Good

Cumbria Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RNNDJ	Voreda	Access Liaison Integrated Service (ALIS) - South	LA14 4LF
RNNDJ	Voreda	Access Liaison Integrated Service (ALIS) - East	CA1 3SX
RNNFG	Dova Unit	Health based place of safety - Barrow	LA14 4LF
RNNBJ	The Carleton Clinic	Health based place of safety - Carlisle	CA1 3SX

Summary of findings

RNNX5	Langdale Unit	Health based place of safety - Kendal	LA9 7RG

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

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Cumbria Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cumbria Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

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

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- There were sufficient staff within the crisis teams to ensure that patients received appropriate support.
- The environment of the health based place of safety (HBPoS) at Barrow was good.
- There was good multidisciplinary working in the crisis teams and good interagency working with the police around the crisis concordat work.
- Staff were skilled with good levels of experienced Band 6 nurses within the crisis teams.
- Crisis teams proactively attended the wards on a daily basis to facilitate patients' discharge.
- We saw staff providing person centred care to patients in a crisis.
- Staff we spoke with demonstrated a caring attitude.
- Crisis teams saw patients quickly, within two, four and 24 hour targets.
- There was a single referral protocol to ensure referrals into the service were co-ordinated to ensure all key information was captured.
- There were low numbers of complaints.
- Staff were committed to providing good quality care in line with the trust's vision and values.
- Managers provided good leadership, were aware of the shortfalls and were working to address them.
- There was good auditing of the use of section 136 activity.

However:

- We found that the HBPoS at Kendal and Carlisle were not fit for purpose. There was a lack of washing or toilet facilities in these HBPoS and no risk assessments were used when patients in the HBPoS accessed the public toilet. The rooms were used for multiple purposes so may not be immediately available in an emergency. The furniture in the HBPoS was not suitable for its purpose.
- Mandatory training levels of staff within the crisis teams were below trust targets.
- The majority of staff from the ALIS teams who attended the HBPoS did not have the appropriate training to deal with episodes of violence or aggression.
- Some patients had to wait more than nationally recommended three hours within the health based place of safety but the delays were beyond the trust's control because of the lack of staff external to the trust. Delays were monitored and fed back to appropriate agencies through the audits of section 136.
- Patients detained using section 136 of the Mental Health Act weren't always informed of their rights in a timely manner and there were minor gaps in the recording of episodes of section 136, such as times of key events.

We found that the environment of the HBPoS breached regulations about premises and equipment. We have issued a requirement notice to the trust. We have asked for an action plan telling us how they will improve the environment of the HBPoS.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The health based places of safety (HBPoS) at Carlisle and Kendal were not fit for purpose and did not meet current guidance. There were no washing or toilet facilities within the HBPoS. Patients had long waits in the HBPoS without appropriate facilities. There was no risk assessment tool to consider and manage the risks of patients subject to section 136 using the public toilet areas. One patient detained under section 136 absconded when using the public toilet. The health based place of safety at Carlisle and Kendal was used as a multiple purpose room so the room may not be available in a psychiatric emergency. The furniture in the HBPoS was not suitable for its purpose.
- Mandatory training levels of staff within the crisis teams were below trust targets.
- The majority of staff from the ALIS teams who attended the HBPoS did not have the appropriate training to deal with episodes of violence or aggression.
- When patients moved up and down in levels of support in the crisis pathway, the reasons for the change in levels of input wasn't always clearly recorded in written records.
- Staff could not always articulate what changes to practice needed to be made to support the suicide reduction plan.
- There was no robust system to ensure that all patients were clinically reviewed on at least a weekly or fortnightly basis for patients being treated by ALIS East.
- There was a lack of interview rooms at ALIS South but this was being looked into.
- The recording of medicines on referral was not routinely completed and further medicines reconciliation was not recorded.

However:

- There were sufficient staff within the crisis teams to ensure that patients received appropriate support.
- Patients had timely access to a psychiatrist attached to the team to provide medical input to patients referred to the crisis teams.
- Staff were debriefed following an incident and there was a review held within 72 hours following an incident.

Summary of findings

Are services effective?

Good

We rated effective as good because:

- There was good multidisciplinary working in the crisis teams and good interagency working with the police around the crisis concordat work.
- Staff were skilled with good levels of experienced Band 6 nurses within the crisis teams.
- There had been improvements in supervision and appraisal rates of staff working in crisis teams.
- We found evidence which demonstrated the teams had implemented best practice guidance within their clinical practice.
- Patients seen by the ALIS teams had their physical needs considered alongside their mental health needs.
- Staff had a good awareness of the Mental Health Act and Mental Capacity Act although formal staff training rates did not reflect this.

However:

- There were multiple systems of care recording with paper and electronic records being used. The trust was working to introduce fully electronic records to help improve access to patient information and reduce duplication.
- Patients detained under section 136 weren't always informed of their rights in a timely manner and there were minor gaps in the recording of episodes of section 136.
- When people were brought into the HBPoS, it was not always clear that patients were assessed for any ongoing physical health problems which required follow up.

Are services caring?

Good

We rated caring as good because:

- We saw staff providing person centred care to patients in a crisis.
- Staff we spoke with demonstrated a caring attitude.
- Patients' needs were considered holistically so staff worked with patients to look at their family and life circumstances as well as their mental health crisis.
- Patients were asked their experience of the crisis teams when they were discharged, through a formal questionnaire. Most patients who responded were happy with the care they had received.
- Patients were involved at a strategic level through the recruitment of staff and through commenting on the new crisis pathways.

Summary of findings

However:

- People detained under section 136 of the Mental Health Act were not routinely given an opportunity to comment on their experience of being assessed within the health based places of safety.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Crisis teams saw patients quickly, within two hours for urgent assessments and 24 hours for routine assessments.
- Crisis team staff attended wards daily to facilitate discharge.
- Communication to the crisis teams when patients were discharged from the Dova unit had improved.
- There was no exclusion criteria. The crisis teams assessed everyone that was referred into the service.
- There were good levels of qualified staff to respond to patients' needs.
- There was a single referral protocol to ensure referrals into the service were co-ordinated so that all key information was captured.
- Patients were offered appointment times that suited their needs.
- There were low numbers of complaints.

However:

- Whilst there was an Improved Access to Psychological Therapies service, there was not the full range of primary care mental health service within Cumbria. This meant that patients were referred into the crisis teams with ongoing mild to moderate mental health conditions because they could not be referred to an appropriate primary care mental health service for longer term condition management.
- Some patients had to wait more than nationally recommended three hours within the health based place of safety.
- These delays were frequently beyond the trust's control because of the lack of staff external to the trust who were available to carry out assessments of patients detained on a section 136; including approved mental health professionals (AMHPs) and section 12 approved doctors (doctors with specialist training in mental health).
- A small number of patients remained on the home treatment team caseload for longer than required due to delays in allocating a care co-ordinator within the community mental health team.

Summary of findings

- There were lengthy waits for patients to be assessed when specialists from CAMHS or LD needed to be involved.

Are services well-led?

Good

We rated well led as good because:

- Staff morale was good. There was a level of uncertainty amongst the staff about a recent consultation on new shift patterns but managers were committed to making any changes work for patients.
- Staff were committed to providing good quality care in line with the trust vision and values.
- Managers provided good leadership, were aware of the shortfalls and were working to address them.
- One team had received more intensive leadership support from the trust when issues of staff sickness and incidents were flagged.
- Recent improvements had been made so that crisis and home treatment pathways were clearer for staff and patients.
- There was good auditing of the use of section 136 activity and a functioning local crisis concordat group.
- A suicide prevention plan had been developed by the trust.

However:

- Staff we spoke to did not have a clear understanding of what changes had been made to support the suicide prevention plan.
- An external agency had struggled to implement training to staff within the ALIS teams about suicide prevention.

Summary of findings

Information about the service

Cumbria Partnership NHS Foundation Trust have three crisis teams for adults of working age across Cumbria in mental health crisis. The trust have four health based places of safety (HBPoS) across Cumbria.

The crisis teams known as Access Liaison Integrated Service (ALIS) provided short term work to help support patients at home when in mental health crisis and support with earlier discharge from hospital. The teams aim to facilitate the early discharge of patients from hospital or prevent patients been admitted to hospital by providing either home or unit based support and treatment.

Section 136 of the MHA sets out the rules for the police to arrest a person in a public place where they appear to be suffering from mental disorder and are in immediate need of care or control in the interests of that person or to protect other people. The arrest enables the police to remove the person to a place of safety to receive an assessment by mental health professionals. This would usually be a HBPoS unless there are clear risks, for example, risks of violence which would require the person being taken to a police cell instead. The trust's four HBPoS are across Cumbria at Whitehaven, Barrow, Kendal and Carlisle.

People could be detained for a period of up to 72 hours so they can be examined by doctors and assessed by an approved mental health practitioner (AMHP) to consider whether compulsory admission to hospital is necessary. National best practice guidance from the Royal College of Psychiatrists states that the assessment should occur quickly and within three hours and ideally with two hours. The trust audited itself against the two hour ideal target for people brought in by the service by the police. The HBPoS was available at all times - 24 hours a day, seven day a week service and 365 days per year.

Cumbria Partnership NHS Foundation Trust have been inspected on a number of occasions since registration. Cumbria's mental health crisis services have not been specifically inspected by the Care Quality Commission. Following an inspection in September 2014, we issued a compliance action about records across in-patient and community mental health services at Barrow. This was because we found improvements were needed in health care and risk recording, delays in discharge information being provided and the management of the paper records when patients moved between mental health teams, including when patients moved to and from crisis services.

The trust provided an action plan telling us how they would improve, including a long term strategy to introduce electronic recording. On this inspection we found there was improved information when patients moved between teams, including the crisis teams.

In August 2015, we carried a Mental Health Act monitoring visit to look at the arrangements

the trust had for supporting section 136 of the MHA. This showed that the trust had good arrangements and positive inter agency working to manage patients in mental health crisis.

We found that there were issues with the conveying of patients in police vans, communication from the police, delays in the assessment process in specific circumstances, staff availability to receive patients, recording key details on the local form used to record section 136 and lack of recording of patient rights. The report noted that the environments of the HBPoS were generally good at Barrow. There were improvements needed to ensure that the environments of the HBPoS at the other locations adhered to current best practice guidance.

Managers in the trust have provided an action statement explaining how they would improve, or work with partner agencies to improve, adherence to the MHA and MHA Code of Practice around section 136 practices.

Our inspection team

The team was led by:

Chair: Paddy Cooney, Chief Executive (retired)

Summary of findings

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leaders: Brian Cranna, Inspection Manager (mental health), Care Quality Commission and Sarah Dronsfield, Inspection Manager (community health), Care Quality Commission

The team that inspected the mental health crisis services and health-based places of safety included two CQC inspectors, a CQC pharmacist inspector, a CQC Mental Health Act reviewer and two nurse specialist advisors.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand people's experiences, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about Cumbria's mental health crisis services and health based places of safety, asked a range of other organisations for information and sought feedback from patients at focus groups.

We carried out announced visits on 10 and 11 November 2015 visiting:

- Access Liaison Integrated Service (ALIS) - South which was the crisis and home treatment teams at Barrow
- Access Liaison Integrated Service (ALIS) - East which was the crisis and home treatment teams at Carlisle
- three health based places of safety (HBPoS) at Barrow, Carlisle and Kendal.

During the inspection visit, the inspection team:

- spoke with ten patients who used the service
- spoke with 19 members of staff from a range of disciplines and roles, including the associate director of nursing, two consultant psychiatrists, three operational or clinical managers, six nurses, five support workers, a police liaison officer and one single point of access worker
- looked at 16 care records
- looked at Mental Health Act (MHA) records relating to 27 recent episodes of admissions to the health based place of safety under section 136 of the MHA
- attended one multidisciplinary team meeting
- accompanied staff on two home visits and three assessments observing how they provided care and treatment to patients
- observed a transition meeting between one patient, the crisis and community mental health teams
- spoke with the police liaison officer who coordinated information about patients who were detained using section 136 of the Mental Health Act
- looked at the environments and equipment where the ALIS teams were based
- looked at the arrangements for the management of medicines
- looked at five treatment records of patients currently being seen by the ALIS team
- looked at recent audits of section 136 of the Mental Health Act activity across Cumbria
- looked at the minutes, declaration and action plan of the local multi-agency crisis concordat meetings
- met with a group of Approved Mental Health Professionals (AMHPs) who were involved in carrying out MHA assessments, including assessments within the health based place of safety
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

During the inspection, patients had an opportunity to comment on the services they received on comment cards prior to the inspection. We received no comment card from patients receiving support from the crisis services or about their experiences in the health based place of safety.

We spoke with ten patients who were using, or had recently used, the crisis service. All but one of the patients were very positive about how staff supported them. Patients told us staff treated them with respect, actively listened to them and were compassionate. Patients told us that staff provided appropriate emotional support and information.

Patients told us that whilst they saw different staff from the crisis teams at each visit; staff were well informed about the patients' particular needs.

During the observations of care provided by the crisis teams, patients were complimentary about the support they were receiving.

The health based places of safety were not in use during our visit so we were not able to speak to patients who were being assessed. One patient we spoke with on the telephone had used the health based place of safety and told us about the long wait they had in the health based place of safety awaiting a full assessment.

Good practice

The ALIS South crisis team proactively attended the wards on a daily basis to facilitate patients' discharge through the acute admission pathway process. This had led to reduced in-patient stays and patients were supported on discharge to help with the transition between hospital and returning home.

Areas for improvement

Action the provider MUST take to improve

- The trust must improve the environment of the health based places of safety (HBPoS) through a credible improvement plan and ensure that the HBPoS can be immediately available at all times in the event of a psychiatric emergency. In the interim, the trust must mitigate the risks of the current environments of the HBPoS and equipment used in the HBPoS.

Action the provider SHOULD take to improve

- The trust should continue to address the mandatory training levels of staff within the crisis teams; including crisis staff who support the supervision of patients in the health based place of safety receiving appropriate training in the prevention and management of violence and aggression training.
- The trust should ensure that patients detained using section 136 of the Mental Health Act are given their rights in a timely manner and ensure the recording of episodes of section 136 are improved.
- The trust should continue to work with other agencies to ensure that assessments in the health based place of safety are not unduly delayed due to the availability of assessing doctors and approved mental health professionals.
- The trust should monitor the need for the fuller range of primary care mental health services (for example, longer term condition management of mild to moderate mental health needs) and the impact on its current services (such as crisis teams) as evidence towards any future commissioning strategy.
- When people are first brought into the HBPoS, patients should be routinely assessed for any ongoing physical health problems which requires follow up investigation.

Cumbria Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Access Liaison Integrated Service (ALIS) - South	Voreda
Access Liaison Integrated Service (ALIS) - East	Voreda
Health based place of safety - Barrow	Dova Unit
Health based place of safety - Carlisle	The Carleton Clinic
Health based place of safety - Kendal	Langdale Unit

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.

- In August 2015, we carried a Mental Health Act (MHA) monitoring visit to look at the arrangements the trust had for supporting section 136 of the Mental Health Act. This showed that the trust had good arrangements and positive inter-agency working to manage patients in mental health crisis.
- There were robust audits in place how the trust monitored people being cared for under section 136 of the MHA.
- There were no patients on a community treatment order being treated by the crisis teams we visited on this inspection.
- Crisis team had trained approved mental health professionals working as part of the teams.

Detailed findings

- Staff demonstrated a good knowledge of the MHA. Staff had a good understanding of the duties placed on the different agencies when people were brought in on a section 136 of the MHA
- There was a police liaison officer who worked with the trust to co-ordinate care and treatment of people who were detained under section 136 of the MHA.

However:

- Mental Health Act (MHA) training formed part of the mandatory training for staff. Figures for the ALIS teams were low, ranging from 15% of staff in ALIS South and 21% of staff in ALIS East having completed training in the past 12 months. This was against a trust target of 80%.
- Patients were still not routinely informed of their rights when subject to a section 136.
- Some key information on the local form to record section 136 was not always recorded.

Mental Capacity Act and Deprivation of Liberty Safeguards

Patients using the crisis teams lived in the community independently. Staff took practical steps to enable patients to make decisions about their care and treatment wherever possible, such as providing information on treatment and side effects of medication in order to seek informed consent.

Patients were involved in drawing up their crisis care plans. We saw examples of detailed crisis care plans which included the support available during the day, at night and at weekends. This meant that patients were supported to think about the care they wanted before they reached mental health crisis. Staff followed patients' crisis care plans. This meant staff took account of any decisions patients made in advance.

Staff looked to see if patients could consent to a stay in hospital if they were in mental health crisis and may benefit from a hospital stay. Staff understood the process to follow if they needed to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the Mental Capacity Act.

There were good levels of uptake of training on the MCA within staff of the ALIS teams; training records showing that 75% of staff in ALIS South and 86% in ALIS East have completed MCA training in the last 12 months.

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

Access Liaison Integrated Service (ALIS) - South

Access Liaison Integrated Service (ALIS) – East

Safe and clean environment

Patients were generally seen by the crisis teams in their own home for ongoing assessment and treatment. Where there were concerns about risks to patients, staff would visit in pairs or arrange to see patients in a safer environment such as interview rooms available within the main hospitals where the crisis teams were located.

There were rooms available for patients to be seen on-site. The rooms included a pinpoint alarm system which meant that staff could raise an alarm if they felt unsafe or there was an incident. Staff at ALIS South had a range of rooms available to use. However staff in the ALIS East team told us there was a lack of availability of rooms. We observed one service user being seen by staff in the cafeteria area of Carleton Clinic due to the lack of available rooms. However the staff member ensured confidentiality by seeing the patient in a quiet area away from other people. The ALIS East team had recently relocated offices and there were plans to make one of the spare rooms into an interview room to help alleviate this problem.

All areas were clean and well maintained, including staff and patient interview areas.

Safe staffing

There were sufficient staff within the crisis teams to ensure that patients received appropriate support. Crisis staff reported manageable caseloads. Staff were able to meet targets to see patients within set periods of time. This ensured patients referred into the service were seen within target times of two hours for urgent assessments in the day which extended to a four hours overnight (including in the emergency department and medical assessment unit of the nearby general hospitals along with psychiatric liaison services) and 24 hours for routine assessments. Patients reported that they did not face delayed or cancelled appointments from the crisis teams.

The staff vacancy rate had ranged from 3% in one ALIS team to 15% in another when looking at the past 12 months but there had been recent appointments to vacant posts and the teams were now fully staffed.

Patients had timely access to a psychiatrist attached to the team to provide medical input to patients referred to the crisis teams. If there was a need for medical input out of hours, the out of hours on call general practitioner service or accident and emergency doctor would provide cover. There was access to one on-call consultant psychiatrist at night covering Cumbria.

A shift leader role had been recently developed but had not been fully embedded within the team at the time we went to inspect the teams. The shift leader's role was to co-ordinate daily activity, communicate specific tasks and interventions to the other staff on the shift in order to maximise efficiency and safety.

Sickness in the teams ranged from 6-10% from July to September 2015. There had been a reduction in staff sickness more recently due to appointment of new team managers and improved stability within the teams. Staff shortages were covered by team members who volunteered for extra shifts and bank or agency staff who were familiar with the service. For example, the ALIS East team had an agency social worker who regularly provided cover where necessary.

Mandatory training levels of staff within the crisis teams were below the trust target of 80%. The mandatory training rate across all areas was 50% for staff within the ALIS East team and 59% for staff with the ALIS South team. It was acknowledged that this was an issue in all of the teams and managers were working to address this through appraisal and discussions with staff in supervision. Recent increases in staffing in the teams meant that more staff could be released to attend training.

The majority of staff in the teams were experienced band six nurses. They demonstrated good knowledge of areas covered in mandatory training such as infection control, safeguarding and the Mental Health Act. We did not identify any significant deficits in staff learning despite lower staff training figures in some areas of training.

Requires improvement

Are services safe?

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

Assessing and managing risk to patients and staff

Referrals to the ALIS teams were taken by the single point of access worker who was a non-clinical member of staff. We observed a referral to the team being taken over the telephone and found this to be completed comprehensively. Basic information and presenting problems were taken including, specific questions about risk of suicide, physical health, safeguarding and the rationale for referral to home treatment. A triage risk assessment and threshold assessment grid were both completed and scored. The information gathered was then passed immediately to a qualified member of staff in the relevant team. The single point of access worker was situated within the ALIS East team and had access to clinical members of staff if required.

There was a broad inclusion criteria into the ALIS teams. The out of hours ALIS team also provided a first line out of hours assessment and crisis response for children and adolescents and people with a learning disability. There was no upper age limit and patients below the age of 16 could also be seen at times when no other care was available. Referrals were discussed in a multi–disciplinary meeting on a daily basis. All patients referred were taken into the ALIS team on the 72 hour pathway for assessment of risk, need and treatment. During this time, a decision would be made regarding further treatment pathways such as home treatment, admission to hospital or discharge back to the general practitioner. Patients already admitted to acute wards could be referred for home treatment to facilitate early discharge from wards.

A comprehensive risk assessment using a nationally recognised tool was completed for all patients. The risk assessments were compiled on the trust's risk assessment documentation called GRIST. GRIST stands for the Galatean Risk Screening tool. This was a structured risk assessment tool designed to help clinicians assess risk of suicide, self harm, harm to others, self neglect and vulnerability. Risk formulation was based on the '5 P's' model, which were identifying risks based on looking at presenting needs (current risks), predisposing factors (historical risks), precipitating factors (triggers), perpetuating factors (those that maintain risk) and protective factors (those that promote recovery). The risk assessment was updated on at least a weekly basis. A team decision was made as to whether patients needed to be taken into the home treatment pathway for further assessment and treatment. The risk assessments that we observed were up to date and detailed. They were electronically recorded and were also printed out and placed in the paper notes.

The teams we visited used different systems to determine levels of risk. ALIS East used numbers rating from one to three and ALIS South used a traffic light system. High risk patients were visited on a daily and sometimes twice daily basis and this visit was conducted by a qualified practitioner. Lower risk patients were visited twice weekly and this could be by a support worker. There was no explicit written rationale as to why a particular rating was given to each patient at any given time; however this was often inferred though the daily clinical notes and frequency of visits after reading written records rather than through a clearly determined escalation or reduction in risks.

At ALIS East, patients were discussed on a rotational basis with all higher risk patients being discussed each day. For those patients presenting with lower risks, the team discussed them on a less frequent basis. There was no clear rationale for who was discussed at any given meeting when they fell into the lower risk categories. There was no robust system to ensure that all patients were clinically reviewed on at least a weekly or fortnightly basis for patients being treated by ALIS East. This meant that patients may only be discussed once or twice in their whole care episode. Managers told us that the current development of the shift leader role would help to ensure an improved co-ordinated approach to all patients, including those who were presenting with lower risks.

Staff knew how to refer actual or suspected safeguarding incidents and had good links with safeguarding adults and childrens teams. Staff told us they could ring the safeguarding teams for advice and guidance and to check whether a safeguarding alert needed to be made.

Where there were concerns about risk to staff, staff visited in pairs or arranged to see patients in safer alternative venues. Staffing had recently been increased to improve the busier period up until 12 midnight. There were concerns expressed by staff that there was lone working on the night shift from 12am-9am within each team. There had previously been two staff on duty on the night shift but this had been reduced to one staff after an audit had been undertaken regarding the amount of work coming into the team at night. Some staff felt this was unsafe. The night shift duties included providing telephone support,

supporting the co-ordination of MHA assessments and providing support to assessments within the emergency department of the general hospital. Out of hours staff also had the opportunity to call upon ward based staff on duty at night. There had been improvements in the staffing in the psychiatric liaison services to make sure they could better manage when people presented at the emergency department. When the sole staff within the out of hours crisis team were not available, the phones were diverted to out of hours staff in another locality to ensure calls were responded to.

We looked at the medicines storage and at the medicines related records for five patients receiving support from the crisis team in Carlisle. We found that details of patients' prescribed medicines were requested on their first contact with the ALIS team. A standard trust community prescription and administration chart was used for recording the prescribing of new medicines. However, the recording of a full list of medicines on referral was not routinely completed and further checks to ensure that all medicines which were prescribed matched those that were administered was not recorded. This meant that there was no simple overview of all the medicines that the patient was taking.

Where patients were supported to take their medication, this was clearly documented within care notes and followed-up. However, care plans did not always include details of how patients could be supported and encouraged to ensure they took their prescribed medication, for example by involving family members to monitor the taking of medicines or by the use of compliance aids and reminders.

Staff confirmed that they could access pharmacist advice on request but regular support from a specialist mental health pharmacist was not provided to support and drive forward medicines optimisation.

We saw that medicines were safely stored and records were made when medicines were removed from patients' homes for safe disposal. However, we saw several unwanted medicines still awaiting disposal. Pre-packs of medicines were available to facilitate access to an agreed range of supportive medicines.

Track record on safety

Information provided by the trust showed that in the last 12 months there had been three serious incidents relating to the ALIS teams. This included the suspected suicides of patients open to or recently accessing the ALIS teams. There had been no recent reported adverse coroner's rulings for patients accessing the ALIS teams. The ALIS East team were preparing to attend a coroner's inquest for a patient in receipt of crisis services; the internal review had not identified any significant issues.

The trust acknowledged that there had been a higher level of suicide in the county than the national average and had produced a suicide prevention plan to address this.

Reporting incidents and learning from when things go wrong

Staff we spoke with knew how to report incidents on the electronic risk management system and were able to describe what should be reported. The system escalated notification of incidents to ward managers, and if appropriate to senior managers, dependent upon the severity. This ensured appropriate investigation. Staff were debriefed after serious incidents by a manager from the team. Team meetings were used to discuss incidents and lessons learned from these. There was a robust post incident review policy in place.

ALIS teams participated in investigations into serious incidents if they had been involved with the patient in the last 12 months, irrespective if their input was ongoing. This demonstrated the commitment of the teams to learn from these incidents in order to improve future practice.

Staff knew about duty of candour. They were aware of the need for openness and transparency if there was an incident. Staff encouraged patients and their carers to complain if there was something they were concerned about which meant that issues were dealt with in a timely manner.

The trust had developed a suicide prevention plan, however staff were not always able to articulate what changes to practice were made or were due to be made to support the suicide prevention plan.

Health based place of safety - Barrow

Health based place of safety - Carlisle

Health based place of safety - Kendal

Safe and clean environment

All of the health-based places of safety (HBPoS) were commissioned for use 24 hours a day, seven days per week.

Requires improvement

Are services safe?

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

The HBPoS at Carlisle and Kendal were not suitable environments to provide fully safe care and treatment for those detained under section 136 of the Mental Health Act 1983. In particular, the environments of the two HBPoS did not meet current standards, according to regulations around the safety and suitability of premises and guidance on good practice published by the Royal College of Psychiatrists. This meant that patients who used the service and others were put at risk.

The rooms used at Carlisle and Kendal were adapted rooms and were not sufficient size to comfortably accommodate people to assess the patient with the numbers of assessing and observing staff and the patient. There were no washing or toilet facilities within the HBPoS in Carlisle. Patients used the public toilet in an adjoining corridor. There were ligature points on the taps in the public toilet. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. One patient who had been subject to section 136 at the HBPoS at Carlisle escaped when using the public toilet. There were no risk assessments in place to consider the safety of people in the HBPoS if they required to use the external toilets. The external toilets were single person toilets with minimal space making it difficult for staff to observe higher risks patients.

The HBPoS at both Carlisle and Kendal were used as multiple purpose rooms. There were regular incidents of the police not telephoning prior to arrival to inform staff that they were bringing in a patient under section 136. A memo had recently been sent to all police officers to remind them of the protocol for this. The room at Carlisle was used as a family room which meant that there was a risk that the room may not be immediately available to patients requiring the HBPoS or that children would have visits cut short if a patient needed to be assessed in the HBPoS.

The furniture in the HBPoS at Carlisle was not suitable for purpose. The chairs were not fully appropriate for a HBPoS because they were not attached to the floor or sufficiently weighted and therefore could be thrown causing injury to others. The HBPoS at Carlisle also had a blind spot in one alcove that was not covered by a curved mirror on the opposite wall.

At the Kendal HBPoS, there was a viewing panel in the door to the room, but we noted that there were blind spots and a patient who was sitting on the settee could not be fully observed through the panel.

However the HBPoS at Barrow was suitable for its purpose. The environment was good and there were toilet and washing facilities within the HBPoS. It was connected to an alarm system with the rest of the hospital so staff could be called in an emergency. Patients had access to outside space for fresh air. There was direct access to the suite from outside so the police could bring someone to the HBPoS safely and discretely.

The HBPoS were kept clean. The HBPoS were assessed as part of the acute in-patient wards scoring relatively well in recent patient-led assessments of the care environment (PLACE) annual assessment. These self-assessments were undertaken by teams of NHS and independent heath care providers and patient assessors (members of the public must make up at least 50% of the team). On the wards where the HBPoS were, the PLACE score were at or above the England average across many areas. For example, PLACE results from 2015 showed PLACE scores for Dova Unit were 99% and Carleton Clinic, and 99 % respectively. This was above the trust average of 98%.

Safe staffing

All HBPoS were staffed by the ALIS teams or the acute ward. The HBPoS at Dova unit was staffed by the crisis team during working hours and the ward staff out of hours. This was an experienced Band 6 nurses within the crisis team who would ensure that the HBPoS was staffed when it was being used during the day for a patient being assessed. All other units were staffed from the existing resources of the adjoining acute admission wards. Each ward allocated a member of staff to co-ordinate the assessment of patients under section 136.

The HBPoS were next to the acute wards at each of the four main hospital sites. This meant that staff from the wards were available to assist if required. At times this had created extra pressures on staffing levels and safety as we were told that most patients were admitted out of hours. There was also discussion around who was responsible for accepting a patient due to these pressures.

Requires improvement

Are services safe?

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

Assessing and managing risk to patients and staff

There was no CCTV coverage at the HBPoS in Carlisle, which meant that the safety and security of patients and staff could not be monitored at all times.

Staff told us that they carried a personal alarm and radio as the HBPoS could be single staffed. In the event of an alarm being raised, staff from acute wards would attend. Staffing levels on the acute wards at weekends reflected that staff may be required as an escort to convey patients (including any children brought to the HBPoS) to another hospital site.

Staff attending the HBPoS at night were isolated from others due to the location of the suite at the end of the ward which meant that staff were potentially at risk of harm. Staff from the acute wards could be called to help deal with episodes of violence and aggression that occurred in the HBPoS through a pinpoint alarm system.

The police agreed to stay in the HBPoS if there were risks of patients being violent or aggressive and staff felt that this arrangement worked well. Training in prevention and management of violence and aggression (PMVA) for staff attending the HBPoS was below trust target. Between 22% and 29% of staff in the ALIS teams had completed PMVA level two over the past 12 months. No staff had completed level three PMVA. The trust's policy states that level three PMVA should be attended by all inpatient staff and staff who may be required to use control and restraint techniques safely and effectively.This meant that the majority of staff from the ALIS teams who attended the HBPoS did not have the appropriate training to deal with episodes of violence or aggression. Staff from the acute wards were deployed to help deal with incidents that occurred in the HBPoS through the pinpoint alarms.

Track record on safety

It was not clear from the information provided by the trust that there had been any serious and untoward incidents relating to the HBPoS in the previous 12 months. This was because the incidents that occurred in the HBPoS were reported through the ward reporting systems and weren't always identified as occurring in the HBPoS. We learned of one incident where a patient detained under section 136 escaped whilst using the external toilets at the HBPoS at Carlisle.

Cumbria NHS Partnership NHS Trust were one of the main agencies who were part of the local crisis care concordat group whose aims were to work together to improve the system of care and support, so that patients in crisis were kept safe and were helped to find the support they need. The agencies involved have developed an action plan to ensure that these aims are achieved.

Reporting incidents and learning from when things go wrong

HBPoS were staffed by the ALIS teams and acute wards. The same protocols for reporting incidents were used when working within this environment. The audit of the use of section 136 highlighted where lessons could be learnt.

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

Access Liaison Integrated Service (ALIS) - South

Access Liaison Integrated Service (ALIS) – East

Assessment of needs and planning of care

We looked at 16 care records of patients receiving crisis services; records were electronically stored. Patients had an appropriate crisis assessment and a crisis intervention care plan which was developed with the person to meet their identified needs. The care plans we looked at were reviewed regularly, centred on the needs of the individual person and demonstrated knowledge of current evidence-based practice. Care and intervention plans were of a good standard.

Crisis intervention plans showed clear evidence of appropriate referral to other services such as other community teams, inpatient admission or discharge to primary care based on patient needs. Assessments of patients focused on patients' strengths and support systems in line with recovery approaches.

There were multiple systems of care recording with paper and electronic records being used. The trust was working to introduce fully electronic records to help improve access to patient information and reduce duplication.

Best practice in treatment and care

We found evidence which demonstrated that the teams had implemented best practice guidance within their clinical practice. For example staff were following guidance on risk assessments and integrated best practice into their risk assessments. Crisis staff provided intensive short term crisis careplanned for up to 72 hours.If patients required further ongoing care beyond 72 hours, then they were moved to the home treatment pathway which involved staff providing regular input on an ongoing basis to help keep patients safe at home and out of hospital.

Crisis teams offered a range of short term interventions including anxiety management, medication concordance and relapse prevention work.

Patients' physical health needs were considered alongside their mental health needs. This included monitoring symptoms, alerting the general practitioner or encouraging or making referrals to the appropriate health care professionals. This included regular and proactive physical health clinics co-ordinated between the crisis teams and community mental health teams. The trust was further developing its physical health policies at the time of our visit, to help promote patient wellbeing through prompt referral to physical health monitoring.

Staff we spoke with were able to describe specific interventions they used to assist patients with managing their crises and distress such as anxiety management, psychological interventions, medication and relapse prevention work. The teams also provided a range of activities and therapeutic interventions to patients to support their recovery including support workers who assisted patients with practical issues.

The ALIS South team were working to benchmark their service against the Royal College of Psychiatrists' home treatment accreditation scheme which aimed to assure and improve the quality of crisis resolution and home treatment services.

Skilled staff to deliver care

There was evidence of effective multidisciplinary team working within the service. The crisis teams generally included community mental health nurses, support time recovery workers, assistant practitioners, social workers, approved mental health professionals, occupational therapists, administrative support, consultant psychiatrists and more junior doctors including speciality doctors and higher trainees. This meant that patients were supported by staff from a range of mental health disciplines providing input to the team.

The majority of nurses were band six nurses. This meant that patients were supported by experienced higher level nurses.

Figures from the trust showed current appraisal rates as being 52% of staff in the ALIS South team and 27% of staff in the ALIS East team having received an appraisal in the last 12 months. Managers told us that the figures should be higher but data had been sent to the personnel department but had not been uploaded to reflect current appraisal rates. Staff we spoke with and records we reviewed confirmed that most staff had received or were due to receive an annual appraisal. Staff told us they had access to training to support them in their roles. This included specialist training. Staff told us that their manager

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supported them to access specific training to meet the needs of patients who used the service. Team meeting minutes showed that staff had access to a range of training relevant to their role.

Most staff had received regular clinical and managerial supervision. The appointment of operational and clinical managers within the teams was leading to supervision occurring more frequently, with plans in place to ensure all staff received supervision on a more regular basis. A small number of staff were on enhanced performance monitoring. In these cases, we saw evidence of more frequent supervision to support these staff to address the concerns raised.

Staff were knowledgeable and committed to providing high quality and effective crisis care.

Multi-disciplinary and inter-agency team work

There was good multidisciplinary team (MDT) working in the teams we visited. The teams had daily MDT meetings to review patients who used the service. There was visible and active consultant psychiatrist input within the teams. Medical staff were supportive and responsive, going out on request to undertake joint assessments when concerns had been raised. The teams had established positive working relationships with a range of other service providers such as the inpatient wards, general practitioners, and local services.

The ALIS East team had effective working arrangements with the acute wards to holistically plan patients' discharge through proactive involvement with daily acute patient pathway meetings. This meant that crisis staff could plan and support patients to be discharged from hospital. This was an improvement from our last inspection to the Dova unit when patients were discharged from hospital without the crisis teams or community mental health teams being involved.

Shared care agreements were in place outlining suggested ways in which the responsibilities for managing patients and the prescribing of a medicine was shared between secondary mental health services such as the crisis teams and community mental health teams and the patient's GP. We saw clear records of communication with GPs following patients having a medication review.

There were regular acute and crisis pathway meetings for managers to raise issues. This had led to effective discussions to resolve issues such as delays in patients being allocated a care co-ordinator within the community mental health teams.

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

Staff within crisis teams included nurses that had undergone approved mental health professional (AMHP) training. This meant that staff within the crisis teams had access to staff who understood the legal powers of detention under the Mental Health Act (MHA). Staff had a good understanding of the MHA despite low numbers of staff undertaking formal training with records showing that 15% of staff in ALIS South and 21% in ALIS East having completed MHA training in the last 12 months. There was a local MHA administrator that could be contacted for advice and guidance. Staff also spoke to their AMHP colleagues on an informal basis if there was an issue regarding the MHA. If more formal advice was needed then the legal department could be accessed.

In August 2015, we carried a Mental Health Act monitoring visit to look at the arrangements the trust had for supporting section 136 of the MHA. This showed that the trust had good arrangements and positive inter-agency working to manage patients in mental health crisis. There were issues with the conveying of patients in police vans, communication from the police, delays in the assessment process in specific circumstances, staff availability to receive patients, recording key details on the local form used to record section 136 and lack of recording of patient rights. Managers in the trust were in the process of providing an action statement explaining how they would improve, or work with partner agencies to improve, adherence to the MHA and MHA Code of Practice around crisis response and section 136 practices.

The crisis teams we visited were not supporting anyone who was subject to a community treatment order (CTO). We saw one record for one patient who had recently been through the crisis team at Barrow. This identified that the person had a detailed crisis care plan to support the patient, a plan of care to prevent relapse and detailed advice to the patient to avoid recall to hospital and revocation of their CTO.

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There was an awareness by staff that independent mental health advocacy services were available but these were not used frequently because of the short term nature of crisis work. However, when they were used staff worked with advocates too support patients' involvement.

Good practice in applying the Mental Capacity Act

Patients using the crisis teams lived in the community independently. Staff took practical steps to enable patients to make decisions about their care and treatment wherever possible, such as providing information on treatment and side effects of medication to seek informed consent.

Patients were involved in drawing up their crisis care plans. We saw examples of detailed crisis care plans which included the support available during the day, at night and at weekends. This meant that patients were supported to think about the care they wanted before they reached mental health crisis. Staff followed patients' crisis care plans. This meant staff took account of any decisions that patients made in advance.

Staff looked to see if patients could consent to a stay in hospital if they were in mental health crisis and may benefit from a hospital stay. Staff understood the process to follow if they needed to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the Mental Capacity Act (MCA).

There was good levels of uptake of training on the MCA within staff of the ALIS teams; training records showing that 75% of staff in ALIS South and 86% in ALIS East have completed MCA training in the last 12 months.

Health based place of safety - Barrow

Health based place of safety - Carlisle

Health based place of safety - Kendal

Assessment of needs and planning of care

Whilst many assessments were carried out within the three hour guidelines in most cases, there were occasions when this did not happen. This was often outside the full control of the trust. There were delays due to the availability of approved mental health professionals (AMHPs) from the co-ordinated AMHP rota, the availability of local GPs that knew the patient and section 12 approved doctors (doctors with specialist mental health training). Delays also occurred following a patient's assessment whilst a bed was being located.

Patients were frequently brought to the health based place of safety (HBPoS) by the police rather than an ambulance. Patients would be received by a nurse from the ward or the ALIS team who would stay and observe the patient until the assessment could be completed. Where it was clear that the patient required medical attention for a physical health problem, they would be diverted to the accident and emergency department for immediate medical treatment. The section 136 record highlighted when the patient had received a medical examination. It did not record whether any baseline assessments were carried out by the receiving nurse, especially where there may be a delay in receiving an assessment by a doctor. This meant that it was not always clear that patients were assessed for any ongoing physical health problems which required follow up.

Records relating to section 136 episodes were stored securely and available within the MHA offices. Key information was added to electronic database records for auditing purposes.

Best practice in treatment and care

Patients detained under section 136 were taken to one of the four HBPoS rather than into police custody, unless there were pressing risk issues. This was in line with current national guidance which stated that people with suspected mental health problems should be taken to hospital for an assessment rather than the police station. Recent audits showed that where patients had been taken to the police station rather than HBPoS there were clear risks identified, such as violence and aggression. This is in line with the MHA Code of Practice and multi-agency protocol.

There were a small number of people being taken to the police station because the local HBPoS was already occupied without any reason recorded as to whether another health based place of safety was considered or used. The trust shared a recent email that had been sent to police officers to remind them of the need to make sure people were taken to an HBPoS in an ambulance. There were a small number of people being taken under section 136 to the local general hospital due to the clinical need to

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ensure they received appropriate treatment. However the multi-agency protocol did not recognise the general hospitals as being designated health based places of safety.

The trust had a police liaison officer who worked with the trust to co-ordinate care and treatment of people who made contact with the police and the trust. This had led to improved information sharing and good working relations between each organisation.

Skilled staff to deliver care

The HBPoS at Dova unit was staffed by the crisis team during working hours and the ward staff out of hours. Experienced Band 6 nurses within the crisis team would ensure that the HBPoS was staffed when it was being used for a patient being assessed.

Staff had a good understanding of the duties placed on the different agencies when people were brought in on a section 136 of the MHA. This was further enhanced by having a police liaison officer who worked with the trust to co-ordinate care and treatment of people who were detained under section 136 of the MHA.

Multi-disciplinary and inter-agency team work

There was a locally agreed joint inter-agency protocol for the management of the places of safety under sections 135 and 136 of the MHA across Cumbria. This was dated 2010 and was under review. We were told that the protocol will be updated by March 2016. There was a commitment to multi-agency working for the conveyance and assessment of people detained using section 136. Whilst the protocol had not been updated, there was evidence of significant effort to improve multi-agency working which was led by the police liaison officer employed by the trust.

There was a jointly agreed declaration and published action plan to improve the arrangements for crisis care across Cumbria as part of recent national guidance in the crisis care concordat. The action plan was comprehensive and included reviewing the current crisis care pathways, improving out of hours provision, considering the environment of the health based places of safety and addressing the availability of assessing doctors to reduce delays in MHA assessments.

The local protocol clearly stated that, prior to admitting patients to the HBPoS; the police should consider contacting the ALIS team in order to discuss potential options or to notify the ward where the use of section 136 was unavoidable. Staff confirmed that this rarely happened in practice and this was highlighted by the most recent audit. Some of the HBPoS were multi-purpose rooms (including used as child visiting areas), which meant that when the police brought people to the designated area without calling first, the room may not be immediately available. We saw that the local audit had attempted to highlight and address this issue.

There were local arrangements in place to make sure that patients were fully risk assessed prior to joint decisions being made about police officers leaving patients and passing responsibility to trust staff to ensure the assessment occurred. These arrangements worked well with staff feeling well supported by the police if they requested their continued presence to help manage difficult situations.

Where there were delays in patients' being assessed, this was often beyond the full control of the trust as it related to the availability of assessing doctors and approved mental health professionals. The crisis concordat action plan acknowledged these issues across the rural county of Cumbria and identified key actions to help improve and address avoidable delays in the assessment process.

One patient we spoke with had used the HBPoS and told us about the long wait they had in the HBPoS awaiting a full assessment.

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

In August 2015, we carried a Mental Health Act monitoring visit to look at the arrangements the trust had for supporting section 136 of the Mental Health Act. This showed that the trust had good arrangements and positive inter-agency working to manage patients in mental health crisis. The report noted that the environments of the health based places of safety were generally good at Barrow. There were improvements needed to ensure that the environments of the health based places of safety at the other locations adhered to current best practice guidance. Managers in the trust were in the process of providing an action statement explaining how they would improve, or work with partner agencies to improve, adherence to the Mental Health Act (MHA) and MHA Code of Practice (CoP) around section 136 practices.

There was a multi-agency pro forma for recording detentions under section 136. The records that we were

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.

able to view showed that assessments seemed to be carried out in line with the guidance in the Mental Health Act CoP and in accordance with time lines outlined in the protocol.

Records relating to episodes of section 136 showed that most key information was being captured to show the patient's details, the circumstances that brought the patient to the HBPoS, details of the assessment and the time taken at each stage and the outcome of the assessment. Records relating to section 136 episodes at Carlisle were generally well completed; records at Barrow had examples of missing or incomplete information on the records. Some of these gaps in records related to the parts of the form that the police officer completed. The police liaison officer had privileged access to the police database so gaps in records could be accounted for to ensure that audits were more robust and comprehensive. The police liaison officer highlighted any shortfalls in recording key details within the audits which were sent to the relevant agencies and discussed in the local crisis care concordat meetings.

When we visited in August 2015 to carry out the MHA monitoring visit, we highlighted that the local form did not indicate whether a patient subject to section 136 of the MHA had been given information regarding their rights as required by section 132 of the MHA. Whilst patients on as section 136 cannot appeal against their detention and do not have an automatic right to independent advocacy input; they do have the right to refuse treatment, the right to seek legal advice and the right of complaint. It was therefore not clear whether patients were informed of this right verbally and in writing of their rights to refuse treatment, to seek legal advice and to complain. On this inspection we continued to find that patients were not being informed of these rights. Following our inspection, the forms had been amended to include a box to record to show whether rights have been given and understood by patients. This meant that the trust had improved it processes to make sure that there was documented evidence of section 132 rights being given at any of the HBPoS we visited.

Trust staff we spoke with had a good understanding of the duties placed on the different agencies when people were brought in on a section 136.

Good practice in applying the Mental Capacity Act

Patients within the health based place of safety were being care for under the legal framework of the MHA rather than the MCA. As part of the assessment carried out by the AMHP, the outline report produced by them highlighted if the patient could consent to informal admission to hospital or whether the MHA needed to be used.

On the MHA monitoring visit in August, staff expressed concerns about patients who would consent to a local informal admission following assessment in the HBPoS, but not to an admission if the nearest available bed was at another hospital across the county of Cumbria. These patients may then need to be compulsorily detained under the MHA in order to admit them to a bed some distance away from their home. Due to bed pressures, we were told that there would be a significant likelihood that an available bed would be somewhere other than the local hospital.

Good

Are services caring?

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

Our findings

Access Liaison Integrated Service (ALIS) - South

Access Liaison Integrated Service (ALIS) – East

Kindness, dignity, respect and support

We spoke with ten patients who used the service. All but one of the patients were very positive about how staff behaved towards them. Patients told us that staff treated them with respect, actively listened to them and were compassionate. The staff provided appropriate emotional and practical support to patients. Patients were provided with written information on their mental health condition as well as leaflets on local services, medication and help-lines.

Patients told us that they saw different staff at each visit. However staff were well informed about the patients' particular needs and reasons for referral to the service. This meant that patients did not feel they were repeating their story on each occasion.

One patient was seen in the cafeteria area of Carleton Clinic due to the lack of availability of rooms. This may have compromised their confidentiality, privacy and dignity. However the staff member ensured confidentiality by seeing the patient in a quiet area away from other people. The ALIS East team had recently relocated offices and there were plans to make one of the spare rooms into an interview room to help alleviate this problem.

We attended and observed five visits or assessments by staff to patients who used the service and observed one telephone based assessment of a patient. Staff treated patients who used the service with respect and communicated effectively with them. They showed the desire to provide high quality and responsive care.

When staff discussed patients who used the service in handover meetings or with us, they discussed them in a caring and respectful manner. They showed a good understanding of their individual needs. They were aware of the requirement to maintain confidentiality at all times.

The involvement of people in the care that they receive

Patients told us that they were involved in care planning and discussions around medication and side effects. However some patients told us that they had not received a copy of their care plan.

Patients were provided with a patient experience form to enable them to give feedback about the service. They told us that although they didn't know formal procedures for making a complaint, they would feel comfortable to do so.

Patients were asked their experience of the crisis teams when they were discharged from crisis care, through a formal questionnaire. There was only a small number of recent returns received but these showed that most patients who responded were happy with the care they received.

Managers received details of the service comments to help ensure that feedback from patients was taken into account.

Patients were involved at a more strategic level through the recruitment of staff and also through commenting on the new crisis pathways.

Health based place of safety - Barrow

Health based place of safety - Carlisle

Health based place of safety - Kendal

Kindness, dignity, respect and support

The location and layout of the HBPoS at Carlisle was not suitable for the purpose for which it was being used. It compromised patient safety, privacy, dignity and confidentiality. The HBPoS had no discrete entrance.

People detained in the HBPoS were brought in through the public area and this compromised their privacy, dignity and confidentiality. The toilet and washing facilities were not integral to the suite but located further down a corridor which was open to the public. People were escorted to the toilet through the entrance to the ward and onto a public corridor. This also meant their privacy, dignity and confidentiality were compromised and could put the patient or other people at risk.

Due to the rural nature of Cumbria, we heard that people were regularly taken to the HBPoS by police vehicle instead of an ambulance. This was not in accordance with the MHA code of practice and the local multi-agency policy. These concerns had been identified as part of the annual audit of the use of section 136. The trust shared a recent email that had been sent to police officers to remind them of the need to request an ambulance to ensure people were taken to a health based place of safety in an ambulance which offers

Good

Are services caring?

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a more dignified and safer environment. This also reminded police officers to detail the response time and if they were significant delays to record the justification for the conveyance of patients in a police vehicle.

We spoke briefly with one patient who had used the HBPoS at Carlisle. They told us they had been brought in to the HBPoS at around 10pm by the police and they were not seen until around 11.30am the next day. They told us that overall they had been treated with respect and dignity by the staff in the HBPoS with the exception of one member of staff. They were given a blanket and pillow and slept overnight on the settee which they said was uncomfortable.

The involvement of people in the care they receive

People subject to a section 136 were not routinely given an opportunity to comment on their experience of being brought in and assessed within the health based places of safety either during or following their time in the HBPoS.

Users, carers and third sector organisations were consulted and involved in the reviewing of the policy and procedures as part of the crisis concordat action plan group.

Are services responsive to people's needs?

Good

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

Our findings

Access Liaison Integrated Service (ALIS) - South

Access Liaison Integrated Service (ALIS) – East

Access and discharge

ALIS teams could be accessed from a variety of different sources. These included self referrals if a patient had been known to mental health services in the previous three years or through referrals from GPs, community teams, and inpatient wards.

ALIS teams kept to specified target times for response to referrals from different sources. There was a two hour response time for those in police cells. There was a two hour and four hour response time in the day and overnight respectively for patients admitted to accident and emergency and the medical assessment unit. There was a 24 hour response time for other wards and for all other referrals.

Referrals were taken by a senior administrative member of staff who then triaged these into 'urgent' and 'non urgent'. Urgent referrals were sent to the relevant ALIS team and meant that patients were seen within the relevant target times. We observed this system working well and all referrals were dealt with in an efficient and timely manner. Out of hours, referrals were taken by various qualified and unqualified staff members on duty.

Whilst there was an Improved Access to Psychological Therapies service, there was not the full range of primary care mental health service within Cumbria. This meant that patients were referred into the crisis teams with ongoing mild to moderate mental health conditions because they could not be referred to an appropriate primary care mental health service for longer term condition management.

Patients referred to the teams were discussed at the daily multidisciplinary team meetings attended by all staff on duty. Patients were able to be seen on the same day if necessary. At these meetings it was also decided when the medical review would take place.

Patients were seen in their own home or could attend the team base, dependent upon level of risk. There was a 24 hour telephone line that patients could contact in times of distress. The patients we spoke to who had used this service commented that they had found it to be very helpful.

ALIS teams were proactive at facilitating early discharge for those admitted onto acute wards. Staff attended acute admission pathway meetings on the ward on a daily basis in order to assess whether individual patients could be provided with home treatment and to help plan early discharge.

There had been delays in discharging patients to community mental health teams, however this was due to the community teams' capacity to take on referrals. More recently this had been addressed and there were low numbers awaiting allocation to other teams when we visited.

ALIS teams were responsible for finding acute admission beds. There were sometimes problems accessing beds within the trust and this meant that sometimes patients were admitted to hospital a long distance away from home.

The ALIS teams were gatekeepers for the mental health in-patient beds and were tasked with sourcing a bed for anyone who had been assessed within the HBPoS who required an admission to hospital. The current bed state was available electronically through a clearly designed dashboard. Bed occupancy across the trust had historically been high with the acute wards routinely operating at over 95% in the last 12 months. This is above the recommended levels of below 85% for optimum patient care. A new acute patient pathway has been introduced to improve patient flow and bed management. Figures showed high proportion of beds being gate kept by the crisis teams with rates being consistently above or near England average rates.

When we visited Dova unit in September 2014, we issued a compliance action about records across in-patient and community mental health services at Barrow. This was because we found improvements were needed in health care and risk recording, delays in discharge information being provided and the management of the paper records when patients moved between mental health teams, including moving to and from crisis services. The trust provided an action plan telling us how they would improve.

On this inspection we found there was improved information when patients moved between teams,

Are services responsive to people's needs?

Good

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

including the crisis teams. Crisis teams in Barrow were more fully involved in patient discharge arrangements so that staff were aware of the details of patients being discharged from hospital to help manage and mitigate risks when patients moved between services.

The facilities promote recovery, comfort, dignity and confidentiality

ALIS team worked within the principles of the recovery model. This meant that patients were able to stay in control of their lives by focusing on building their resilience, not just on treating or managing their symptoms.

However, there was an issue with availability of rooms which sometimes impacted upon patients' privacy in talking about their needs. This was being addressed by managers.

Meeting the needs of all people who use the service

There was no information provided about mental health problems, treatments, local services, help-lines, complaints or advocacy services within the HBPoS at Carlisle.

ALIS teams had access to a language line which enabled those whose first language was not English to have access to an interpreter.

Listening to and learning from concerns and complaints

There were low numbers of complaints recorded for each team. Some staff reported that they were not aware of the complaints process but would escalate any complaints to the team manager. Other staff reported that they would encourage patients to complain and would signpost patients to the patient advice and liaison service if necessary.

With one exception, patients we spoke with reported positive experiences of being supported by the crisis teams and did not report any complaints.

Health based place of safety - Barrow

Health based place of safety - Carlisle

Health based place of safety - Kendal

Access and discharge

The section 136 audit completed between November 2014 and January 2015 showed long delays for some patients being assessed under a section 136. The time from patients being brought to the HBPoS to the time that the assessment concluded did not meet the nationally recognised three hour target for 34% of the assessments to be commenced. However, the audit showed the vast majority of these were cases where the police detention occurred late afternoon or early hours of the morning. Availability of AMHPS and section12 doctors during these times were limited and meant that patients had long waits in the health based places of safety and without appropriate facilities in both Carlisle and Kendal.

There was evidence that patients detained under section 136 were being appropriately taken to a health based place of safety rather than into custody. A recent audit (April to June 2015) showed that 15% of patients had been taken to the police station rather than the HBPoS over this period. The reasons given for this were due to the patient being intoxicated or extremely violent which was in line with the Code of Practice and multi-agency protocol.

The facilities promote recovery, comfort, dignity and confidentiality

The ward staff ordered a small number of extra meals and could make snacks throughout the day to ensure that patients admitted into the HBPoS had access to meals whilst in the HBPoS.

The HBPoS at Barrow afforded comfort, dignity and confidentiality. It was a purpose built suite on the ground floor of the hospital with its own discrete entrance, ensuite toilet and shower facilities and access to fresh air. The HBPoS at Kendal and Carlisle did not promote recovery, dignity and confidentiality. There was no discrete entrance and the toilet and washing facilities were located outside of the suite. The rooms were bare apart from a settee and chairs. Patients who were in the HBPoS overnight at Carlisle had to sleep on the settee because there was no other equipment, such as a reclining chair or a bed settee. At the Carlisle HBPoS, the clock had recently been broken.

The most recent section 136 audit showed that one patient was taken to the police station because the HBPoS was already occupied. It was not clear if an alternative place of safety was considered in this case or whether the police station was used as an automatic second choice. This was not in accordance with the Mental Health Act Code of Practice and was not covered by the current section 136 protocol. This was being addressed as part of the action following the audit.

Are services responsive to people's needs?

Good

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

Meeting the needs of all people who use the service

The existing section 136 protocol clearly defined that prior to bringing a patient to the place of safety, the police should consider contacting the ALIS team in order to discuss potential options or to notify the ward where the use of section 136 was unavoidable. Staff across all wards confirmed that this rarely happened in practice and this was highlighted by the most recent audit. Staff informed us that resource issues within the police control room was one possible reason for this and there had been issues in the past of there not being anyone available within the ALIS team to respond to the call.

There was no specialist HBPoS for young people within Cumbria. Children and young people would therefore be admitted to one of the HBPoS. There were arrangements in place to fund an additional member of staff on the acute mental health wards over the weekend. This person would then be available should there be a child and adolescent mental health CAMHS patient admitted to the HBPoS. If the assessment concluded that the CAMHS patient required hospital admission, they would be conveyed to the specialist inpatient CAMHS services within neighbouring mental health trusts, escorted by the funded additional member of ward staff.

Staff from the CAMHS team would be involved from the outset should a CAMHS patient be admitted to HBPoS. A specialist CAMHS doctor would be available within normal working hours. Out of hours telephone support would be available from the on call service.

For both CAMHS admissions and for patients with a learning disability (LD), a specialist consultant psychiatrist would be involved with the assessment within working hours. However, we were informed that where CAMHS and LD consultants were involved, this would often involve a delay in the assessment taking place. Similarly, whilst there were specialist CAMHS and LD AMHPS within the county, in practice the assessment would be provided by the first available AMHP in order to avoid a lengthy wait.

Listening to and learning from concerns and complaints

It was not clear from the data we received whether there had been any complaints regarding the HBPoS. Prior to the inspection we gathered information from a range of organisations. We also asked those involved in focus groups for their opinions. We found that no significant concerns or complaints had been received about the use of section 136 or the HBPoS.

We observed that there were no leaflets or written information regarding concerns and complaints provided to patients detained under section 136 of the MHA or available within the HBPoS.

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

Access Liaison Integrated Service (ALIS) - South

Access Liaison Integrated Service (ALIS) – East

Vision and values

The trust had the following vision:

- people in our communities living happier, healthier and more hopeful lives.

The values of the trust were

- kindness
- fairness
- spirit and
- ambition.

Staff were aware of the trust's vision and values. The trust had a behavioural framework which identified how staff should demonstrate these values in their everyday work. Staff were motivated and dedicated to give high quality care and treatment to patients in receipt of community crisis mental health services in line with the values and vision. For example, crisis teams ran regular physical health clinics promoting healthier living for patients.

The trust had developed a suicide reduction plan as one of its high level aspirations, recognising the specific problems of incidents of suicide in rural communities. We could see that changes to the crisis and home treatment pathways would help support patients and support the trust's aspirations. Staff could not always tell us what changes had been made, or would be made, to their everyday practice to support the trust's suicide prevention strategy. The local MIND association told us that they had been contracted to provide training as part of the suicide prevention strategy but, despite their efforts, had struggled to fully engage with the crisis teams to deliver this training. Managers in the ALIS teams hoped that improved management and clinical leadership would address such issues as take up of training.

Good governance

We found the services were well managed. Teams had recently been given more management support through the appointment of an operational manager and a clinical manager. Staff had clear roles and a management structure that was understood by staff. Where we identified shortfalls in the crisis teams, we found managers and staff were usually aware of these and working to address these.

The trust had a good governance structure in place to oversee the running of the crisis teams. The trust had recently changed its quality assurance processes from locality based directorates to service specific acute and urgent care directorates. Crisis team managers reported into acute and urgent care governance meeting monthly. Staff felt that the service quality assurance provided more informed oversight and was more responsive to their needs because they were service specific rather than locality based.

We saw that the trust monitored services and where issues were identified, the trust provided more intensive support. For example, due to staff sickness rates and analysis of incidents occurring in ALIS East team, the team were put into an internal quality improvement programme. Senior managers made changes to support improvement including enhancing the management structure and providing specific and regular training to the team led by a senior clinician from outside the team, for example care and risk formulation training to promote reflective practice. This had led to improved morale, reducing sickness and a reduction in incidents.

Staff mostly reported they had been appraised and supervised by their line managers and that they were supported by them as well as by their peers.

Leadership, morale and staff engagement

Staff told us that they felt supported by their line manager, more senior managers and the executive team. The executive team had engaged with many of the crisis teams.

Staff morale was generally good with staff showing a commitment to providing quality care which responded to patients' needs. Staff felt able to raise concerns and were aware of the trust whistleblowing policy. There was a recent consultation for staff on changing their shift patterns to better meet patients' needs. Staff were awaiting the outcome of the consultation and some concerns were expressed about this period of change. Managers were committed to make the changes work in the best interests of 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.

Commitment to quality improvement and innovation

There was a commitment to quality improvement with improved management staffing levels in crisis services, improved care pathways and improved input into psychiatric liaison services at the neighbouring general hospitals.

Staff in some crisis teams were looking at benchmarking their service against Royal College of Psychiatrists' peer review accreditation, the home treatment accreditation scheme.

Health based place of safety - Barrow

Health based place of safety - Carlisle

Health based place of safety - Kendal

Vision and values

There was a local joint agency policy for the implementation and monitoring of section 136 of the MHA. This policy and procedure had been jointly agreed by the trust, local police forces and relevant NHS ambulance service. The duties of each agency were clearly set out to ensure that patients received timely and appropriate assessment.

Relevant staff that we spoke with were aware of how the joint agency policy affected their practices, for example whether they could expect the police to stay with patient whilst the assessment was completed.

Good governance

There were appropriate audits of the use of section 136 and the use of health based places of safety carried out by the trust's police liaison officer. The audits were overseen and discussed through the trust's criminal justice group. Section 136 MHA reports were discussed which included quantitative data on the use of section 136 (for example, how long the police remain at the trusts' health based places of safety, and how long it takes for clinicians to attend and assess) and qualitative data such as information on any incidents or issues that occur in the HBPoS. There were attempts to resolve any problems or shortfalls either in the three monthly monitoring meeting or in discussion between appropriate senior staff in relevant agencies.

The environment of the HBPoS at Barrow was of a very good standard and clearly met or exceeded the Royal College of Psychiatrists guidance which sets out the environmental expectations. The environments of the HBPoS at Carlisle and Kendal did not meet these standards.

We identified environmental concerns in our thematic MHA monitoring visit to look at section 136 arrangements in August 2015. We saw that the trust had made some minor improvements to the environments since August 2015, for example addressing exposed wires at the HBPoS at Kendal. The section 136 audit carried out by the trust and the local crisis concordat action plan recognised that the health based places of safety did not meet the current guidance and there was a commitment to improving these, subject to there being available capital resources.

Leadership, morale and staff engagement

The HBPoS do not have regular staff based there. The management of the units were shared between the ward managers of the crisis and home treatment teams linked to HBPoS and the acute wards. Staff told us that they felt well supported by their managers and peers and that senior managers were accessible, approachable and encouraged openness.

Staff were aware of their role in the process for any future incidents where patients experienced harm in line with regulations regarding duty of candour.

Commitment to quality improvement and innovation

There were good systems in place to monitor the HBPoS and section 136 in order to improve the performance. The locality interagency operational groups monitored the use of the health based places of safety, use of section 136 and interagency working. The group regularly reviewed performance indicators, such as the reasons for delays in assessments, the number of times section 136 was used, liaison with the agencies involved in assessments and reviewed the effectiveness of the HBPoS.

There was a crisis concordat group which met who were looking to improve the crisis pathways and patient experience. The group had produced a declaration committing itself to improved mental health crisis care across Cumbria. There was an associated action plan to establish a step change in the delivery of crisis care in Cumbria. The three phased local priorities were:

- to establish a crisis helpline and professional point of contact to support triage and section 136

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.

- more complete service redesign for crisis care for triage, out of hours assessment and section 136 and support the development of the Cumbria model of care programme for mental health
- completion of a comprehensive business case for crisis centres including the design and implemented services of the above phases 1 and 2.

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
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Locations: The Carleton Clinic and Langdale Unit** The environment of the health based place of safety at the Carleton Clinic and Langdale Unit were not suitable for the purpose. This was a breach of regulation 15 – Premises and Equipment. In particular the trust was in breach of regulation 15 1(c) and (d). This states that all premises and equipment used by the service must be suitable for the purpose for which they are being used and properly used. This was because: • The HBPoS did not meet the good practice requirements of the Royal College of Psychiatrist section 136 reports. • Patients had long waits in the HBPoS without appropriate facilities. • There were no washing or toilet facilities within the HBPoS and there was no risk assessment tool to consider and manage the risks of patients subject to section 136 using the public toilet areas which contained ligature risks. One patient subject to section 136 absconded from the HBPoS at the Carleton Clinic when using the public toilet. • The HBPoS at Carlisle and Kendal was used as a multiple purpose room so the room may not be available in a psychiatric emergency. • The furniture in the HBPoS was not suitable for its purpose. The chairs provided were heavy but were not sufficiently weighted or attached to the floor and could be thrown, placing patients and staff at risk of harm.