolution home treatment teams delivered recalled notices along with arranging inpatient admission for patients subject to Mental Health Act Community Treatment Orders. At the time of the inspection staff reported that they were not currently involved in the care or treatment of any patients subject to Community Treatment Orders.
- Staff we spoke with knew who their provider of independent mental health advocacy was and how to refer patients to this service.

Rapid, Assessment, Interface and Discharge (RAID):

Are services effective?

Good

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

- The trust provided training in the Mental Health Act (MHA). Figures for January2017 indicated that 97% of crisis services and health-based places of safety staff had completed training in the MHA. This course was mandatory for staff and repeated every three years.
- Staff we spoke with to demonstrated a good understanding of the Mental Health Act (MHA), the Code of Practice and the guiding principles. Staff knew where to seek advice on the Mental Health Act if they needed it.
- Staff reported that they received patients detained under Section 135/136 of the Mental Health Act at accident and emergency departments when there were concerns for a patient's physical health. Staff reported that they recorded times of arrival and discharge in patients care records, and provided patients with information on their rights under the Mental Health Act.
- Staff reported that they provided information on rights to patients detained under the Mental Health Act at University Hospital Birmingham. We saw that Mental Health Act documentation was present and correct in two applicable records that we reviewed.
- Staff accessed administrative support and legal advice on the implementation of the Mental Health Act from the trust's centrally located lead team.
- Staff that we spoke with were not aware of any regular audits undertaken locally to ensure that the Mental Health Act was being applied correctly to patient care.
- Staff we spoke with knew who their provider of independent mental health advocacy was and how to refer patients to this service.

Health-based places of safety:

- The trust provided training in the Mental Health Act (MHA). Figures for January 2017 indicated that 97% of crisis services and health-based places of safety staff had completed training in the MHA. This course was mandatory for staff and repeated every three years.Staff we spoke with to demonstrated a good understanding of the Mental Health Act (MHA), the Code of Practice and the guiding principles. Staff knew where to seek advice on the MHA if they needed it.
- Staff accessed administrative support and legal advice on the implementation of the Mental Health Act from the trust's centrally located lead team.
- Police and staff at the health-based place of safety completed a Section 135/136 place of safety monitoring form that accompanied detained patients. Staff at the health-based place of safety were responsible for recording legal matters at the place of safety and the outcome of assessments. Staff uploaded completed forms to patient's electronic records.
- We reviewed 11 Section 135/136 place of safety monitoring forms. There was inconsistency in recording of people receiving their rights. Staff had recorded that five patients had received their rights in verbal and written form and six patients had not received any information on their rights. However, during the inspection we saw staff giving a Mental Health Act rights leaflet to a patient detained for assessment. Staff also talked to the patient and provided explanation about information in the leaflet.
- We found an overall lack of consistency in the completion of Section 135/136 place of safety monitoring forms. Only two demonstrated full completion. We found that two forms did not record a time of arrival to the place of safety. On six forms, staff had not calculated the total time from arrival at the first place of safety to release or section. This demonstrated that staff did not follow guidelines set by the Mental Health Act Code of Practice and the Royal College of Psychiatrist's guidance for Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales).
- The trust had not audited the quality or completeness of information recorded on Section 135/136 monitoring forms and reported that this was planned to take place in September 2017 as part of the urgent care audit schedule.
- We saw information about independent mental health advocacy services on posters and in leaflets available to patients at the health-based place of safety.

Psychiatric decisions unit:

- The psychiatric decisions unit did not accept referrals of patients already detained under the Mental Health Act. If a patient's mental health deteriorated while on the unit, staff could arrange for assessment under the Mental Health Act.
- The trust provided training in the Mental Health Act (MHA). Figures for January2017 indicated that 97% of crisis services and health-based places of safety staff had completed training in the MHA. This course was mandatory for staff and repeated every three years.

Are services effective?

Good

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

- Staff we spoke with to demonstrated a good understanding of the Mental Health Act (MHA), the Code of Practice and the guiding principles. Staff knew where to seek advice on the Mental Health Act if they needed it.
- In the event of a patient requiring a Mental Health Act assessment, staff accessed administrative support and legal advice on the implementation of the Mental Health Act from the trust's centrally located lead team. The unit's manager was an approved mental health professional.
- We saw information about independent mental health advocacy services on posters and in leaflets available to patients at the psychiatric decisions unit.

Good practice in applying the Mental Capacity Act

Crisis resolution home treatment teams:

- The trust provided training in the Mental Capacity Act (MCA). Figures for January 2017 indicated that 99% crisis services staff had completed training in the MCA. This course was mandatory for staff and repeated every three years.
- Staff we spoke with displayed understanding of the Mental Capacity Act and its guiding principles. Staff could explain the presumption of mental capacity and acting in a patient's best interests where the patient lacks capacity.
- Staff assessed a patient's capacity to consent or refuse treatment if concerns were identified during assessments or patient reviews. Staff recorded outcomes as part of a patient's electronic care record.
- Staff at the north crisis resolution home treatment team reported that the service had not yet been involved in any best interests meetings of patients that lacked capacity.
- The trust provided a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and accessed it on the trusts intranet when they needed advice on the Mental Capacity Act. Staff also reported opportunities to discuss patient's capacity at handovers and multidisciplinary meetings.

Rapid, Assessment, Interface and Discharge (RAID):

- The trust provided training in the Mental Capacity Act (MCA). Figures for January 2017 indicated that 99% crisis services and health-based places of safety staff had completed training in the MCA. This course was mandatory for staff and repeated every three years.
- The trust provided a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and accessed it on the trusts intranet. Staff also reported opportunities to discuss patient's capacity at handovers and multidisciplinary meetings.
- Medical staff assessed a patient's capacity to consent or refuse treatment if concerns were identified during admission, patient reviews or assessment under the Mental Health Act. Staff recorded outcomes as part of a patient's electronic record.
- The RAID team supported staff from acute hospitals where concern for a patient's capacity was identified. Staff provided examples of attending best interests meetings, particularly in determining the discharge destination of patients.
- The trust provided a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and accessed it on the trusts intranet. Staff also reported opportunities to discuss patient's capacity at handovers and multidisciplinary meetings.

Health-based places of safety:

- The trust provided training in the Mental Capacity Act (MCA). Figures for January 2017 indicated that 99% crisis services and health-based places of safety staff had completed training in the MCA. This course was mandatory for staff and repeated every three years.Staff we spoke with displayed an understanding of the Mental Capacity Act and its guiding principles. Staff could explain the presumption of mental capacity and acting in a patient's best interests where the patient lacks capacity.
- Medical staff assessed a patient's capacity to consent or refuse treatment if concerns were identified during assessment under the Mental Health Act. Staff recorded outcomes as part of a patient's electronic record.
- The trust provided a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and accessed it on the trusts intranet.

Psychiatric decisions unit:

Are services effective?

Good

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

- The trust provided training in the Mental Capacity Act (MCA). Figures for January 2017 indicated that 99% crisis services and health-based places of safety staff had completed training in the MCA. This course was mandatory for staff and repeated every three years.
- Staff we spoke with displayed a good understanding of the Mental Capacity Act and its guiding principles. Staff could explain the presumption of mental capacity and acting in a patient's best interests where the patient lacks capacity.
- The trust provided a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy and accessed it on the trusts intranet.
- Patients referred to the unit, were required to have capacity as part of the eligibility criteria. If a patient's presentation deteriorated while on the unit, capacity was re-assessed as part of the assessment process.

Requires improvement

Are services caring?

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

Our findings

Kindness, dignity, respect and support

Crisis resolution home treatment teams:

- During the inspection, we observed five community visits provided by crisis resolution home treatment teams. Staff demonstrated caring, respect and expertise during their interactions with patients. We saw that staff demonstrated active listening skills, sensitivity and used language that patients could understand. We saw staff discussing treatment options with patients, identifying additional sources of community support and concluding appointments with a plan.
- We conducted telephone interviews with eight patients that had experience of using crisis resolution home treatment services. Seven patients reported that staff were polite, respectful and caring. Three patients reported that on occasions their appointments had felt hurried and staff had not always given their full attention. Seven patients recalled that staff had provided contacted numbers for crisis resolution home treatment services in and out of hours. Patients commonly reported that they had experienced frequent changes in the staff delivering their care; however, they also appeared to understand the reason why this happened.The 2016 MH Community Patient Survey, reported 75% of trust patients felt sufficient time was made available to meet their needs and treatment,and reported 98% of patients felt they were able to contact those in charge of organising their care
- During the inspection we saw that staff demonstrated a good understanding of the individual needs of patients. Staff supported patients in areas other than mental health including physical health, financial, employment, and social needs.
- During the inspection we saw that staff maintained patient confidentiality by using only trust approved electronic communication systems, accessing records correctly and not discussing patient information in public areas. Five patients we spoke with could not recall discussions with staff about how or with whom information could be shared. We also found this information not to be routinely recorded or accessible in the crisis resolution home treatment team electronic records we viewed.
- We received eight completed CQC comment cards from patients that had experience of using crisis services and health-based places of safety. Of these, seven were about the Handsworth crisis resolution home treatment team. Three were positive comments about the quality of care and three were negative comments about waiting times, staff attitudes and cleanliness of environments.

Rapid, Assessment, Interface and Discharge (RAID):

- During the inspection, we observed two inpatient reviews conducted by RAID. Staff demonstrated caring, respect and expertise during their interactions with patients. Staff demonstrated active listening skills, sensitivity and used language that patients could understand. We saw staff discussing treatment options with patients and identifying additional sources of community support.
- We conducted one telephone interview with a patient that had experience of using RAID services. They reported that staff were polite, respectful and caring. Staff provided clear information to the patient and considered areas other than mental health including diet and medication. The patient reported that staff provided emergency contact details and a summary letter to their GP.
- Leaflets provided by RAID included details on where patients could locate more information about confidentiality. During the inspection, we saw that staff maintained patient confidentiality by using only trust approved electronic communication systems, accessing records correctly and not discussing patient information in public areas.
- We received eight completed CQC comment cards from patients that had experience of using crisis services and health-based places of safety. Of these, none were about the trusts' RAID teams.

Health-based place of safety:

- During the inspection we saw staff interacting with patients admitted to the health based place of safety. Staff demonstrated caring, respect and expertise during these interactions. We also saw staff offering drinks and snacks to patients during their stay.
- We saw that staff maintained patient confidentiality by using only trust approved electronic communication systems, accessing records correctly and not discussing patient information in public areas.

Requires improvement

Are services caring?

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

- We received eight completed CQC comment cards from patients that had experience of using crisis services and health-based places of safety. Of these, none were about the health-based place of safety.

Psychiatric decisions unit:

- During the inspection, we saw staff interacting with patients admitted to the psychiatric decisions unit. Staff demonstrated caring, respect and expertise during these interactions.
- Leaflets provided by the psychiatric decisions unit included details on where patients could more information about confidentiality. We saw that staff maintained patient confidentiality by using only trust approved electronic communication systems, accessing records correctly and not discussing patient information in public areas.
- We received eight completed CQC comment cards from patients that had experience of using crisis services and health-based places of safety. Of these, one was about the psychiatric decisions unit. This was a positive comment about the attitudes of staff working at the unit.

The involvement of people in the care that they receive

Crisis resolution home treatment teams:

- We conducted telephone interviews with eight patients that had experience of using crisis resolution home treatment services. Five patients reported that they had not felt involved or been given choices in their care; five out the eight patients could also not recall whether staff had given them a copy of their care plan. We saw that staff at one crisis resolution home treatment base recorded on a patient information board when patients had been given a copy of their care plan. However, staff had not recorded this same information in the patient's electronic care record. This meant that the trust could not monitor if staff were involving patients in their care or sharing documentation with them.
- Of the patients with experience of crisis resolution home treatment teams, two felt that staff had involved or provided support to family or carers. However, one patient reported that their partner had felt isolated from the care provided, and another believed that staff should've involved their family members but hadn't. We saw that the trust offered a family and friends forum, offering help, support and information to those with a patient receiving crisis resolution home treatment services.
- Staff we spoke with were familiar with advocacy services and knew where to obtain information for patients.
- The trust had a service user project that aimed to promote greater involvement in planning and delivery of local mental health services. Staff we spoke with provided examples of how the trust involved people in making decisions about services. This included participation in staff recruitment and service re-design events.
- The trust collected feedback from patients that had used crisis services and health-based places of safety through 'Friends and Family Test' freepost postcards and survey links on the trust website. The trust scored lower than the England average for four of the six months between July and December 2016 for recommending the trust as a place to receive care

Rapid, Assessment, Interface and Discharge (RAID):

- We spoke with two carers who had experience of using RAID services. Both reported that they'd felt supported by the service and were happy with the care that their relative had received.
- We saw that services displayed leaflets that included information about advocacy services and how to access them.
- The trust had a service user project that aimed to promote greater involvement in planning and delivery of local mental health services.
- The trust collected feedback from patients that had used crisis services and health-based places of safety through 'Friends and Family Test' freepost postcards and survey links on its website. The trust scored lower than the England average for four of the six months between July and December 2016 for recommending the trust as a place to receive care.

Health-based place of safety:

- Staff told us that patients could request that family members or carers attend to support them at the health based place of safety.
- We saw that the service displayed leaflets that included information about advocacy services and how to access them.

Are services caring?

Requires improvement

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

- The trust had a service user project that aimed to promote greater involvement in planning and delivery of local mental health services.
- The trust collected feedback from patients that had used crisis services and health-based places of safety through 'Friends and Family Test' freepost postcards and survey links on its website. The trust scored lower than the England average for four of the six months between July and December 2016 for recommending the trust as a place to receive care.

Psychiatric decisions unit:

- We saw that services displayed leaflets that included information about advocacy services and how to access them.

- The trust had a service user project that aimed to promote greater involvement in planning and delivery of local mental health services.
- The trust collected feedback from patients that had used crisis services and health-based places of safety through 'Friends and Family Test' freepost postcards and survey links on its website. The trust scored lower than the England average for four of the six months between July and December 2016 for recommending the trust as a place to receive care.

- Staff at the psychiatric decisions unit displayed comments taken from discharged patient feedback on a piece of artwork. This provided patients with the opportunity to learn about the experiences of people that had used the service.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

Crisis resolution home treatment teams:

- Crisis resolution and home treatment teams operated 24-hours a day, seven days a week. The trust was commissioned to provide services to adults aged 25 and above in Birmingham and 16 years and above in Solihull. The service supported those with serious mental illness in acute psychiatric crisis of a severity that would require hospitalisation without the involvement of crisis resolution home treatment.
- The operational policy stated no exclusion criteria and the decision to offer services are made in response to individual need. However, it did identify mental health presentations where, beyond an initial assessment, crisis resolution home treatment services would not usually be appropriate. For example; mild anxiety disorders, primary diagnosis of alcohol or other substance misuse, and crisis related solely to relationship issues.
- Crisis resolution home treatment teams aimed to assess urgent referrals within four hours and all other referrals within 24 hours unless otherwise agreed with the referrer and/or patient. The trust reported that all crisis resolution home treatment teams had recorded referral to assessment times of 24 hours. The reported average length of a treatment episode with crisis resolution home treatment was 15 days.
- Crisis resolution home treatment teams accepted referrals from professionals and self-referrals from patients with open referral to any trust services. The trust had identified pathways for referrals made in and out of hours. New patients could not refer themselves to crisis resolution home treatment services. The trust's website provided information about who to contact if experiencing a mental health crisis. Advice for people not known to the service was to contact their GP, emergency services or support helplines. New patients could access an assessment with a Rapid, Assessment, Interface and Discharge team when attending at accident and emergency departments with a mental health crisis.
- The trust operated a single point of access (SPOA) from 08:00am to 7:30pm Monday to Friday. SPOA was for all mental health referrals to the trust from professionals and was staffed by senior nurses. After receiving a referral, staff contacted patients directly, recording a range of information including patient contact details, an assessment of risk and safeguarding. Staff at SPOA prioritised referrals to crisis resolution home treatment teams. SPOA staff contacted emergency services when immediate risk was identified.
- In the period December 2015 to November 2016, the trust recorded 9075 referrals made to crisis resolution home treatment teams. Following triage the trust recorded that crisis resolution home treatment teams offered 7807 assessment appointments during the same period.
- Crisis resolution home treatment teams had systems in place that enabled staff to be available to assess patients; for example, one team operated a dedicated assessment nurse each shift. In others, a nurse in charge prioritised referrals and co-ordinated staff accordingly. Crisis resolution home treatment teams responded promptly and adequately when patients telephoned the service. The trust had introduced a Band 6 nurse dedicated to providing crisis resolution home treatment telephone support from 5pm to 8pm. It had been identified that staff could be difficult to access during this period because of scheduled community visits. Out of hours, we saw staff responding to crisis resolution home treatment patients that had phoned in. Staff shortages were identified as an obstacle to providing prompt responses to patient calls.
- Crisis resolution home treatment teams acted as a gatekeeper to inpatient beds in the trust. The trust reported that it had achieved the national 95% target for the proportion of admissions to acute wards gate kept by crisis resolution home treatment teams.
- Crisis resolution home treatment teams provided follow-up to patients discharged from trust inpatient beds. In the period December 2015 to November 2016, 96% of patients on Care Programme Approach received followed up within seven days of discharge from inpatient care. Team managers identified rare occasions when follow-up was requested for patients discharged directly for psychiatric intensive care units.
- Staff described steps taken to engage patients who found it difficult, or were reluctant, to work with mental health services. This included continued attempts to engage at the patients' home, identifying additional engagement opportunities from the patients support network and professional discussions in and outside of the team.

Are services responsive to people's needs?

Requires improvement

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

- Crisis resolution home treatment teams had processes in place to re-engage with patients who did not attend their appointments. Staff described actions they would take depending on the level of patient risk identified. This could include contact by telephone, additional visits to the patient's home and escalation to police.
- Crisis resolution home treatment mainly saw patients in their homes. Staff reported that they provided patients with an estimated time of arrival rather than appointment times to allow for flexibility in their working schedules. Staff maintained contact with their patients, advising them of delays or schedule changes to visits. Staff reported that they accommodated patient requests when arranging visits, for example, providing evening visits where the patient was in employment.

Rapid, Assessment, Interface and Discharge (RAID):

- RAID teams operated 24-hours a day, seven days a week at four acute hospitals across Birmingham. The RAID team at Solihull operated between 7am and 9pm, seven days a week with the crisis resolution home treatment service providing assessments in Solihull out of hours. The teams provided a single point of access to mental health service for patients aged 16 years and over, who attended at accident and emergency departments or were inpatient on acute hospital wards.
- RAID accepted referrals from all acute hospital professionals where teams were based. Clinical responsibility of patients referred to RAID remained with acute hospital until discharge. In the period December 2015 to November 2016 the trust recorded 16819 referrals made to RAID teams.
- RAID teams had allocated referral to assessment target times that varied according to department initiating the referral; for example, staff aimed to see patients referred from accident and emergency departments within one hour of referral. Teams monitored referral to assessment time as a key performance indicator. Information provided by the trust for the period December 15 to November 16 indicated that 94% of referrals from accident and emergency departments had been seen within one hour. This was just below the trust's target of 95%.
- In the period December 2015 to November 2016 the trust recorded the average length of a RAID staff/patient contact as 43 minutes.
- RAID staff could describe the actions they would take if a referred patient left the hospital without being assessed. This included reviewing risk information, trying to telephone the patient or escalation to the police.

Health-based place of safety:

- The health-based place of safety at the Oleaster Centre operated 24-hours a day, seven days a week. Only patients aged 18 years and over detained under Section 135 or Section136 of the Mental Health Act accessed the health-based place of safety. Patients were accompanied to the health-based place of safety by police and ambulance staff. .
- In the period December 2015 to November 2016 the trust recorded 537 referrals to the health-based place of safety. In the same period, recorded outcomes from the health-based place of safety included 208 inpatient admissions under the Mental Health Act, 57 informal inpatient admissions, 91 referrals to crisis resolution home treatment teams and 40 GP follow-ups.
- Crisis resolution home treatment teams were not required to gate keep inpatient admissions referred from the health-based place of safety.

Psychiatric decisions unit:

- The psychiatric decisions unit (PDU) at the Oleaster Centre operated 24-hours a day, seven days a week. The unit was an area where up to eight patients received an extended assessment and decision making service for up to 12-hours. The PDU accepted referrals only from RAID staff of patients aged 18 years and over. Staff then referred patients meeting the age criteria to the provider of 18 to 25 year olds mental health services.
- In the period December 2015 to November 2016, the trust recorded 1620 referrals to the psychiatric decisions unit (PDU). In the same period, recorded outcomes from the PDU included 312 admissions to inpatient beds, 681 crisis resolution home treatment episodes and 214 community mental health team follow-ups.
- The trust recorded an average length of stay of 17 hours for patients on the psychiatric decisions unit (PDU). This was above the 12-hour target identified in the operational policy.
- In the period December 2015 to November 2016, the trust recorded 436 occasions where patients had stays of over 24 hours on the psychiatric decisions unit. The unit did not provide the necessary facilities to accommodate patients for stays of this length, for

Are services responsive to people's needs?

Requires improvement

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

example, patients did not have access to beds. Staff reported that delayed discharges from the psychiatric decisions unit were often because of waits for inpatient bed availability.

The facilities promote recovery, comfort, dignity and confidentiality

Crisis resolution home treatment teams:

- Staff in crisis resolution home treatment teams worked from community bases but primarily saw patients in their own homes. Community bases included patient waiting areas, interview rooms, toilets and access to refreshments.
- The crisis resolution home treatment services we visited had access to interview rooms that provided adequate sound proofing to protect patient confidentiality. We also saw examples of where windows had been obscured to protect patients' privacy.
- Crisis resolution home treatment leaflets included out-of-hours telephone numbers and information about how to obtain urgent or crisis support. We also saw a range of information leaflets available to patients in waiting areas. This included advocacy, access to care records, carers groups, health and medication.

Rapid, Assessment, Interface and Discharge (RAID):

- RAID staff at University Hospital Birmingham had no dedicated area adapted for mental health assessments. Staff often interviewed patients in curtained cubicle areas that lacked privacy for interviews. Staff reported that they could request a high visibility cubicle if they had concerns about interviewing a patient in more isolated areas of the accident and emergency department.
- The RAID team at University Hospital Birmingham had an information leaflet specific to the service which explained the range of interventions and trust services on offer to patients.

Health-based place of safety:

- The health-based place of safety had an outside entrance so people detained for assessment did not have to walk through the Oleaster Centre's reception area.
- The suite provided the necessary rooms and equipment for assessing patients detained under Section 135/136 of the Mental Health Act.
- The two patient areas at the health-based place of safety did not provide patients with access to clocks. This did not meet the standards set out in the Royal College of Psychiatrist's guidance for Standards on the use of Section 136 of the Mental Health Act 1983 (Englandand Wales). However, staff always supervised patients in these areas and explained they would provide the time when asked.
- The health-based place of safety provided sandwiches and refreshment to patients. Staff accessed locked kitchens to obtain hot water for patient drinks. During the inspection, we saw staff offering drinks and snacks to patients. We also saw that clean linen was available for use in patient areas.
- The health based place of safety had a range of information leaflets available to patients.

Psychiatric decisions unit:

- The psychiatric decisions unit provided the rooms and equipment for accommodating patients for periods of up to 12-hours. However, the unit did not have a dedicated room for patient interviews and assessments.
- The psychiatric decisions unit provided facilities for patients to obtain drinks and snacks.
- Patients used reclining chairs for comfort during their stay. However, only one of the lounges used to accommodate patients overnight had blinds to prevent light entering when patients were trying to sleep.
- The psychiatric decisions unit had a range of information leaflets available to patients.

Meeting the needs of all people who use the service

Crisis resolution home treatment teams:

- All the locations visited were accessible to people with disabilities, including wheelchair users.
- Information leaflets displayed were in English. Many of them had information on the reverse detailing how to obtain the leaflet in a different language or format, however, this was also in English. Staff we spoke with were uncertain if locally developed and team specific information leaflets were available in other languages. Staff reported that only verbal translations of these leaflets would be made available to patients.
- Staff reported that they could access interpreters or signers for patients through a contract that the trust

Are services responsive to people's needs?

Requires improvement

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

held. One team manager provided an example of using an Asian-speaking staff member within the team to communicate with patients who didn't use English as their first language.

Rapid, Assessment, Interface and Discharge (RAID):

- The RAID services at University Hospital Birmingham were accessible to people with disabilities; including wheelchair users.
- Information leaflets displayed were in English. Many of them had information on the reverse detailing how to obtain the leaflet in a different language or format, however, this was also in English. Staff we spoke with were uncertain if locally developed and team specific information leaflets were available in other languages. Staff reported that only verbal translations of these leaflets would be made available to patients.
- RAID staff reported that the acute hospital in which they were based was responsible for accessing interpreters or signers for patients. Difficulties in accessing rooms with telephones or monitors created delays in seeing patients.

Health-based places of safety:

- Access to the health-based place of safety and psychiatric decisions unit was step free and both areas had sufficient space to mobilise a wheelchair. One bathroom provided disabled access toilet and shower facilities including grab rails.
- Information leaflets displayed were in English. Many of them had information on the reverse detailing how to obtain the leaflet in a different language or format, however, this was also in English.
- Staff reported that they could access interpreters or signers for patients through a contract that the trust held.

Psychiatric decisions unit:

- The unit was accessible to people with disabilities, including wheelchair users. One bathroom provided disabled access toilet and shower facilities including grab rails.
- Information leaflets displayed were in English. Many of them had information on the reverse detailing how to obtain the leaflet in a different language or format, however, this was also in English.
- Staff reported that they could access interpreters or signers for patients through a contract that the trust held.

Listening to and learning from concerns and complaints

Crisis resolution home treatment teams:

- From December 2015 to November 2016, crisis resolution home treatment teams received 19 complaints. Of those, 12 had been at least partially upheld. None had been referred to the ombudsman.
- We saw information about how to complain on posters and in leaflets at all the locations we visited. Information on how to raise a complaint or compliment was also included on the trust's website.
- Leaflets specific to crisis services identified service managers as the first point of escalation for complaints. However, during our patient interviews none of the respondents reported that they had been given information about how to complain. One respondent reported that they wouldn't feel confident to raise a complaint, believing that their treatment would be negatively affected as a result.
- Staff were aware of the complaints process and reported that they would first try to resolve complaints informally before escalating them in line with guidance. Staff talked about the importance of listening and acknowledging to concerns raised by their patients.
- There were processes in place to inform staff of outcomes and learning from complaints. Team managers told us that they discussed complaints at local governance meetings, summaries of which were made available to staff. Managers also identified where they would raise outcomes with staff individually through emails or supervision practices. Staff reported discussing complaints at handovers, clinical reviews, and operational meetings.

Rapid, Assessment, Interface and Discharge (RAID):

- From December 2015 to November 2016, the rapid assessment interface and discharge teams received six complaints. Of these, five had been at least partially upheld. One had been referred to the ombudsman but the outcome of this referral was not known at the time of the inspection.

Are services responsive to people's needs?

Requires improvement

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

- We saw that information about how to complain was included in leaflets specific to the service. Information on how to raise a complaint or compliment was also included on the trust's website.
- Staff were aware of the complaints process and reported that they would first try to resolve complaints informally before escalating them in line with guidance. Staff talked about the importance of listening and acknowledging to concerns raised by their patients.
- There were processes in place to inform staff of outcomes and learning from complaints. Team managers told us that they discussed complaints at local governance meetings, summaries of which were made available to staff. Managers also identified where they would raise outcomes with staff individually through emails or supervision practices. Staff reported discussing complaints at handovers, clinical reviews, and operational meetings.

Health-based places of safety:

- From December 2015 to November 2016, the health based place of safety received one complaint. This complaint had been at least partially upheld and had not been referred to the ombudsman.
- We saw information about how to complain on posters and in leaflets at the health based place of safety. How to raise a complaint or compliment was also included on the trust's website.

Psychiatric decisions unit:

- From December 2015 to November 2016, the trust reported that no complaints had been received about the psychiatric decisions unit.
- We saw information about how to complain on posters and in leaflets at all the locations we visited. How to raise a complaint or compliment was also included on the trust's website.
- Staff were aware of the complaints process and reported that they would first try to resolve complaints informally before escalating them in line with guidance. Staff talked about the importance of listening and acknowledging to concerns raised by their patients.

Are services well-led?

Good

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

Our findings

Vision and values

Crisis resolution home treatment teams:

- Staff were aware of the organisation's values. Staff we spoke to reported a commitment the trust's core values including compassion, commitment, honesty and openness, and dignity and respect. We saw posters in patient waiting areas detailing the trust values.
- Team managers reported that local statements of purpose reflected the organisation's values and objectives. We also saw the trust's values and objectives reflected in the supervisory and appraisal processes use.
- Staff we spoke with knew who the senior managers in the organisation were. They described them as visible and provided examples of these managers visiting teams. Staff reported that the chief executive wrote a weekly brief, made available to staff via email.

Rapid, Assessment, Interface and Discharge (RAID):

- Staff were aware of the organisation's values.
- The team manager reported that local statements of purpose reflected the organisation's values and objectives. We also saw the trust's values and objectives reflected in the supervisory and appraisal processes use.
- Staff we spoke with knew who the senior managers in the organisation were. They described them as visible and provided examples of these managers visiting the team. Staff reported that the chief executive wrote a weekly brief, made available to staff via email.

Health-based places of safety:

- Staff were aware of the organisation's values. We saw posters in patient waiting areas detailing the trust values.
- We saw the trust's values and objectives reflected in the supervisory and appraisal processes use.

Psychiatric Decisions Unit:

- Staff were aware of the organisation's values. We saw posters in patient areas detailing the trust values.
- We saw the trust's values and objectives reflected in the supervisory and appraisal processes use.
- Staff we spoke with knew who the senior managers in the organisation were. They felt that senior managers were positive about the service and supported it's development.

Good governance

Crisis resolution home treatment teams:

- Staff received mandatory training; however, completion rates in some areas fell below the trust's target completion rate of 85%.
- Staff had access to clinical and managerial supervision and appraisals. The overall appraisal rate for crisis resolution home treatment teams was 90%.
- Services included administration staff; this allowed clinical staff to spend time on direct patient care activities.
- Staff knew what incidents to report and how to report them. The trusts used an electronic system that allowed staff to record, receive feedback and learn from incidents across the trust.
- Teams used key performance indicators (KPI) to gauge performance. Staff could access the trust's electronic KPI system to review their team's performance and compare it with others in the trust. The system reported on a range of information relevant to this core service including referral to assessment times, length of stay, demographics and onward referrals
- Team managers believed they held sufficient authority to carry out their role. They felt trusted to deliver and supported by senior managers. They reported receiving good support from their administrative staff.
- Staff reported that they were able to view and submit items to the trust's risk register. Team managers provided examples of items that they had submitted to the risk register.
- Since December 2015, the trust reported one case within crisis home treatment teams where staff had been subject to suspension and supervised practice.
- The teams reported participation in a range of clinical audit activities.
- Local governance systems had not ensured that patient care was consistently delivered safely and effectively.

Rapid, Assessment, Interface and Discharge (RAID):

- Staff received mandatory training; however, completion rates in some areas fell below the trust's target completion rate of 85%.

Are services well-led?

Good

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

- Staff had access to clinical and managerial supervision and appraisals. The overall appraisal rate for RAID teams was 88%.
- All services had administration staff; this allowed clinical staff to spend time on direct patient care activities.
- Staff knew what incidents to report and how to report them. The trusts used an electronic system that allowed staff to record, receive feedback and learn from incidents across the trust.
- Teams used key performance indicators (KPI) to gauge performance. Staff could access the trust's electronic KPI system to review their team's performance and compare it with others in the trust. The system reported on a range of information relevant to this core service including referral to assessment times, length of stay, demographics and onward referrals.
- The team manager believed they held sufficient authority to carry out their role. They felt trusted to deliver and supported by senior managers. They reported receiving good support from their administrative staff.
- Staff reported that they were able to view and submit items to the trust's risk register. Team managers provided examples of items that they had submitted to the risk register. Since December 2015, the trust reported one case within RAID teams where staff had been subject to suspension and supervised practice.
- The team reported participation in a range of clinical audit activities.

Health-based place of safety:

- Staff received mandatory training; however, completion rates in some areas fell below the trust's target completion rate of 85%.
- Staff received appraisals, the overall appraisal rate for crisis services and health-based places of safety staff was 89%.
- The service had administration staff; this allowed clinical staff to spend time on direct patient care activities.
- The trusts used an electronic system that allowed staff to record, receive feedback and learn from incidents across the trust.
- We saw that systems were not always in place to measure the quality of care provided. For example; the trust had not been auditing the quality or completeness of information recorded on Section 135/136 monitoring forms.
- Teams used key performance indicators (KPI) to gauge performance. Staff could access the trust's electronic KPI system to review their team's performance and compare it with others in the trust. The system reported on a range of information relevant to this core service including referral to assessment times, length of stay, demographics and onward referrals.
- Since December 2015, the trust reported no cases where staff had been subject to suspension and supervised practice.
- Local governance systems had not ensured that patient care was consistently delivered safely and effectively.

Psychiatric decisions unit:

- Staff received mandatory training; however, completion rates in some areas fell below the trust's target completion rate of 85%.
- Staff had access to clinical and managerial supervision and appraisals. The overall appraisal rate for crisis services and health-based places of safety staff was 89%.
- Staff knew what incidents to report and how to report them. The trusts used an electronic system that allowed staff to record, receive feedback and learn from incidents across the trust.
- Teams used key performance indicators (KPI) to gauge performance. Staff could access the trust's electronic KPI system to review their team's performance and compare it with others in the trust. The system reported on a range of information relevant to this core service including referral to assessment times, length of stay, demographics and onward referrals.
- The team manager believed they held sufficient authority to carry out their role. They felt trusted to deliver and supported by senior managers.
- Staff reported that they were able to view and submit items to the trust's risk register. Team managers provided examples of items that they had submitted to the risk register.
- Since December 2015, the trust reported no cases where staff had been subject to suspension and supervised practice.
- The team reported participation in a range of clinical audit activities.
- Local governance systems had not ensured that patient care was consistently delivered safely and responsively.

Are services well-led?

Good

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

Leadership, morale and staff engagement

Crisis resolution home treatment teams:

- Trust data from December 2015 to November 2016 reported a range of sickness rates from 0% to 20% for crisis resolution home treatment teams. The Solihull team recorded the greatest range of sickness rates from 3.5% to 20%, and the south east team the lowest range from 0% to 4.7%.
- Team managers we spoke with identified no bullying or harassment cases within their teams. One staff member recalled an incident where they felt that their manger had not spoken to them in a professional or sensitive manner.
- Staff we spoke with were aware of the trust's whistle blowing policy and process. Staff felt able to raise concerns without fear of victimisation.
- Staff we spoke regularly identified experiencing stress in their roles. Staff also spoke about the pressures of providing a 24 hour service. Staff reported that the trust had reduced overnight staffing of crisis resolution home treatment services from around 18 staff to current levels of three staff.
- Teams consistently reported strong and supportive local management. Teams reported that they functioned well in respect of team working, mutual support and good will to ensure the delivery of patient care.
- Staff reported opportunities for leadership development through meetings, supervisory practices and mentorship.
- Staff across teams demonstrated that they were open and transparent and would provide explanations to patients if things went wrong.
- The trust offered staff the opportunity to give feedback on services and input into service development through participation in the NHS Staff Survey and local clinical governance meetings.

Rapid, Assessment, Interface and Discharge (RAID):

- Trust data from December 2015 to November 2016 reported a range of sickness rates from 0% to 23% for rapid, assessment, interface and discharge teams. The City Hospital team recorded the greatest range of sickness rates from 0% to 23%, and the Solihull Hospital team the lowest range from 0% to 1.2%.
- The team manager identified no bullying or harassment cases within their teamStaff we spoke with were aware of the trust's whistle blowing policy and process. Staff felt able to raise concerns without fear of victimisation.
- Staff we spoke with regularly identified experiencing stress in their roles. Teams identified risks to staff of emotional, mental, and physical exhaustion caused by excessive and prolonged stress. The team was undertaking a piece of work specifically about stress in the workplace. Staff also spoke about the pressures of providing a 24 hour service and how the impact of working along increased patient waits and contributed to workplace stress.
- Staff reported strong and supportive local management. Teams reported that they functioned well in respect of team working, mutual support and good will to ensure the delivery of patient care.
- Staff reported opportunities for leadership development through meetings, supervisory practices, and mentorship.
- Staff demonstrated that they were open and transparent and would provide explanations to patients if things went wrong.
- The trust offered staff the opportunity to give feedback on services and input into service development through participation in the NHS Staff Survey and local clinical governance meetings.

Health-based place of safety:

- The trust did not provide details of sickness rates, vacancy rates and staff turnover for the period December 2015 to November 2016.
- The trust offered staff the opportunity to give feedback on services and input into service development through participation in the NHS Staff Survey and local clinical governance meetings.

Psychiatric decisions unit:

- The trust did not provide details of sickness rates, vacancy rates and staff turnover for the period December 2015 to November 2016.
- The team manager identified no bullying or harassment cases within their teams.
- Staff we spoke with were aware of the trust's whistle blowing policy and process. Staff felt able to raise concerns without fear of victimisation.
- Staff we spoke with believed that staff morale was good and the unit ran smoothly.

Are services well-led?

Good

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

- Staff reported that they functioned well in respect of team working, skill mix and mutual support.
- Staff demonstrated that they were open and transparent, and would provide explanations to patients if things went wrong.
- The trust offered staff the opportunity to give feedback on services and input into service development through participation in the NHS Staff Survey and local clinical governance meetings.

Commitment to quality improvement and innovation

- The trust was the only mental health provider participating as part of NHS England's 'Test Beds'. The project aimed to pioneer and evaluate the use of novel combinations of interconnected devices such as wearable monitors, data analysis, and ways of working to help patients stay well and monitor their conditions themselves at home. The trust described working with external partners on projects; including the application of capacity and demand dashboards to mental health settings and a decision support tool for patients and carers. It was expected that outcomes would be trialled in clinical practice with rapid, assessment, interface and discharge teams from June 2017. This would enable mobile staff working to better monitor, predict and respond to the needs of patients attending accident and emergency departments with mental health crisis.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust did not have a process in place to record relevant details of prescription stock control. Staff had not completed the allergy status of patients on all prescription charts. This was a breach of Regulation 12 (1) Safe care and treatment.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not use lockable cases to transport medications between crisis resolution home treatment bases and patients homes. This was a breach under Regulation 12(2)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Staff at the health based place of safety did not have access to personal alarms. The alarm triggers use at the psychiatric decisions unit had not been effectively checked or maintained. Shower facilities at the health based place of safety did not have an accessible alarm point. This was a breach under Regulation 15 (1) (e) Premises and equipment.

This section is primarily information for the provider

Enforcement actions

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.