Requires improvement

Sheffield Health and Social Care 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)
TAHCC	The Longley Centre	Place of safety	S5 7JT
TAHXK	Fulwood House	Out of hours team	S3 7EZ
TAHXK	Fulwood House	Liaison psychiatry	S5 7AU

This report describes our judgement of the quality of care provided within this core service by Sheffield Health and Social Care 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.

Summary of findings

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- Arrangements were not robust to keep people safe at all services. Not everyone using the place of safety had a risk assessment in place, evidence of physical health checks or a record of their observation levels. There was no information within the liaison team about the mitigation required to ensure people's safety in relation to identified ligature risks.
- Robust governance structures were not in place within the out of hours service. The team did not have systems to routinely review and monitor service performance and capture feedback. The team felt disassociated from the wider trust. There was limited evidence of sharing learning from incidents amongst all teams.
- Documentation within the place of safety was currently in paper format with mental health assessment paperwork held electronically. Paper records were not always complete and some records contained omissions such as times, dates and names.
- Not all staff had completed necessary mandatory training. Staff supervision did not meet trust targets for the place of safety and liaison team. Formal supervisions had only recently been implemented in the out of hours team.
- There was no single twenty four hour crisis provision in operation which meant people had to access different services for support. Some people using the out of hours service said there were delays and omissions in receiving call backs. The teaching hospital said wait times for people to be assessed in the emergency department by the out of hours team had improved but were still lengthy. People reported waits of several hours to be assessed in the place of safety.

However:

- There was good feedback from people who had accessed the service. Most felt staff were kind, caring and supportive to their needs and carers spoke highly of the staff and service. We observed positive feedback between staff and people. Staff were respectful, listened, and worked collaboratively with people to determine what support they needed.
- We saw good evidence of risk assessment and consideration of risks within the out of hours and liaison psychiatry teams. Staff undertook assessments of people's needs which they used to signpost people on for longer term support. Handover systems allowed staff to share necessary information between teams.
- There were effective working relationships between the teams who often supported the same people. There were also good working relationships with other agencies such as the police and the teaching hospital. Staff morale was good and staff spoke highly of their team colleagues' passion and professionalism.

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:

- Staff did not always complete risk assessments for people using the place of safety. As such, there was no evidence of how any risks would be identified and mitigated and the frequency of how often people in the place of safety needed to be observed.
- People using the place of safety did not always receive physical health checks and assessments in order to determine whether there were any risks to their physical health that could impact on their safety.
- The ligature risk assessment of the liaison psychiatry premises did not state what actions were required to mitigate all identified risks in areas accessible to people using the service.
- Not all staff had completed or were current with their mandatory training. This included key training in safeguarding, immediate and basic life support and managing violence and aggression.

However:

- There was good evidence of risk assessments and consideration within staff practice in the out of hours and liaison psychiatry teams.
- The out of hours team and the place of safety had increased staffing levels to help meet the needs of people requiring these services.
- The place of safety had a detailed environmental risks assessment and ligature risk assessment in place to identify and mitigate any risks within the environment.

Are services effective?

Good

We rated effective as good because:

- Staff completed assessments of people's needs in order to establish what support they required. There were effective systems in place to facilitate handover of information to other services and within the three services.
- Staff and stakeholders reported positive and beneficial working relationships between internal and external services.
- Staff had a good understanding, and records evidenced, consideration of the Mental Capacity Act where applicable. There was good understanding amongst staff about the Mental Health Act

Summary of findings

- Teams had staff with specialist skills they could utilise and there were processes in place to increase skills and knowledge by way of shared learning within, and between, teams.

However

- Some staff within services said that joint working with certain teams in the trust was not always effective. This was due to a lack of understanding from other services and differing criteria for referrals.
- Although staff told us they felt supported, supervision figures were below trust compliance rates. The out of hours team had only recently implemented formal supervisions.

Are services caring?

Good

We rated caring as good because:

- Our observations of staff interactions with people using the service showed staff were kind, caring and compassionate.
- Staff involved people in their own care and took carers views into consideration. Staff worked collaboratively with people to produce plans of care.
- Staff maintained people's confidentiality and took action to preserve people's dignity and respect.

However:

- Some people using the out of hours service felt staff did not always listen to them and that they could be dismissive at times.

There was no system for people to be able to provide feedback in the out of hours team.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- There were eligibility criteria in place to access each service to help ensure referrals were made as necessary.
- The place of safety had recently opened a second bed to try to reduce the number of people having to go to inappropriate locations to receive a mental health assessment.
- There were initiatives in place to aim to meet the needs of people using the service. This included street triage in the out of hours team and supported discharge in the liaison psychiatry team.
- Information was available advising people how to complain and complaints were investigated proportionately.

However:

Summary of findings

- Although services were jointly operational over 24 hours, there was no dedicated service which provided 24 hour overall crisis support.
- Some people said the out of hours team did not always call back or called at a time when their crisis had passed.
- There were some delays in response from the out of hours team at night to the emergency department and some people in the place of safety experienced waits of several hours to be assessed.
- Referral to the out of hours team was by telephone with no other information about alternative ways people could self-refer where they may be unable to use this method.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- There was limited evidence at all services of routine and shared learning from incidents.
- There was a lack of robust governance embedded within the out of hours team. There was no team manager and no system to routinely monitor service performance.
- There was no feedback process for people using the out of hours service.
- There was no administration support to the out of hours team which meant staff had to undertake administration tasks within their own time.
- The out of hours team felt disconnected from the wider trust and senior management team.
- The trust did not provide a full time dedicated crisis service that was available to people 24 hours a day.

However:

- There was good morale amongst staff within the teams. Teams were positive, professional, and supportive of each other.
- Governance meetings took place within teams to share information about the service.

Summary of findings

Information about the service

The health-based place of safety, also known as the S136 suite, is based on Maple ward which is an acute mental health ward based at the Longley Centre. The place of safety accommodates people who are detained under section 136 of the Mental Health Act. This section enables the police to remove a person from a public place to a place of safety for up to 72 hours if they think the person may have a mental illness, is in need of care, and requires an assessment of their mental health. The place of safety is operational 24 hours a day, each day of the year. There are two bedrooms at the place of safety, the second of which opened on 1 November 2016.

Sheffield Health and Social Care Foundation Trust do not operate a 24 hour a day, full time, dedicated crisis service. Support for people in a crisis is accessed via several services in the trust.

Four community mental health teams operate from 9.00am until 5.00pm. These teams have the responsibility for providing crisis support to people already assigned to them within these hours. People not known to the teams are advised to contact their own GP. These teams were not inspected as part of the core service of 'crisis services' as this was not their primary function.

The trust has an 'out of hours' team who are based at Netherthorpe House. They provide mental health duty cover for the whole trust from 4.00pm until 7.00am seven nights a week, and at weekends and bank holidays. The service covers the whole of Sheffield. The statutory duty to provide approved mental health practitioner cover for assessments under the Mental Health Act is also included within this team. The out of hours team provide single interventions and support to people who may be in a crisis.

The liaison psychiatry team provides mental health evaluation and care to patients of Sheffield Teaching Hospital NHS Foundation Trust within their hospitals. The service is based at the Northern General Hospital and staff also work directly within the emergency department. The team provides two services, one for adults of working age and one for older age adults. It operates in the emergency department seven days a week from 7.00am until midnight and elsewhere within the hospitals Monday to Friday between 9.00am and 5.00pm. The out of hours team fulfil the mental health provision to the teaching hospital outside of these hours.

The trust has a service called crisis house which provides short-term accommodation for people experiencing a mental health crisis. People can access the service for a maximum of seven nights and staff provide 24 hour support. Crisis house has six beds. This service is inspected within our adult social care directorate and therefore did not form part of this inspection.

We last inspected the services provided by Sheffield Health and Social Care NHS Foundation Trust in October 2014. At that inspection, we rated the health based place of safety as 'good'. However, the service was not compliant with the following regulations:

- Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014: Safe care and treatment
- Regulation 18 Health and Social Care Act (Regulated Activities) Regulations 2014: Staffing

As a result, we issued two requirement notices and told the trust they must take action to address the following:

- The provider must review the environment allocated to the s136 suite to ensure that the health based place of safety is safe and fit for purpose. The planned refurbishment must ensure that the area use for health based place of safety is safe and fit for purpose.
- The provider must ensure that the appropriate number of suitably skilled staff are available to deliver the service within the health based place of safety.

The out of hours team and liaison psychiatry team were previously inspected as part of 'community-based mental health services for adults of working age' at our inspection of October 2014. Overall these services were rated as requires improvement but were not in breach of any regulations. However, we recommended that the trust should continue to work to ensure appropriate crisis services were available to people 24 hours a day.

Summary of findings

In response to our requirement notices, the trust provided an action plan setting out what actions they were taking to address these shortfalls. At this inspection we found that sufficient action had been taken to consider the regulatory requirements of the breaches had been met.

Our inspection team

Chair: Beatrice Fraenkel

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Jenny Jones, Inspection Manager (Mental Health) Care Quality Commission

The team that inspected mental health crisis services and health based places of safety consisted of one Care Quality Commission mental health inspector, one registered mental health nurse who specialised in crisis care and one social worker.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited the place of safety on Maple ward
- visited the out of hours team during the evening
- visited the liaison psychiatry team based at the Northern General Hospital
- spoke with the operational manager of the out of hours and liaison psychiatry teams
- spoke with 15 staff members from all three services including consultant psychiatrists, doctors, mental health nurses, approved mental health professionals, support workers, administration workers and a housekeeper
- observed an assessment with an out an hours practitioner and police officer as part of the street triage joint working
- observed one crisis assessment and one review undertaken by staff within the liaison psychiatry team
- spoke with four people who had recently used the place of safety
- spoke with ten people who accessed support from the out of hours service
- spoke with two people and two carers of people who had used the liaison psychiatry team
- looked at a sample of 16 people's care and treatment records from all three services
- looked at a range of information and documentation which related to the running of the service

Summary of findings

What people who use the provider's services say

People using the services gave mixed views of their experiences. We spoke with four people who had recently used the place of safety. All said that most staff were kind and caring. One said although staff were polite, they did not like the manner in which one staff member spoke with them. Some were unable to recall the full circumstances or experiences of their stay due to them being unwell at the time.

We spoke with 10 people who used the out of hours service. Six felt that staff were caring and supportive and were positive about the service they received. One said staff were down to earth, good at listening and very helpful at all times. However, some felt staff could be dismissive at times. One felt like their call was unwelcome and another said that whilst staff had been supportive, they felt some staff minimised how they felt.

Two carers we spoke with in the liaison psychiatry team said staff were caring and compassionate. They felt respected and said that staff were helpful and genuine.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff at the place of safety undertake a risk assessment in relation to each person using the service. This must include information about potential risks and plans for how any identified risks are to be mitigated. It must be clear what level of observation each person using the service requires. This is in accordance with trust policy for the place of safety.
- The trust must ensure that staff at the place of safety undertake physical observations and monitoring of people's physical health where necessary. This is in accordance with trust policy for the place of safety.
- The trust must ensure that staff within the place of safety document an accurate, complete and contemporaneous record in respect of each person using the service. This must include information to show which staff have completed entries within people's records and when these have been completed.
- The trust must ensure that areas accessible to people using the service in the psychiatric liaison team have clear guidance in place about how staff are to mitigate identified risks.
- The trust must ensure that the out of hours service has robust and suitable systems and processes in place to effectively assess, monitor and improve the quality and safety of the service. This should enable them to monitor response times and identify any trends and themes within these and use feedback to assess the quality of the service.
- The trust must ensure effective systems are in place to identify and share learning from incidents across each team with a view to improving the service. The provider must have the ability to, and be able to demonstrate, how they capture and utilise feedback within all teams in order to influence service provision as appropriate.
- The trust must ensure that staff are suitably trained to help ensure they have the necessary skills, knowledge and competence to deliver safe care. Staff must have regular supervisions to help identify and address any support needs.

Action the provider SHOULD take to improve

- The trust should review how it can further improve response times to ensure that people do not have excessive waits to be assessed.
- The trust should review whether there are any safe, neutral facilities available in which out of hours staff would be able to conduct face to face assessments.
- The trust should review how it ensures access to the out of hours service is available to people who may not be able to communicate via this method, and that there is guidance for people about how to make access where this is the case.

Summary of findings

- The Trust should continue to review and work with relevant organisations towards implementation of a 24 hour dedicated crisis service

Sheffield Health and Social Care NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Place of safety	Longley Centre
Out of hours team	Fulwood House
Liaison Psychiatry	Fulwood House

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.

Mental Health Act training was mandatory for staff within the place of safety and liaison psychiatry team. However, there was low compliance with this training as only 31% of staff in the place of safety and 52% of staff in liason psychiatry had completed this which had not met trust target of 75%. The training was not a requirement for trust staff within the out of hours team.

Although training compliance was low, staff demonstrated a sound understanding about use of the Act. Staff had access to resources such as the Mental Health Act code of practice and trust policies and information on the intranet.

The joint agency policy for the implementation of section 136 had been updated to reflect the Mental Health Act code of practice updates in April 2015. The manager and senior manager of the place of safety had produced a training package for staff on Maple ward about use of section 136 and the Mental Health Act.

Detailed findings

Records within the place of safety which accepted people detained under section 136 of the Mental Health Act showed that staff informed people about their rights under the Act. Mental health act assessments and documentation were stored within electronic patient records.

Staff were aware of how to access independent mental health advocacy and which people would be eligible for this provision.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 is a law designed to protect and empower people who may lack the mental capacity to make decisions for themselves. The Act applies to people aged 16 years and over. It must be considered where people may be unable to make a specific decision at a specific time and where they meet the eligibility criteria of the Act.

Mental Capacity Act training was mandatory for staff and all teams were required to complete this. There was low compliance with the training across all services, none of which had met the trust target of 75%.

Although training compliance levels were low, staff demonstrated a sound understanding about use of the Mental Capacity Act. Records showed staff considered people's capacity in respect of decision making. We saw examples of completed capacity assessments and evidence of best interest decisions.

During assessments we observed that staff considered and tested people's ability to consent and checked to ensure they understood necessary information they required to make decisions.

Deprivation of Liberty Safeguards training was mandatory for staff at the place of safety and the liaison psychiatry team. These safeguards apply only to hospitals and care homes. The out of hours team did not work within a hospital setting. There had been no applications for Deprivation of Liberty Safeguards authorisations for people using these services.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

Health based place of safety

The place of safety consisted of an assessment room with one bedroom on either side. Each bedroom had an en-suite bathroom. The rooms were designed with anti-ligature fittings but there were ligature points present on a boiler and taps situated in the assessment room and above the ceiling tiles in bedrooms. These were identified on the ward ligature risk assessment and also on an environmental risk assessment solely relating to the place of safety. The mitigation for these was that people were not to have unsupervised access to the assessment room and increased observations. Observation windows were present on external and internal doors. Alarms were situated in the suite and all staff carried personal alarms to enable them to summons assistance.

All the rooms were clean, tidy and had been recently refurbished. Cleaning rotas showed that housekeeping staff cleaned the rooms regularly. There were weighted chairs and beds with further furniture on order for the new room designed to meet the safety requirements for a place of safety. A computer chair on wheels was in the assessment room which was easily moveable and could cause a potential safety risk. We highlighted this and the chair was removed during our inspection. We also highlighted that plastic holders containing leaflets were not fixed securely and had potential to cause a hazard.

There was access to a clinic room on the main ward. This included an examination chair, blood pressure monitor, scales and resuscitation equipment. Emergency drugs were stored appropriately and staff kept daily checks of the room and fridge temperatures to help maintain safe storage of medicines.

Crisis services

The liaison psychiatry team operated from premises on the site of the acute general hospital which were provided by this separate trust. During a recent peer review, reviewers had identified that the interview room in the emergency department used for undertaking high risk assessments was unsuitable due to two ligature points. Plans were in place to relocate the room to one which met safe practice guidance for liaison services. In the interim, staff took action to mitigate the risk such as removal of unsecured furniture and supervision of people.

The liaison service held a psychiatric outpatient clinic from the premises. We saw the rooms were clean and tidy. Some rooms used only by staff required maintenance. Staff had reported these issues through the necessary channels via the teaching hospital maintenance team. A health and safety inspection and a separate ligature point risk assessment had been completed in October 2016. The premises were classed as a low risk on the ligature risk assessment. Due to the layout of the environment, most people would be in staff eyesight whilst using the service as the waiting area was in front of reception. In addition, people would be with a staff member during their assessment. However, the ligature assessment did not make clear what mitigation was in place to address all identified risks in areas that were not observable, for example, ligature points in client toilets.

The out of hours team did not see people at the premises they operated from. Access to the building was by way of a secure key code which only staff had access to.

Safe staffing

Health based place of safety

The place of safety was staffed by Maple ward staff. There had been four separate occasions in 2016, the latest of which occurred in April, where the place of safety had been unavailable due to insufficient staffing levels. However, additional staff had recently been recruited to help facilitate the place of safety and to accommodate the second bed which opened on 1 November 2016. One qualified nurse on each shift was designated with responsibility for staffing the place of safety. Staff spoke positively about the benefits of the extra staff used to resource the place of safety. If additional staff were required, for example where two people were using the place of safety, extra staff could be requested. There were on-call rotas in operation so that staff could request doctors out of hours where necessary. There were

vacancies within Maple ward, however the manager said that staffing within the place of safety was not impacted as this was protected and additional to general ward numbers.

Not all staff were current with necessary mandatory training as required by the trust. On Maple ward, 46% of staff had completed the overall requisite training. No individual subjects for Maple ward had more than 75% of staff trained.

This meant that there were a number of key training courses with significantly less than three quarters of staff trained. This included training such as life support, and safeguarding adults and children. There was a risk that without having completed necessary mandatory training, people could be at risk of unsafe care if staff did not have the required skills and competence their roles demanded.

Crisis services

The out of hours team was a nurse led service. The liaison psychiatry team consisted of a mixture of staff grades including consultant psychiatrist and doctors. Due to the nature of these services, workload was dependent on contacts made to the team which varied each shift. As such, staff members did not carry a predetermined caseload. The out of hours team was staffed by:

- Approved mental health practitioners (seconded from the local authority):5.3 whole time equivalent
- Registered mental health nurses (band 6):11.8 whole time equivalent

The senior practitioner at the service was an approved mental health professional and was included within those numbers. Staffing levels had increased since our last inspection on each shift. Current minimum staffing levels at night were three members of staff and a minimum of four at weekends and bank holidays. These numbers included at least one approved mental health professional. Staff said that having additional staff had made a positive difference.

Shifts were 12 hours in duration from 7.30am to 7.30pm for the day shift and 7.30pm until 7.30am for night shifts. An additional twilight shift operated from 4.00 pm until 12.00 midnight on Mondays to Fridays. This shift consisted of three staff members, usually one approved mental health practitioner and two mental health nurses. There were no current vacancies at the service. Sickness levels within the team were low at 1.7% against the trust average of 6%. Staff said they were able to obtain doctors to undertake Mental Health Act assessments.

The liaison psychiatry team was staffed by:

- Consultant: 2.3 whole time equivalent
- Speciality doctor: 1.2 whole time equivalent
- Trainee doctor: 4.5 whole time equivalent
- Team Manager: Nurse (band 8a): 1 whole time equivalent
- Registered mental health nurse (band 7): 2 whole time equivalent
- Registered mental health nurse (band 6): 11.8 whole time equivalent
- Registered mental health nurse (band 5):2 whole time equivalent
- Support Worker (band 3):3.5 whole time equivalent
- Medical secretary (band 4):2 whole time equivalent
- Administration (band 3): 3.3 whole time equivalent

Within the liaison team were two sub teams, one of which worked with older adults and one of which worked with adults of working age. The Older adults team had vacancy for a nurse which was being recruited into. Staff were able to provide cover for sickness absences by filling in across both teams. There were on call arrangements available in place for doctors outside of set working hours. Sickness levels in the team were reported to be low.

Not all staff in the teams were current with necessary mandatory training as required by the trust. All were below the trust target of 75%. Fifty five percent of eligible staff in the out of hours team had completed their training, with the courses of 'clinical risk assessment' and 'fire safety' being the only subjects in excess of 75%. The liaison psychiatry team had a higher rate of compliance with 67%. Four subjects recorded in excess of 75% compliance which were equality and diversity, slips, trips and falls, hand hygiene and health and safety.

This meant that there were a number of key training courses with significantly less than three quarters of staff trained. This included training such as life support, and

safeguarding adults and children. There was a risk that without having completed necessary mandatory training, people could be at risk of unsafe care if staff did not have the required skills and competence their roles demanded.

Assessing and managing risk to patients and staff

Health based place of safety

Risk assessment processes were not always robust. In the place of safety, staff did not always assess people's risks to help maintain their safety. The policy for the place of safety stated a joint risk assessment must be undertaken by the police and S136 staff on arrival at the place of safety prior to a full risk assessment. A 'place of safety process' document also said staff should undertake a risk assessment which would be used to determine the level of observations the person required. Records in the place of safety were currently documented in paper format. We looked at the records of eight people and found that six had no risk assessments present and no evidence of what observation levels the people had required. An entry in one person's records stated they were to be observed every ten minutes, even though no risk assessment was present to determine this. There was no evidence that staff had undertaken these observations.

The manager told us, and policy stated, that as part of the risk assessment staff should take people's physical observations and keep these under review if necessary. There was no evidence of any physical health checks in six of the eight records we reviewed and no information to state whether these had been attempted. This meant that people were potentially at risk of unsafe care in relation to their physical health needs.

One person was a frequent attender at the place of safety. There had been two incidents within the several months previously where the person had attempted self-harm in the same manner. Both were logged as incidents. The manager said staff were fully aware of the risks the person presented with. There were several various warning markers on the person's electronic record, but no risk management plan accessible to all staff within the person's electronic record about how these risks were to be mitigated. There was a paper copy of a management plan in a drawer in the office but this was not available to staff who accessed the record electronically.

Not all staff were current with their mandatory safeguarding training. On Maple ward, 48% of staff had completed safeguarding adults training. Maple ward also had low compliance rate with safeguarding children's' training with 27% and 21% of staff who had completed level two and level three respectively.

Despite low figures, all staff we spoke with could describe the trust's safeguarding processes and procedures. There was a safeguarding lead at the trust that staff were able to escalate concerns to. Staff were also aware of how to make referrals directly to the local authority and gave examples of the types of concerns they would raise. Due to the nature of how people accessed the service, other organisations had often made initial safeguarding referrals where necessary; for example, if the police had first contact with someone and identified safeguarding concerns which they referred. Staff told us they would always check and ensure necessary information was handed over so they were aware of any safeguarding considerations.

Between October 2015 and October 2016 no safeguarding referrals had been made or raised in relation to the place of safety.

Staff undertook training to help enable them to positively manage behaviour which may challenge, including violence and aggression. Maple ward staff were required to undertake this training to level three which was an advanced level as they were ward based. Only 51% percent of staff had completed their annual update of this training which meant there was a risk that all staff may not have the suitable skills to safely use restraint should they be required to do so.

In the six months prior to our inspection, the time period we looked at, staff on Maple ward had used restraint on four occasions in the place of safety. All had been reported as incidents as required. Staff had access to a de-escalation facility called the 'green room' on the main ward which could be used as a quiet, supportive, non stimulating environment for people who may require this.

Crisis services

We also saw good practice and good evidence of risks being considered and used to inform delivery of care. The trust used a risk assessment tool called the detailed risk assessment management plan within their electronic patient record system. Staff in the out of hours and liaison psychiatry teams had completed risk assessments in relation to their contacts with people. We saw evidence of these within records we looked at in these teams. Prior to

Requires improvement

Are services safe?

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

undertaking assessments and making contact with people, staff researched information and took risk factors into account. For example, before the street triage and liaison assessments we attended, staff ascertained risk information about the person including that held by other agencies. They discussed potential risks from the information they knew. The staff members undertaking the assessments updated the person's risk assessment on their return to the office. We saw evidence of risk assessments on the electronic patient record system which were reviewed at each contact and updated where necessary.

Seventy five percent of staff on both the liaison psychiatry and out of hours team had completed their mandatory safeguarding training. Liaison psychiatry compliance rates for safeguarding children's' level two and three training was 63% and 69% and out of hours was 46% and 71% respectively.

All staff we spoke with could describe the trust's safeguarding processes and procedures. There was a safeguarding lead at the trust that staff were able to escalate concerns to. Staff were also aware of how to make referrals directly to the local authority and gave examples of the types of concerns they would raise. Due to the nature of how people accessed the service, other organisations had often made initial safeguarding referrals where necessary. For example, if the police had first contact with someone and identified safeguarding concerns which they referred. Staff told us they would always check and ensure necessary information was handed over so they were aware of any safeguarding considerations.Out of hours staff also had access to safeguarding information within their data store.

Between October 2015 and October 2016 staff had identified and raised 13 safeguarding concerns within both liaison psychiatry and the out of hours teams. These referrals had been escalated to necessary agencies where required.

Staff undertook training to help enable them to positively manage behaviour which may challenge, including violence and aggression. Liaison psychiatry and out of hours teams completed level two training which was a lesser level than required of ward based staff. The compliance rates with this training liaison psychiatry and out of hours was 65% and 62% respectively.

Liaison psychiatry staff did not get involved in restraint of people as this was the responsibility of staff in the hospitals in which they worked. Out of hours staff did not, and were not expected to, use restraint on people using the service. In the six months prior to our inspection, the time period we looked at, there were no incidents of restraint at either of these services.

A lone working policy was in place at the trust. Lone working was on the risk register for both the out of hours team and liaison psychiatry team. Control measures were in place such as joint working, security measures in place at premises and staff being aware of the policy. Staff at the out of hours team worked in pairs to reduce the risk of lone working. The control measures also referred to 'personal alarms'. However not all staff were aware of these as one staff member said no lone working devices were available and another said they used a mobile phone for emergencies and had no personal alarm. Other staff said they had mobiles which they used whilst in the community. Subsequent to our inspection, the trust informed us that lone working devices were available in both the out of hours and liaison psychiatry team and had been at the time of the inspection.

Track record on safety

Heath based place of safety

No serious incidents were reported for the place of safety.

Crisis services

Crisis services reported three serious incidents between April 2015 and October 2016. These were two suicides and a serious self-harm incident of people who had had contact with either the liaison psychiatry or out of hours team.

Senior staff at the trust had completed investigations and reviews of care into the incidents. The investigation into the most recent incident was still ongoing at the time of our inspection. A review of care was the initial investigation which determined whether the incident needed to be escalated for a full comprehensive investigation. One of the incidents had been subject to this level of investigation and we saw that it was thorough, detailed, included notable practice and areas for further learning with specific action plans and timescales for each party involved where identified.

Requires improvement

Are services safe?

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

Reporting incidents and learning from when things go wrong

Heath based place of safety

All staff we spoke with were aware of the incident reporting procedure, had access to the incident reporting system and were aware of what incidents to report.

We saw incident reports for the 12 months prior to our inspection and saw that actions had been taken on an individual level within each report. However, there was a lack evidence of shared learning from incidents at team level. For example, we did not see evidence of incident discussion within minutes from Maple ward.

Staff told us about individual experiences, such as a manager offering a debrief to a staff member following a serious incident and discussion of a specific incident within an multidisciplinary meeting but this appeared to be happen reactively as opposed to a proactive measure to take learning from incidents to improve practice at team level.

Crisis services

All staff we spoke with were aware of the incident reporting procedure, had access to the incident reporting system and were aware of what incidents to report.

We saw incident reports for the 12 months prior to our inspection and saw that actions had been taken on an individual level within each report. However, there was a lack evidence of shared learning from incidents at team level. For example, the out of hours team did not routinely review and share information about incidents and learning from these. The liaison psychiatry team said incidents were discussed within meetings although we did not see evidence of this within.

Staff told us about individual experiences, such as a manager offering a debrief to a staff member following a serious incident and discussion of a specific incident within an multidisciplinary meeting but this appeared to be happen reactively as opposed to a proactive measure to take learning from incidents to improve practice at team level.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

Health based place of safety

Staff routinely researched information about people that used the service. For example, by checking systems to see if people were known to services and whether they had current support and care plans they needed to be aware of. Assessments that staff completed for people included information about the origins and reasons for referrals into the service and other pertinent information such as any medication needs and presenting behaviour. An approved mental health professional undertook an assessment of the person's mental health.

There were systems in place for staff to access and complete information about people's care and treatment**.** Maple ward had a designated S136 desk area within the ward office where staff could be based to complete necessary documentation. This was currently in paper format. Mental health act assessments were stored electronically and not present in the paper files. We found that some records were incomplete. Two people's paper records we looked at contained various omissions such as times of entries, dates of documentation and names of staff completing the entry. One person's documentation did not state the time the person was taken to the suite. This information was recorded in a separate book that was held separately to the records.

Electronic records were being rolled out in the upcoming weeks and there was a plan for staff to use tablet devices to complete information. We spoke with someone from the trust IT team who showed us how information would be input and stored electronically onto the new system. This method was more robust than the current system as it required full completion of one section before enabling access to the next section. This was expected to improve the quality and completeness of information that staff obtained.

Crisis services

Staff undertook assessments of peoples' needs and used these to determine how best to support each person. We observed how staff routinely researched information about people making contact with the service. For example, by checking systems to see if people were known to services and whether they had current support and care plans they needed to be aware of. Assessments that staff completed with people were holistic and included discussions about plans of care for the future. Physical health needs were taken into consideration as part of these assessments. Records included information about the origins and reasons for referrals into the service and staff consideration as what support people needed. Records showed that staff signposted people on to additional, more tailored services, where it was considered these were better able to meet their longer term needs.

Within the liaison psychiatry team, referral documentation asked for structured information about each person being referred. For example, this included information about the referral reason, physical health needs, cognitive impairment, medication, allergies and other pertinent information. This helped staff make an appropriate assessment of the person's needs.

There were systems in place for staff to access and complete information about people's care and treatment**.** The out of hours and liaison psychiatry teams used the trust's electronic system for accessing and inputting information. All information was held within one system which made it more accessible and allowed staff to see previous entries and information held about people. The system showed who had completed entries and when these had been made. Staff felt the system used by the trust was generally good and user friendly. The liaison team took referrals from the acute trust and had identified some issues with transfer of information as the acute hospital trust did not use the same patient record systems. However, they were normally able to obtain all relevant information they required and reported no impact due to this. We saw that information was passed on and shared with necessary parties in accordance with information sharing agreements.

Staff in the out of hours team had access to electronic tablets to aid their work in the community. They did not all use these as some felt they were not always reliable. They updated electronic records where necessary on return to the office and we observed staff doing this.

Best practice in treatment and care

Health based place of safety

Staff we spoke with at all services demonstrated a good understanding of current best practice guidance. They

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were able to cite current relevant recommendations such as published guidance by the National Institute for Health and Care Excellence. For example, recommendations and best practice for supporting people presenting with specific conditions that may access the service.

Staff at the place of safety kept information about bed usage and disposal statistics but did not complete any recurring audits at service level.

Crisis services

Staff we spoke with at all services demonstrated a good understanding of current best practice guidance. They were able to cite current relevant recommendations such as published guidance by the National Institute for Health and Care Excellence. For example, recommendations and best practice for supporting people presenting with specific conditions that may access the service.

Teams were able to signpost and make referrals for people including those requiring psychological therapies to other services within the trust. The liaison psychiatry team felt that direct therapists or psychology input into the teams would be beneficial due to the nature of the people they supported.

The liaison psychiatry team had recently completed a range of audits in advance of their application for accreditation. The out of hours team did not undertake any recurrent audits of their service at team level.

Skilled staff to deliver care

Health based place of safety

Staff had additional skills and knowledge they were able to utilise to support people using the service. Some staff on Maple ward were trained to offer support to people in relation to smoking cessation. Some had previous experience of working with people requiring detoxification for opiates or alcohol. The manager told us they could draw on these staff members' skills and knowledge, for example if a person in the place of safety needed support in relation to substance misuse.

Staff told us they received supervision and support from their peers and managers. Trust policy stated that the expected frequency for supervision was every four to six weeks. Maple ward achieved 60% for clinical supervision, 20 percentage points lower than the trust target of 80% compliance. Staff told us they received annual appraisals. Seventy nine percent of staff on Maple wards had a current annual appraisal.

Staff performance shortfalls were addressed in accordance with necessary policies and by way of extra training and support if this was identified as necessary.

Crisis services

Staff had additional skills and knowledge they were able to utilise to support people using the service. Liaison psychiatry staff worked alongside staff from the acute hospital and were able to share knowledge and skills as a result of their close working. The team provided mental health and other training to acute staff to enable them to gain skills to identify people who may require input from liaison psychiatry. The team hosted a drug and alcohol worker from the substance misuse team. One staff member was being supported to undertake training to become an approved mental health practitioner. Staff each took a lead within a certain area, for example, infection control and training which helped them to develop skills in these subjects. The team held monthly continuing professional development sessions. Staff were able to put forward topics for discussion.

Feedback from the link person from the police service who worked with street triage was positive about the skills of the out of hours team. They said they were able to call the team for advice and guidance in relation to mental health and that police officers found this resource useful. One staff member was trained as a nurse prescriber so they were able to prescribe medicines to people where appropriate. A social worker also worked as part of the team.

Staff told us they received supervision and support from their peers and managers. Trust policy stated that the expected frequency for supervision was every four to six weeks. We did not obtain formal compliance rates from the trust for the out of hours and liaison psychiatry team however a recent audit undertaken by the liaison team showed compliance rates with supervision was at 62%. The out of hours team had only recently introduced formal supervisions when the new operational manager had taken up responsibility for the service. Most staff had received a formal supervision. One staff member had suggested

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implementing a forum where nurses in the team could meet for group supervision to ensure clinical skills were kept up to date. All staff we spoke with felt supported in their roles.

Staff told us they received annual appraisals. We did not receive formal compliance rates from the trust for the out of hours and liaison psychiatry team however, staff we spoke with told us they had these annually. Staff performance shortfalls were addressed in accordance with necessary policies and by way of extra training and support if this was identified as necessary.

Multi-disciplinary and inter-agency team work

Health based place of safety

There were effective processes in place to hand over information. People using the place of safety were discussed as part of Maple ward staff handover. One staff member on each shift was designated responsibility for the place of safety and therefore staff knew who to pass relevant information on to.

Staff liaised with other services that people were being transferred from, and to, in order to help ensure continuity of care. The place of safety staff worked well with the out of hours team but felt community teams were not always as effective in providing timely support.

There were good relationships with external partners such as the local authority. Staff from the local police service were in regular contact with staff at the place of safety. Both parties described good working relationships. Regular meetings took place between other relevant parties including the police, liaison team, out of hours and place of safety staff.

Crisis services

The nature of the teams and how they worked meant staff routinely had to share key information with other teams. The out of hours team provided mental health cover for the emergency department outside of liaison team working hours. These teams handed over to each other by way of a dedicated email box. The out of hours team had a night log for outstanding issues from the shift. This was sent to the operational manager each morning so they had oversight of outstanding issues and could follow these up. The majority of people using the out of hours service were already in receipt of other services within the trust. Staff passed information on to their teams and keyworkers via entries on individual electronic patient records accompanied by emails and electronic fax. People we spoke with said that when they had accessed support from the out of hours team or had been in the place of safety, their keyworkers within other teams had always been aware of this so had oversight of their care and treatment.

The liaison psychiatry team had a daily staff handover to share information and weekly multidisciplinary meetings which enabled them to discuss complex cases and share information.

Staff reported good working relationships with other teams that were part of the trust. There were some variances in these relationships. For example, the out of hours team felt other services did not always understand their role which led to inappropriate referrals and lack of understanding. The liaison team in the emergency department and out of hours team worked at night. They said this was sometimes problematic as there were a lack of services in operation at this time to which they could hand people over.

There were good relationships with external partners such as the local authority. The police service worked jointly with the out of hours service as part of the street triage and were also in regular contact with staff at the place of safety. All parties described good working relationships. Regular meetings took place between relevant parties including the police, liaison team, out of hours and place of safety staff. Staff within the emergency department at the teaching hospital held bi-monthly meetings to review and enforce the working relationships between the emergency department, out of hours and liaison team. A senior professional from the teaching hospital said the working relationship between all groups had improved 'substantially' in recent times.

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

Health based place of safety

Mental Health Act training was mandatory for staff. Only 31% percent of staff on Maple ward had completed this training. However, staff we spoke with demonstrated a sound understanding about use of the Act and how it applied to their roles. There were resources available such as current code of practice that staff could consult in addition to trust policies and information on the intranet. The joint agency policy for the implementation of section 136 policy had been updated to reflect the Mental Health

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Act code of practice updates in April 2015. The manager and senior manager of the place of safety had produced a training package for staff on Maple ward about use of section 136 and the Mental Health Act. Twenty four out of 29 staff had completed this.

Records within the place of safety showed that staff informed people about their rights under the Act and people were offered a patient information leaflet which provided these in writing. Mental Health Act assessments and documentation were stored within electronic patient records.

Staff were aware of how to access independent mental health advocacy and which people would be eligible for this provision.

Crisis services

Mental Health Act training was mandatory for staff in the liaison psychiatry team. Only 52% of staff had completed this training. Mental Health Act training was not a requirement for the out of hours team as the trust did not make this mandatory for community based teams. The out of hours team included approved mental health professionals who were trained via the local authority and worked primarily to undertake Mental Health Act assessments. This team completed most of the Mental Health Act assessments that were required for people needing an assessment. Nursing staff sought advice and guidance from within the team where they had any queries relating to the Mental Health Act.

Staff we spoke with in both teams demonstrated a sound understanding about use of the Act and how it applied to their roles. We saw that relevant documentation such as Mental Health Act assessments were stored within people's records.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act 2005 is a law designed to protect and empower people who may lack the mental capacity to make decisions for themselves. The Act applies to people aged 16 years and over. It must be considered where people may be unable to make a specific decision at a specific time and where they meet the eligibility criteria of the Act.

Health based place of safety

Mental Capacity Act training was mandatory for staff. Qualified staff groups had to complete a higher level of training than non qualified staff. Trust data showed there was low compliance with this training which were as follows:

Mental Capacity Act level 1: Maple ward 22%, Mental Capacity Act level 2: Maple ward 0%

Although compliance levels were low, staff demonstrated a sound understanding about use of the Mental Capacity Act. We did not see any records where staff had had to undertake an assessment to consider people's capacity although they could give examples of where they may be required to do so. There were resources and guidance in place if staff needed further support and guidance about the Act.

Deprivation of Liberty Safeguards training was also mandatory for staff within the place of safety and 100% of staff had completed this. Staff had made no applications for Deprivation of Liberty Safeguards authorisations in relation to people using the service. As people were already detained under a section of the Mental Health Act when they arrived at the place of safety, the circumstances where a Deprivation of Liberty safeguard authorisation would be necessary were infrequent.

Crisis services

Mental Capacity Act training was mandatory for staff. Qualified staff groups had to complete a higher level of training than non qualified staff. Trust data showed there was low compliance with this training which were as follows:

Mental Capacity Act level 1: Out of hours team 32%; liaison psychiatry 56%

Mental Capacity Act level 2: Out of hours team 38%; liaison psychiatry 32%

Although compliance levels were low, staff demonstrated a sound understanding about use of the Mental Capacity Act. There was information within people's records to show staff had considered people's capacity in respect of decision making. Where staff had doubts about a person's capacity, they undertook capacity assessments to ascertain whether the person was able to make a decision. Some staff had not had to undertake a formal assessment of a person's capacity but they were still able to explain the principles of the Act.

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.

During assessments we observed that staff considered and tested people's ability to consent and checked to ensure they understood necessary information they required to make a decision.

We saw examples in the liaison psychiatry team where staff had assessed a person's capacity and they were found to have capacity to make their own decision; as well as assessments where people had lacked capacity. Staff told us they would occasionally be involved in best interest meetings for decisions such as where would be the best accommodation for a person to reside. These situations were more prevalent within the older adult population of the service. One consultant told us of a situation where the team had go to the Court of Protection to resolve a disagreement between professionals about one person's wish to refuse treatment.

Deprivation of Liberty Safeguards training was also mandatory for staff in the liaison psychiatry team and 30% of staff had completed this. These safeguards apply only to hospitals and care homes. The out of hours team did not work within a hospital setting. Staff had made no applications for Deprivation of Liberty Safeguards authorisations for people using the services.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

Health based place of safety

No one was using the service at the time of our inspection however we spoke with four people who had recently used the place of safety. They gave mixed views of their experiences. All said that most of the staff had been kind and caring. One person told us a staff member had sat with them providing reassurance for a long period of time which they appreciated. Another referred to a 'very kind nurse' who had met them on their arrival. However, two people said there were instances when they felt staff had not had a caring approach. One said although staff were polite, they perceived one nurse had been 'having a go' at them by how they spoke. Some people were unable to recall the full circumstances or experiences of their stay due to them being unwell at the time.

There were measures in place to help maintain people's dignity whilst using the service. The place of safety stocked dignity packs which included personal care items for people to use. Spare clothing was available and there were facilities to launder clothes if required. Staff spoke about the importance of preserving dignity and had reported an incident where a person had arrived at the place of safety in a way that impacted their dignity which they had reported.

Crisis services

Our observations of assessments that we attended demonstrated that staff were kind, caring, professional and supportive in their interactions with people and carers. Staff employed a sensitive approach, demonstrated active listening skills and provided reassurance to the people they were supporting. Two carers we spoke with who were present during the assessments said that staff were caring and compassionate. They spoke highly of the staff, felt respected and said that were helpful, genuine and interested.

We spoke with 10 people who used the out of hours service. Six felt that staff were caring and supportive. Two said that staff had helped save their lives due to the care and support they provided. One person described a specific member of staff as being a 'rock'. They were positive about the service they received. One said staff were down to earth, good at listening and very helpful at all times. However, some people felt staff were dismissive at times. One said a staff member had told them that they had limited resources and had other work to prioritise first. The person acknowledged this but said the comment made them feel like their call was unwelcome. Another person said that whilst staff had been supportive, they felt some staff minimised how they felt.

There were measures in place to help maintain people's dignity whilst using the service. In the liaison psychiatry team, the consultation rooms had been recently soundproofed so that people could not over hear personal discussions. Whilst we observed an assessment within the interview room in the emergency department, we noted the assessment was interrupted three times by other staff which had potential to impact on people's privacy.

During assessments, staff explained to people about the confidentiality framework in place and circumstances where they may need to share information. Staff sought consent from people to do this and care records showed staff had asked people for consent before sharing information.

The involvement of people in the care that they receive

Health based place of safety

It was not clear that staff in the place of safety made all people aware of how to access advocacy or support whilst using the service. One person told us they would have liked to speak with an advocate whilst in the place of safety but had not been aware of how to go about this.

The place of safety had recently introduced feedback forms to capture the views of people using the service. There had been a limited response to these so far with only 17 responses being received between October 2015 and May 2016. People we spoke with could not recall being offered the opportunity to provide feedback during their stay. However, they told us that it probably would not have been the best time as most people were unwell or in distress. The manager said there were barriers to capturing feedback from people whilst using the service and they were looking at alternative ways and times to obtain this.

Crisis services

During assessments staff explained to people what the role of the service was and what they were there to do. Staff

Good

Are services caring?

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

checked that people were happy to continue with assessments and gave people the opportunity to ask any questions. People were involved and had input into their own plans of care. For example, we observed a staff member on the liaison team produce a collaborative care plan with one person setting out clear self-help strategies. They gave this to the person along with relevant information leaflets. The staff member, with consent, also discussed the plan with the person's carer so they were aware of the person's support needs.

The liaison psychiatry team had feedback forms available for people to complete. A box was available in the waiting room where people could put forward their suggestions. People using the out of hours service told us they were not aware, and had not been asked, by the service about any feedback.

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 and discharge

Health based place of safety

Access to the place of safety was primarily via people being detained under a section 136 of the Mental Health Act by the police. Bed use statistics from January 2016 until October 2016 showed that the place of safety had been used 221 times at the time of our inspection, averaging 22 admissions per month. There had been ten instances of people being unable to access the bed due to it being in use, and four occasions when the bed was unavailable due to lack of staff. On 1 November 2016, a second bed at the place of safety had been made available. Feedback from the acute hospital trust highlighted this as a significant improvement to help reduce the number of people being taken to the emergency department as a place of safety. The police also gave positive feedback about the second bed.

The manager told us the only times the suite was used outside of people being detained on a section 136, was for people detained under section 135 of the Mental Health Act. Use of this section enables police officers to enter premises and remove a person to a place of safety for the purposes of a Mental Health Act assessment. These instances were not frequent and would be planned in advance to reduce potential impact on availability of the place of safety. No out of area placements were reported in 2016 for people needing to access this service.

Three out of the four people we spoke with who had used the place of safety reported waits of several hours to be assessed. Average wait times for assessments were eight hours which was in excess of Royal College of Psychiatry guidelines of three hours and the trust's own policy of two to three hours. Staff chased up teams to speed up response times and reported excessive waits. The manager said the most problematic time was between 4 and 5pm when community mental health teams handed over assessment responsibilities to the out of hours team. There were current plans to look at making approved mental health practitioners a citywide service, as opposed to the current model of them working in sectors, with an aim to prioritising assessment requests and speeding up response times. No one had stayed at the place of safety in excess of the 72 hour period allowable under a section 136. The trust aimed for a maximum stay of 24 hours only.

Where professionals authorised further detention under the Act, requests were made to named bed managers who sought to identify a suitable bed. Staff said this usually worked satisfactorily although there could be problems at times dependent upon demand elsewhere.

Crisis services

There was no single twenty four hour crisis service in operation. People in a crisis had to contact their own community mental health teams between 9.00am and 5.00pm during the week or alternatively their own GP if they were not assigned to a community team. Outside of these hours they were advised to contact the out of hours team or emergency services if necessary. The community mental health teams had a number of other functions as well as day time crisis support. The out of hours team dealt with one off interventions for people in a crisis.

The majority of the out of hours team's work consisted of telephone contacts which staff aimed to respond to as soon as possible. There was no triage system, calls were assessed and responded to by available staff at the time. Most people we spoke with said they often waited long periods of time for calls back and in some cases did not get a response, or got told to call another helpline that was available unrelated to the trust. The result was that some people had to try to find other support networks or access the emergency department. Some people said when the team did get in touch, their crisis may have passed. However, we also heard positive feedback where people told us staff always rang them back and usually very quickly. Staff in the out of hours team told us they always called people back and did not recognise instances of people having to wait significant lengths of time to be called back.

The out of hours team was also responsible for people within the emergency department overnight who required a mental health assessment. The out of hours team had a higher referral threshold than the liaison team. Feedback from the acute hospital stated that this did cause some issues however it was due to how the services were

Are services responsive to people's needs?

Good

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

commissioned and not attributable to the service itself. They also fed back that response times had improved considerably due to recent increased staffing, but could still be lengthy when compared to national standards.

The out of hours team had recently updated their referral criteria and circulated this to referrers within the trust to make it explicit what types of situations met their threshold. This was an attempt to ensure access to the service was as necessary and to make best use of the resources within the team.

Staff aimed to attend urgent assessments within an hour time period. The street triage crisis assessment we attended was responded to within an hour. Staff were clear about the need to prioritise assessments of people within the place of safety in order that the beds became available as soon as possible.

There was no exclusion criteria for people referred to the liaison psychiatry team. Nursing staff worked directly within the emergency department to enable them to be responsive to people presenting with concerns. A triage system was in place for telephone referrals that were graded against criteria and assigned a category of response time. Staff told us the system worked well. It could be hindered at times dependent upon where referrals were as the team covered several sites. The referrals process for older people and working age adults were different. In the working age adults team, all qualified staff were able to make referrals. However, in the older adults team, referrals had to be made via a doctor, direct to the consultant. The service aimed to streamline this in future so there was a consistent referral procedure to access the service.

Where people were referred to the outpatient clinic of the liaison psychiatry team, there was a process in place to try to engage people who did not attend. Information about non attendance was provided in correspondence and the team sent two further letters to encourage engagement before people were discharged from the service. Other relevant professionals, such as the person's GP was copied in so they were aware the person may still require some level of support.

The facilities promote recovery, comfort, dignity and confidentiality

Health based place of safety

The place of safety consisted of two bedrooms and an assessment room situated on an acute mental health ward for adults of working age. One bedroom was close to a patient's bedroom on the main ward which meant both patients' privacy could be compromised due to noise being overheard. The manager told us they would aim to use the second bedroom when only one person was using the place of safety.

There was a phone available that people using the place of safety could use to make calls and a clock visible in the suite. A beverage bay was situated in the assessment room with facilities to provide hot drinks and soups. One person told us they were offered drinks, food and asked about any dietary needs they had during their stay. Another said staff gave them hot drinks but they were not offered any food and had not eaten for a while.

There was access to an outside area via the main ward. Two people told us they had been bored in the place of safety as there was little to do. The manager told us the trust was considering having televisions installed in each bedroom so people would have some stimulation.

Crisis services

The out of hours team had an office base where staff operated from. They did not see people using the service at these premises. Staff undertook face to face assessments in various community locations, people's homes or in the emergency department. Staff told us they would find it beneficial to have dedicated facilities whereby they were able to undertake assessments.

The liaison psychiatry team had a waiting area for people and private assessment rooms for them to see staff. The assessment rooms had been soundproofed to help maintain people's privacy and confidentiality. There were a variety of leaflets on display for people, including easy read versions, which gave information about a range of services including health advice, complaints and feedback. The service had a hearing loop available for people who may have hearing difficulties. Staff at the services had access to interpreters should they require this resource.

Meeting the needs of all people who use the service

Health based place of safety

The external dedicated entrance to the place of safety was not accessible to wheelchair users which meant people

Are services responsive to people's needs?

Good

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

requiring such access would have to use another entrance. The manager told us, and the risk assessment documented, that there were plans to build a ramp to facilitate wheelchair access. The bathrooms in the suite were not accessible to wheelchair users and people who required disabled access. Staff supported people requiring these facilities to access these on the main ward which did accommodate disabled access bathrooms.

The place of safety had leaflets available in the five most commonly spoken languages within the area. There was no information about how people could access advocacy support. There were information leaflets in the liaison service waiting room for people to access including information on how to make complaints.

The place of safety accommodated people aged 16 and 17 where appropriate and detained under section 136 of the Act. When this occurred, staff requested input and assessment from a child and adolescent mental health psychiatrist. There was a policy for admission of people of this age onto wards.

Crisis services

Access to the out of hours team was via telephone where individuals left a voice message. There was no provision for people to access the service who were not able to communicate in this manner. If staff were aware of someone with alternative communication needs they would try to facilitate this. One example was a staff member who supported a person by way of email exchanges. However, this was reliant on the person's needs already being known to services or them having someone able to request alternative communication on their behalf.

The street triage team operated between the hours of 4pm and midnight. The senior practitioner had recently conducted some research and identified the core hours of activity tended to be between the hours of 6pm and 2.00am. There was scope within the team and within the police service to possibly look at varying triage times to better suit demand for this service but no changes to this had been decided.

The liaison psychiatry team currently supported some older people by way of a supported discharge service. This was facilitated by three support workers whose role was to support people on discharge from hospital in their own home up to a period of two weeks. The service also provided specialist clinics to meet people's needs and had input into clinics ran by the acute trust.

Listening to and learning from concerns and complaints

Health based place of safety

Complaint information was provided in the place of safety assessment room. Most people said they would raise any concerns with a member of staff. Where people expressed dissatisfaction with the service some had declined to raise this with staff and others said they had but felt staff did not always act on this.

Within the 12 months prior to our inspection, the place of safety had received one complaint which was partially upheld.

Crisis services

Complaint information was provided in the liaison psychiatry waiting room The liaison psychiatry service had two complaints within the 12 months prior to our inspection which were investigated and not upheld. Both related to separate issues. There were two complaint investigations ongoing for this service at the time of our inspection. The out of hours service had one complaint in this same period which was upheld.

We saw that complaints had been proportionately investigated in order to arrive at conclusions. No complaints had been referred to the parliamentary and health service ombudsman.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

Health based place of safety

All staff spoke positively of their roles and of working for the trust and more specifically the service they worked in. Several staff commented that they felt proud of the professionalism and passion of their colleagues in displaying trust values. These values were; respect, compassion, partnership, accountability, fairness and ambition. Managers used values based recruitment in order to ensure they attracted and retained staff who displayed these values. Staff told us they saw senior managers attend the ward.

Crisis services

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The out of hours team operated at times when the majority of other trust services did not. As a result staff felt disassociated from the wider trust at times, especially the senior executive team. Staff could not recall any instances of senior board level staff attending the service to meet staff and to experience and see the team in operation. However, staff within the liaison team gave recollections of having seen the Chief executive and other senior executive staff at their services before.

Good governance

Health based place of safety and crisis services

The place of safety was managed by the team manager of Maple ward who had systems to monitor training and supervision. Relevant agencies met quarterly as part of a joint service liaison meeting to review use of the place of safety and identify areas for improvement and further development

The joint agency policy, the latest version of which was issued in July 2016 stated that information to be collected by staff included methods of conveyance for people taken to the place of safety. The purpose of this was to have oversight of the use of conveyance methods with a view to a reduction in the use of police vehicles. The service did not start to capture this data until several days prior to the inspection which meant there was no evidence to analyse any trends. Maple ward and the place of safety had activity data included within a monthly dashboard. There was a risk register in place for Maple ward which incorporated risks relating to the place of safety.

Crisis services

Since our last inspection of the out of hours team in 2014, changes had been made to improve the governance structure. The current operational manager had taken responsibility for the team several months earlier and had introduced some formal systems. This included team governance meetings and formal supervisions. The team acknowledged that governance processes still needed to be strengthened.

The team did not have a manager. The trust subsequently told us that this post was in the process of being recruited to. The senior practitioner who oversaw the team spent approximately half of their time as a practicing approved professional and the remainder undertaking management duties. The practitioner was responsible for overseeing all staff supervisions which meant they had 20 members of staff to supervise, over half of whom were of a different profession and a different skill set. Although we saw staff had regular supervisions there was a risk that this arrangement may impact upon the senior practitioners role and they may not have the necessary skill set to supervise some staff. Following our inspection, the trust told us that the operational manager was also able to support with staff supervisions.

The team had no administration support which meant clinical staff were responsible for undertaking these duties. Two staff told us this impacted upon their time. The lack of administration had also been mentioned to us as a risk by the senior operational manager. Some administration support was available for tasks such as typing meeting minutes and logging staff sickness. The nature and working hours of the team meant there were practical difficulties, for example ensuring staff had time and availability to attend training and meetings. The senior practitioner said they did not have the means to monitor training

Are services well-led?

Requires improvement

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

The team monitored a range of activity including referral sources, police contact and admission times. There were other areas where performance was not routinely reviewed such as response times. The operations manager and senior practitioner said this information could be obtained by way of accessing individual records but there was no current system to monitor this overall. The team had recently started to try to obtain feedback by signposting people to participate in friends and family test which is an NHS feedback tool. However, there was no current feedback from people using the service and no people we spoke with had been asked to give feedback. There were no other mechanisms to obtain feedback from people using the service which could be used to improve practice. The team had recently started to collate feedback from stakeholders. We saw these and all comments were positive about the service.

The liaison psychiatry team had a team manager in post. The liaison team was initially an older people's service and a working age adults service but these had now merged together. There were still some differences in practice but the service aimed to streamline and adopt a one system approach in the future. There was administration support to the team and senior practitioners had oversight of staff training and supervision.

The out of hours and psychiatric liaison service's performance was discussed as part of a quarterly performance review that senior managers attended. Minutes from these showed actions that were required of each service along with actions plans and progress updates.

Each team had a risk register and managers were able to add risks to these as necessary. The risks documented for the out of hours and liaison psychiatry teams did not all have timescales for review recorded within them. This meant it was unclear at what frequency these were to be reviewed and how the services could accurately monitor progress.

Leadership, morale and staff engagement

Health based place of safety and crisis services

Staff told us they felt supported by their teams and were able to raise concerns and use their own initiative. There was a positive morale and clear regard for supporting colleagues amongst all teams. We observed an open culture within the teams and between staff. The senior practitioner and managers of each team spoke highly of the staff and were proud of their compassion towards people they supported, some of whom could have quite complex needs and presentation. Staff also spoke positively about the support they got from their team managers.

Staff said they felt able to raise concerns and would speak up about any issues they had. They were aware of how to do this via various methods. No staff reported being subject to bullying or harassment.

Although the out of hours team reported they felt disassociated from the wider trust, they were a very cohesive and mutually supportive team. Staff told us they had chosen to work on the team and felt personal satisfaction within their roles.

Commitment to quality improvement and innovation

Health based place of safety

The manager of the place of safety used current Royal College of Psychiatry guidance for section 136 suites as a benchmark to assess the quality and suitability of the environment.

Crisis services

The liaison psychiatry team had recently applied, and been subject to peer review, for accreditation with the Psychiatric Liaison Accreditation Network . This network works with services to assure and improve the quality of psychiatric liaison in hospital settings. There were two areas where the service had not fully met the standards which the team were acting upon and resubmitting for further review in December 2016.

Staff from the liaison team had also undertaken visits to liaison services in other trusts to see how these operated and to look at good practice which could be shared and implemented within their own team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment was not provided in a safe way. We were not assured that staff had done all that was reasonably practicable to mitigate any risks Staff had not completed risk assessments for all people using the place of safety. Information was not present in all records as to the frequency that staff needed to observe people in the place of safety. Staff had not completed physical health checks on all people using the place of safety. Ligature risk assessments in the liaison psychiatry team did not clearly state what actions were required to mitigate all identified risks. Regulation 12 (1) (a) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Staff at the place of safety did not always maintain an accurate, complete and contemporaneous record in respect of each person using the service. There were omissions in documentation such as times, names and dates of entries. The out of hours team had limited feedback mechanisms to capture, and use, peoples' views of the service.

This section is primarily information for the provider

Requirement notices

There was a lack of learning from incidents at a shared team wide level. It was not evident how incidents were used to identify and improve practice within the service.

Regulation 17 (1) (b) (c) (e) (f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** Not all staff within the three services were current with necessary mandatory training as required by the trust. A number of key training courses had compliance rates of less than 75%. This included Respect training, life support and safeguarding. Supervision rates were below trust target of 80% Regulation 18 (1) (a)