Inadequate

North Staffordshire Combined Healthcare NHS Trust

# Mental health crisis services and health-based places of safety

## Quality Report

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Date of inspection visit: 7-11 September 2015
Date of publication: 22/03/2016

## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| RLY88 | Harplands Hospital | Acute Home Treatment Team | ST4 6TH |
| RLY88 | Harplands Hospital | RAID Team | ST4 6TH |
| RLY88 | Harplands Hospital | Health Based Place of safety | ST4 6TH |
| RLY88 | Harplands Hospital | Access Team | ST1 2BX |

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

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

Where applicable, we have reported on each core service provided by North Staffordshire Combined Healthcare NHS Trust and these are brought together to inform our overall judgement of North Staffordshire Combined Healthcare NHS Trust.

# Summary of findings

## Ratings

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

| | |
|---|---|
| Overall rating for the service | Inadequate |
| Are services safe? | **Inadequate** |
| Are services effective? | **Inadequate** |
| Are services caring? | **Requires improvement** |
| Are services responsive? | **Requires improvement** |
| 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

## Contents

# Summary of findings

## Overall summary

**We rated mental health crisis services and health-based place of safety as inadequate because**:

- The home treatment team did not complete assessments for new referrals. They did not review or update assessments that were being used by other teams when patients were referred to their service. When patients' needs changed, the home treatment team did not update existing risk assessments which were completed by other services.
- The risk management plans across all teams were not detailed enough to identify how staff were to safely manage patients. There were no clear guidelines on how staff should respond and address the risks identified. The home treatment team did not review management plans regularly.
- All teams did not complete risk assessments for all visits to patients' home to ensure that staff were safe.
- The home treatment team did not have appropriate arrangements for the management of medicines. There were no drug charts for medicines administered by nurses to sign that medicines had been given. Staff did not follow guidance for controlled drugs storage to ensure that controlled drugs were stored safely.
- Staff were able to show how they provided care and treatment to both patients and carers in line with the National Institute for Health and Clinical Excellence (NICE) guidelines. However, the records read did not identify the involvement of patients in partnership with their health and social care professionals. For example; out of 27 records within the access team we found that 18 did not identify the patient's relative or carer's involvement in the care planning/management plan process. We found no evidence of a review of patient's care/management plans within 18 of the records read.
- Observation levels carried out by staff to manage the potential risk of ligature points of taps and a pipe in the Health Based Place of Safety (HBPoS) bathroom compromised patients' privacy and dignity when using the facilities.
- The home treatment team did not complete admission assessments or update the assessments that had been carried out by other teams when patients were referred to their service. The team did not ensure that patients received care and treatment that was based on current assessment of their needs.
- The Access, Raid and home treatment teams did not have care plans that were personalised, holistic or recovery orientated. The home treatment team did not have up to date care plans. The teams provided care and treatment that did not reflect person-centred care that was based on individual needs and preferences.
- Records within the teams were not well organised and different team members could not access patients' records when needed. The Access team out of hours did not have readily available access to paper based records of patients known to other teams. This could not provide staff with easy access to deliver effective patient care.
- The Access team and home treatment teams did not carry out physical health checks and there were no care plans in place for patients with physical health needs to ensure that their needs were monitored.
- Standard operating procedures within the Access team stated that should people need to wait before an assessment, this is for no longer than 20 minutes after the agreed appointment time. The manager we spoke with said the team did not monitor or measure the outcome of whether they were meeting this.
- We looked at the percentage of patients within the access team who were seen within four hours. The records showed that the Access team had achieved a target rate of 100% since November 2014 to April 2015. However, there were no records which measured the outcome of patients seen within 24 to 72 hours and 21 days.
- Staff from all teams did not carry out regular clinical audits to monitor the effectiveness of the service provided.
- Appraisal rates varied between teams. Records showed that staff from Access and home treatment team received appraisals. However, the percentage of non-medical staff that received an appraisal in the last 12 months was 44% in Raid team.
- There were no regular and effective multi-disciplinary team meetings taking place in Access, home treatment and Raid teams.

# Summary of findings

- Confidentiality was not always maintained at the Access team and Raid team.
- Patients from home treatment team did not participate in care plans and care reviews and they did not have copies of their care plans. Patients told us that they not given copies of care plans and were not aware of their written care plans.
- The teams did not carry out formal carers' assessments.
- The Access, Raid and home treatment teams did not have a structured way of getting patients involved in decisions about their service. There were no patient forums or meetings held or involved in recruiting staff.
- Only four out of 21 records reviewed in the health based place of safety showed that patients were seen for mental health act assessment within the target time of three hours.
- The out of hours service could not facilitate admission or find a crisis bed for patients under 18 and those over 65. These cases were referred to social services emergency duty team.
- The assessment details for all teams did not address areas of disability and sexual orientation needs of individuals.
- Patients were not always provided with information about the ways that they could raise complaints and concerns regarding the service.
- The teams did not have robust systems and methods to effectively assess and monitor that the service is performing well around quality and safety of the service.
- However:
- Staff told us that they were trained in safeguarding and knew how to make a safeguarding alert. Staff demonstrated a good understanding of how to identify and report abuse.
- The teams had a clear structure which reviewed all reported incidents. Staff were able to explain how learning from incidents was shared.
- Staff told us they had undertaken training relevant to their role. Staff were trained in cognitive behavioural therapy, solution focussed therapy, open dialogue and clinical risk assessment.
- There was evidence of working with others including internal and external partnership working, such as in-patient services, GPs, police, Royal Stoke hospital, independent sector and local authority.
- Patients and their families were positive about the attitude of staff and the support they received. Our observations and discussions with patients confirmed that staff were friendly, polite and treated them with respect.
- The interaction between patients and staff was positive and staff responded to patients with patience, kindness and ensured that they were treated with dignity and respect.
- The percentage of patients seen for crisis assessment within four hours of referral was 95% in the last 12 months. The target was 90%.
- Appointments were rarely cancelled and where there were cancellations people were seen at the earliest possible opportunity.
- Our observations and discussion with staff confirmed that the teams were cohesive with good staff morale.
- Staff told us the board informed them about developments through emails and intranet and sought their opinion through the annual staff survey.

# Summary of findings

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

### Are services safe?

Inadequate

**We rated safe as inadequate because**:

- The home treatment team did not complete any risk assessments when patients were referred to their team. The home treatment team did not update existing risk assessments when the needs of patients changed.
- The risk management plans across all teams were not detailed enough to identify how staff were to safely manage patients. There were no clear guidelines on how staff should respond and address the risks identified. These management plans were not regularly reviewed.
- None of the records reviewed had a detailed emergency plan in place that informed staff what to do in the event of a crisis. Advance decisions were not recorded.
- Risk assessments were not carried out for all visits to patients' home to ensure that all staff were safe. Staff did not have alarm devices that they could activate to call for assistance when their safety was at risk. There was no risk assessment in place for some areas that had poor network signal and where phones could not work.
- The home treatment team did not have appropriate arrangements for the management of medicines. Medicines were stored in a cupboard next to a radiator. The minimum temperatures were not recorded. There were no drug charts for medicines administered by nurses to sign that medicines had been given. Controlled drugs were not stored following safe guidance for controlled drug storage. We found that the controlled drug records were not accurate.
- The Access team saw patients at their offices site but did not have resuscitation equipment such as defibrillators or a room with facilities to examine patients.
- The potential risk of ligature points of taps and a pipe in the HBPoS bathroom was managed through appropriate levels of observation. This had an impact on patient's privacy and dignity when using the facilities.
- The Access team told us that they only had a psychiatrist for one and a half days a week and the other times they had to use the on-call psychiatrist. This had caused delays in assessments during working hours.

**However:**

- There were no patients on waiting list to be allocated to nurses.

# Summary of findings

- Records showed that the average rate for completed staff mandatory training was 92% for Access team, 98% for home treatment team and 97% for Raid team.
- Staff told us that they were trained in safeguarding and knew how to make a safeguarding alert. Staff demonstrated a good understanding of how to identify and report abuse.
- The teams had a clear structure which reviewed all reported incidents. Staff were able to explain how learning from incidents was shared with all staff.

**Are services effective?**

**Inadequate**

**We rated effective as inadequate because**:

- The home treatment team did not complete admission assessments or update the assessments that had been carried out by other teams. 12 records sampled showed that no assessments were updated by the team or carried out their own assessments when they received patients from other teams. The team did not ensure that patients received care and treatment that was based on assessment of their needs.
- The Access, Raid and home treatment teams did not have care plans that were personalised, holistic or recovery orientated. The home treatment care plans were not up to date. The teams provided care and treatment that did not reflect person-centred care that was based on individual needs and preferences.
- The teams did not have well organised records and different team members could not access patients' records when needed. The Access team did not have readily available access to paper based records of patients known to other teams out of hours. The section 136 paper records were held separately by the Mental Health Act team and not combined with patients' notes.
- We found that staff within the Access team had to input the information twice onto the electronic system. We found there were no processes in place to monitor the information being duplicated onto the electronic system to ensure this was accurate. This meant that there was a risk that staff may have incorrect information to respond to patient risk.
- There was no evidence that staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medication. Records sampled showed that medicines from the Home treatment team were prescribed by different teams.

# Summary of findings

- In the records we checked we saw no clear monitoring of physical health needs within the Access and home treatment teams. Health checks were not carried out and there were no care plans in place for patients with physical health needs to ensure that their needs were monitored.
- The teams did not use any tools to measure clinical outcomes for patients. This meant that staff did not have standard ways to monitor changes in a patient's presentation.
- Staff did not actively participate in clinical audits. Staff told us that they were not involved in any clinical audits.
- Appraisal rates varied between teams. Records showed that staff from Access and home treatment team received appraisals. However, the percentage of non-medical staff that received an appraisal in the last 12 months was 44% in Raid team.
- There were no regular and effective multi-disciplinary team meetings taking place in Access, Home treatment and Raid teams.
- In the records we checked the teams did not have detailed discharge plans when patients were discharged from the service. The Access team records showed no evidence of discharge planning for short term intervention services
- The teams did not have information on independent mental health advocacy services that was readily available to support patients. Staff were not sure of how to access and support patients to engage with the independent mental health advocacy when needed.
- All teams had no arrangements in place to monitor adherence to the Mental Capacity Act.
- Records showed that the Access team's clinical risk course compliance was low at 34% and fire compliance at 65%.

However:

- All the teams had experienced and qualified staff. The teams were mostly staffed with band six and seven nurses. The teams included nurse prescribers and nurses who were also approved mental health professionals.
- Staff told us they had undertaken training relevant to their role. Staff were trained in cognitive behavioural therapy, solution focussed therapy, open dialogue and clinical risk assessment.
- There was evidence of internal and external partnership working with other teams such as in-patient services, GPs, police, acute services, independent sector and local authority.

# Summary of findings

## Are services caring?

Requires improvement 

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

- Confidentiality was not always maintained at the Access team and Raid team. The Access team shared an office with Healthy Minds, a separate team with a different role. This meant that confidential conversations held with patients on the phone could be over heard.
- In the records we viewed we saw that patients did not participate in care plans and care reviews and they did not have copies of their care plans. Patients told us that they were not given copies of care plans and were not aware of their written care plans.
- The teams did not carry out formal carers' assessments.
- Staff in the home treatment team were not aware of how to access advocacy services for patients. Families, carers and patients were not given information about relevant local advocacy contacts. Patients and their families told us that they were not aware of how to access advocacy services when needed.
- The teams had no structured way of getting patients involved in decisions about their service. There were no patient forums or meetings held or involved in recruiting staff. Patients told us that they were not actively involved or encouraged to take part in decisions about the service.
- Patients in Raid team were not given feedback forms to complete about the care they received. Health based place of safety, Access and home treatment staff did not analyse information from feedback forms. Themes and trends picked up from the feedback was therefore not used to improve the services provided.
- We saw no evidence within access team records of people being offered a preference for a male or female health or social care professional to conduct crisis assessments.

However:

- Patients and their families were positive about the attitude of staff and the support they received. Our observations and discussions with patients confirmed that staff were friendly, polite and treated them with respect.
- The interaction between patients and staff was positive and staff responded to patients with patience, kindness and ensured that they were treated with dignity and respect.

# Summary of findings

- Carers were involved in the assessment and discussion of care and treatment where appropriate. Patients were encouraged to involve relatives and friends in care and treatment discussions if they wished.

**Are services responsive to people's needs?**

Requires improvement

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

- Only four out of 21 records reviewed in the health based place of safety showed that patients were seen for mental health act assessment within three hours.
- Patients were moved to police custody if the HBPoS suite at Harplands was occupied. Since April 2015 this happened seven times and 52 times between April 2014 to March 2015.
- The Access Team had responsibility for bed management and we observed staff liaising with the hospital staff regarding the allocation of beds. The manager told us they did not have any measured outcomes to ensure the allocation of beds was effective. The review of the bed management process to identify blockages in system and the undertaking of a capacity and demand exercise was identified as an area of improvement in the trust quality priorities for 2015/16.
- We looked at the percentage of patients who were seen within four hours. The records showed that the Access team had achieved a target rate of 100% since November 2014 to April 2015. However, there were no records which measured the outcome of patients seen within 24 to 72 hours and 21 days.
- The Access team was the single point of access to all patients in crisis out of hours. The team could not facilitate admission or find a crisis bed for patients under 18 and those over 65. These cases were referred to social services emergency duty team.
- The patients in ward one complained that the noise that came from HBPoS was disturbing. The door that separated the two areas was not robust or sound proof enough to keep the noise away from the ward.
- Staff at A&E in Raid team did not have any lockable cupboards to store patients' records or assessment documentation. This posed an information security risk.
- Patients in the Access and home treatment teams were not provided with accessible information on treatments, local services, patients' rights and how to complain.
- The information within assessment documentation did not address areas of disability and sexual orientation needs of individuals. This meant that reasonable adjustments could not be made to appropriately meet the needs of patients.

# Summary of findings

- Patients and their families told us that they were not given information on how they could raise complaints. The teams did not record the complaints received verbally. The managers were therefore unable to analyse the complaints for any themes and trends so that learning from was used to improve services.

However:

- The percentage of patients seen for crisis assessment within four hours of referral was 95% in the last 12 months. The target was 90%
- All routine referrals were seen within seven days. This achieved higher than the target of 90%.
- Appointments were rarely cancelled and where there were cancellations people were seen at the earliest possible opportunity
- The teams maintained their appointment times and when they were running late patients were informed.
- The Access team provided a 24 hours service seven days a week. The out of hours, bank holidays and weekend services were provided by the Access team. The duty clinician role within the ICMHT's operated from 8am to 8pm with out of hours response being provided by the access team

## Are services well-led?

**Requires improvement**

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

- Staff were not familiar with the trust's values. They told us that the values had recently been introduced and they were not yet familiar with them.
- The Access team pathway forms were inconsistent in their completion and the information recorded. There was no evidence of an audit tool to monitor standards.
- We found it difficult to ascertain how the Access team were managing the single point of access without the electronic recordings of live information on the patient's pathway of care.
- There were no robust systems or methods to effectively measure the quality and safety of the service being provided. The inspection team identified such areas where improvements were required.
- The teams were not consistently capturing data on performance. For example, data on late appointments, DNA appointments and numbers of complaints received verbally were not being collected, analysed or used to improve the service.

# Summary of findings

However:

- Staff knew who their senior managers were and told us that they visited the teams.
- Staff told us that they were supported by their line managers and were encouraged to access clinical and professional development courses. They told us that managers were accessible to staff, approachable, had an open culture and willing to listen.
- Our observations and discussion with staff confirmed that the teams were cohesive with good staff morale.
- Staff told us the board informed them about developments through emails and intranet and sought their opinion through the annual staff survey.

# Summary of findings

## Information about the service

The Access team was based at The Hope Centre in Hanley .The Access team was the single point of contact and access for all North Staffordshire Combined Healthcare NHS Trust services. The Access Team provided 24/7 cover for all mental health and learning disability services across Stoke-on-Trent and North Staffordshire. The team had qualified health and social care staff who worked together to provide assessment and advice. The team supported individuals and referrers to get access to the right services.

The Acute Home Treatment Team (AHTT) was based at Harpland's hospital. It provided an alternative to hospital admission for adults with acute mental health needs. The team provided short term intensive support, assessment and treatment to patients in their own homes to improve and maintain mental health. The team consisted of mental health nurses, support time and recovery workers and psychiatrists. The team operated from 8am to midnight seven days a week.

The Rapid assessment interface and discharge also known as the RAID team was based at Harpland's hospital and Royal Stoke hospital. The Raid saw and assessed patients who presented with mental health crisis in the accident and emergency department (A&E) or on the wards in the acute general hospital. Patients seen and assessed were either referred to primary care (GP), admitted to the acute hospital, admitted to a mental health ward, referred to the AHTT or referred to the community mental health team. The team consisted of mental health nurses and psychiatrists. And operated from 7am to 11pm seven days a week.

The health based places of safety (HBPoS) section 136 suite was based at Harpland's hospital. Patients were brought to this place of safety by a police officer because they were concerned that the patient had a mental disorder and should be seen by a mental health professional. Patients were kept in the suite under section 136 of the Mental Health Act so that they can be assessed to see if they required treatment. The 136 suite was managed by staff from ward one (a mixed acute mental health ward). Patients were cared for in the HBPoS for up to 72 hours until they could be assessed by a psychiatrist and an approved mental health professional.

## Our inspection team

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the Harpland's hospital, Royal Stoke University hospital A&E, The Hope Centre and patients in their own homes and looked at the quality of the environments and observed how staff were caring for patients.
- spoke with 13 patients who were using the service and five of their relatives.
- spoke with the three managers.
- spoke with 24 other staff members; including doctors, nurses, nursing assistants, psychologist, administrators, and social workers.
- interviewed the matron with responsibility for the home treatment team.
- attended and observed one handover meeting.
- looked at 24 care records of patients.
- looked at 21 assessment records in the 136 suite.

# Summary of findings

- carried out a specific check of the medication management in the home treatment team.
- looked at a range of policies, procedures and other documents relating to the running of the service.

## 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

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- Is it well-led?

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- spoke with 13 patients who were using the service and five of their relatives.
- spoke with the three managers.
- spoke with 24 other staff members; including doctors, nurses, nursing assistants, psychologist, administrators, and social workers.
- interviewed the matron with responsibility for the home treatment team.
- attended and observed one handover meeting.
- looked at 24 care records of patients.
- looked at 21 assessment records in the 136 suite.
- carried out a specific check of the medication management in the home treatment team.
- looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the provider's services say

Patients and their relatives told us that staff would always visit them on time for their appointments.

Patients told us that they were treated with respect and dignity. Staff were polite, kind and willing to help.

Patients said they were aware of how contact the services when they were in crisis and staff would often respond on time.

Patients said they felt able to ring the team when they needed them and staff always got back to them and were available in the evenings.

Patients told us that they discussed their care and treatment with staff but were not given copies of their care plans.

Patients told us that they were not given enough information about the services.

# Summary of findings

## Good practice

- The access team had recently won the trust "Reach" staff awards for 2015 which was for "difficult journey to overcome". The manager for the access team won two awards which were for "leading with compassion" and "The chairmans award".

## Areas for improvement

### Action the provider MUST take to improve

- The trust must ensure that risk and comprehensive assessments are completed for patients and regularly updated. They must ensure that risk management plans are regularly reviewed and detailed enough to identify how staff are to safely manage patients. These should include detailed emergency plans in the event of a crisis which takes advance decisions into account.
- The trust must ensure that risk assessments for staff home visits are carried out and that staff have reliable systems to call for assistance if required
- The trust must ensure that there are appropriate arrangements for the safe management of medicines. Storage of medicines should be monitored using both minimum and maximum temperatures. Staff must have drug charts to sign that they have administered medicines to patients. They should also ensure that controlled drugs are stored in accordance with safe management of controlled drugs guidance.
- The trust should consider the management of potential risk from ligature points in a way that cannot compromise patient's privacy and dignity.
- The trust must ensure that patients have care plans that are up to date, personalised, holistic and recovery orientated. Patients should participate in care planning and care reviews and that they have copies of their care plans.
- The trust must ensure that records are stored securely and well organised so that different team members can access patients' records when needed
- The trust must ensure that health checks are carried out and that physical health needs are monitored.
- The trust must ensure that clinical audits are regularly carried out in order to monitor the safety, quality and effectiveness of the service.
- The trust must ensure that regular and effective multi-disciplinary team meetings are taking place.
- The trust must ensure that confidentiality is always maintained.
- The trust must ensure that it always takes into account the protected characteristics as set out in the Equality Act 2010.
- The trust should ensure that patients are always provided with information about the ways that they could raise complaints.
- The trust must ensure that it has robust systems and methods to effectively assess and monitor the quality and safety of the service.

### Action the provider SHOULD take to improve

- The trust should ensure that recognised tools are used to measure clinical outcomes for patients.
- The trust must ensure that all staff that receive appraisals.
- The trust should ensure that there are clear and detailed plans in place when patients are discharged from the service.
- The trust should ensure that information on independent mental health advocacy services is readily available to support patients. Staff should know how to access and support people to engage advocacy when needed.

# Summary of findings

- The trust should ensure that formal carers' assessments are carried out.
- The trust should ensure that patients are involved in decisions about their service and are able to give feedback on the care they receive.
- The trust must ensure that all patients receive the right care and treatment at the right time.
- The trust should ensure that patients are provided with accessible information on treatments, local services, patients' rights and how to complain.
- The trust should ensure that information leaflets are available in a variety of different languages and that staff know how to access interpreting services.

North Staffordshire Combined Healthcare NHS Trust

# Mental health crisis services and health-based places of safety

**Detailed findings**

## Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| Acute Home Treatment Team | Harpland's Hospital |
| RAID Team | Harpland's Hospital |
| Health Based Place of safety | Harpland's Hospital |
| Access Team | Harpland's Hospital |

## Mental Health Act responsibilities

**We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.**

- We saw evidence in training records that staff had received training in MHA. Staff from health based place of safety, Access and Raid teams showed a good understanding of the Mental Health Act and the Code of Practice. However, staff in the home treatment team did not appear to know the required documents for consent to treatment for patients on community treatment order such as forms CTO 11 and 12.
- The documentation reviewed for patients' files in the health based place of safety was up to date, stored appropriately and compliant with the Mental Health Act and the Code of Practice. We were told that no patients were on Community Treatment Order.
- Consent to treatment and capacity forms were appropriately completed.
- Patients that used the health based place of safety had their rights explained and were given leaflets of their rights under the Mental Health Act. However, patients that arrived at the Royal Stoke A&E when detained under section136 requiring physical health care did not have their rights explained to them on arrival. The time

spent in A&E was not counted as part of the initial 72 hours that a patient could only be detained under section 136. This meant that some patients could be detained under section 136 for more the required 72 hours.
- Staff knew how to contact the Mental Health Act team for advice when needed.
- Audits were not being carried out to check that the Mental Health Act was being applied correctly.
- Information on independent mental health advocacy services was not readily available to support patients. Staff were not sure of how to access and support people to engage with the independent mental health advocacy when needed.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence in the training records that staff had received training in the Mental Capacity Act.
- Staff demonstrated a fair understanding of Mental Capacity Act and were able to apply the five statutory principles.
- Patients' capacity to consent was assessed and recorded appropriately. These were done on a decision – specific basis with regards to significant decisions. Patients were supported to make decisions for themselves before they were assumed to lack the mental capacity to make those decisions.
- When patients lacked the capacity, decisions were made in their best interest, recognising the importance of their wishes, feelings, culture and history.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. Staff spoken with demonstrated that they understood what type of actions could be viewed as restraint and knew situations when it was the right thing to do.
- Staff were aware of the policy on Mental Capacity Act and knew the lead person in the trust to contact to get advice.
- There were no arrangements in place to monitor adherence to the Mental Capacity Act.
- The records read showed that patient's assessments of mental capacity and best interest were inconsistent within the Access team. We were informed that patients had access to an independent mental capacity advocate (IMCA) when required. However, there was no literature available supporting this. An IMCA could speak to patients on issues relating to for example; health care and accommodation.
- Staff within the Access team said they explained patients' rights to them at regular intervals during their assessment. However, this was not recorded in the records read.

Inadequate

# 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 ward environment**

- The interview rooms at the 136 suite and Access team were fitted with alarms and staff followed the security procedures. The home treatment team and Raid team did not have patients visiting them and saw patients in their own homes or at the A&E
- The 136 suite had well-equipped clinic room with emergency equipment that was checked regularly to ensure it was in good working order. The Access team had no clinic room and as such did not have emergency equipment such as automated external defibrillators and oxygen on site.
- The 136 suite facilities met the Royal College of Psychiatrists section 136 health based place of safety standards. It was separate from the main ward area, suitably furnished, clean and with toilet facilities. However, there were ligature points on the toilet taps, water pipe and door hinge. The risk was identified in the ligature risk assessment and was managed through appropriate levels of observation. This had an impact on people's privacy and dignity when using the facilities
- The environment was clean and well maintained. Cleaning records were up to date and showed that the environment was regularly cleaned. Staff practiced good infection control procedures such as hand hygiene to ensure that patients and staff were protected against the risks of infection.
- Portable appliance tests were carried out for the equipment used. It was checked regularly to ensure it continued to be safe to use and clearly labelled indicating when it was next due for service.
- Some staff within the Access team said they felt vulnerable at night due to poor street lighting. They informed us they locked the doors to the building at 19:30 hours. People could access the site by ringing the door bell and staff told us they responded in pairs.

**Safe staffing**

- The Access team had 22 nurses, nine social workers and nine support time and recovery workers. It had one vacancy for a nurse and one for social worker. The home treatment team had 20 nurses and five support time and recovery (STR workers). There were three vacancies for nurses and none for nursing assistants. The Raid team had 12 nurses, one social worker and one nursing assistant. There were no vacancies in this team
- The health based place of safety was supported by staff from ward one. A qualified nurse and a nursing assistant were made available during day and night shifts.
- The sickness rate in the 12 month period for home treatment team was 8%, for Raid team 2% and for Access team was 6%. The staff turnover rate in the last 12 months for home treatment team was 12%, for Raid team 4% and for Access team was 0%.There were proper arrangements and use of bank staff in place to cover staff sickness, leave and vacant posts to ensure patients' safety. The teams used their own staff on bank to cover shifts. There was a locum consultant psychiatrist covering the home treatment team.
- The teams had reviewed the number and grade of staff required for each team using the safer staffing tool. The staffing levels in each team were appropriate ensuring patient safety. The number of staff on the duty roster matched the number of nurses, social workers and nursing assistants on shifts and we found that this was consistent
- All teams did not have an average caseload allocated per care co-ordinator. The home treatment would allocate cases to each individual per shift. These were based on the needs of the patients and the cases were allocated to a nurse with the most appropriate skill set to meet the needs. The manager told us that they would try to allocate the same nurses to the same patients in order to provide consistency. The Access and Raid teams allocated their cases each shift when the referrals were made depending on how urgent the cases were. All teams had no patients on waiting list to be allocated to nurses. This meant that patients were not waiting long to be seen by nurses. The caseloads and case allocations were discussed and regularly assessed in staff handover meetings and staff meetings
- All of the teams told us that there was quick access to a psychiatrist when required apart from the Access team.

Inadequate

# Are services safe?

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

The Access team told us that they only had a psychiatrist for one and a half days a week and the other times they had to use the on-call psychiatrist. This had caused delays for assessments during working hours.

**Assessing and managing risk to patients and staff**

- We looked at 24 sets of care records across the teams. A risk assessment was completed on all the patients at initial assessment within health based place of safety, Access and Raid teams. However, risk assessments in the health based place of safety were not fully completed. For example, there were gaps on family history, social history and personal strengths. The home treatment team did not complete risk assessments when patients were referred to their team. The risk assessments received from other teams were not updated and when the needs of the patient changed these were not updated.
- Staff within the Access team told us the risk assessments determined whether to respond to the information provided as a crisis, urgent or routine case. The assessment also determined the timeframe for response. All decisions were made in conjunction with the shift's duty lead. Not all the records read within the Access team identified the initial assessment category for the patient. These included; "crisis" being seen within 4 hours, "urgent" within 24 to 48 hours and "routine" within 21 days. This meant that staff may not respond promptly to the sudden deterioration in a patient's health.
- The risk management plans across all teams were not detailed enough to identify how staff were to safely manage patients. There were no clear guidelines on how staff should respond and address the risks identified. The home treatment team did not review management plans regularly
- None of the records reviewed had a detailed emergency plan in place that informed staff what to do in the event of a crisis. Advance decisions were not recorded. These are decisions made by patients earlier to refuse a specific type of treatment at some time in future.
- There were arrangements in place to respond to sudden deterioration in a patient's mental state. The teams would provide an emergency assessment by a nurse or social worker from Access team within four hours. If the patient was known to services, that team would provide a rapid response and make appropriate plans to ensure safety.The Access Team operates and is staffed by nurses/social workers on a 24 hour, 7 day a week model. The Trust has an on call psychiatrist and an on call Manager also available' Patients told us that they were able to get assistance out hours and the teams responded quickly most of the time.
- All teams had no waiting list to monitor. The teams had a way of monitoring and responding to patients' needs in a way that that took into account the level of risk presented by patients. The out of hours team were alerted of patients who were likely to go into crisis to ensure quick response. Response was prioritised according to risk presented.
- We saw evidence in training records that staff were trained in safeguarding. Staff told us that they knew how to make a safeguarding alert. Staff demonstrated a good understanding of how to identify and report abuse. The teams shared some of the safeguarding incidents that they had reported. Staff knew the trust's designated lead for safeguarding and they provided support and guidance. Within the Access team staff had a 85% compliance with safeguarding children level 2
- Safeguarding issues were shared with the staff team via staff meetings and emails. Information on safeguarding was readily available to inform staff on how to report abuse.
- The Access team worked in conjunction with the multiagency safeguarding hub (MASH). The MASH facilitates information-sharing and shared risk assessment and planning in connection with the abuse of vulnerable people. The MASH serves children as well as adults.
- All staff were aware of the lone working policy and told us that they followed it. The teams had established systems for signing in and out with expected time of return so that the staff whereabouts were known at all times. However, risk assessments were not carried out for all visits to patients' home to ensure that all staff were safe. There was a recent incident in home treatment team were staff had been assaulted at a patient's home. The manager told us that where the risk was deemed high, staff saw patients in pairs and this was discussed in handovers. However, this was not recorded in risk management plans and handovers were not recorded. The Access team had a policy of visiting patients in pairs since the patients were unknown to the team.

Inadequate

# Are services safe?

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

- Staff did not have alarm devices that they could activate to call for assistance when their safety was at risk. Staff told us that they used their mobile phones to call for help when needed. They told us that some areas had poor network signal and phones could not work. There was no risk assessment in place around this.
- Raid and Access teams did not store any medicines. In the home treatment team medicines were stored in a cupboard next to a radiator. The radiator was switched off at the time of the inspection. From July 2015 to September staff only recorded maximum temperatures to monitor safe storage of medicines. Staff did not record minimum temperatures. The maximum temperatures recorded were within the range of safe storage of medicines. However, it was not clear what action would be taken to ensure safe medicine storage if the radiator was switched on. We were informed that the radiator would not be switched on.
- Access to the medicine cupboard at the home treatment team was via a key stored in a key pad with a security code. Medicines stored in the cupboard were for named patients only. We were told that all 19 qualified nurses knew the code to this key pad. There was no system to identify who had access or if the number was changed on a regular basis. Nurses took medicines from the cupboard to administer it to patients who were unable to take their own medicines independently. There were no drug charts for medicines administered by nurses to sign that medicines had been given. We were told that nurses recorded in patients' notes that medication was given. The medicines were prescribed by the GP or psychiatrist.
- The home treatment team did not store controlled drugs that we saw held in the cupboard following safe guidance for controlled drug storage. Patients' controlled drugs held by the team were stored in a locked cash tin that was not attached to the medicine cupboard. The key for this cash tin was stored in the locked key pad which was accessed by 19 nurses. There was no safe system for the management and handling of controlled drugs. We found that the controlled drug records were not accurate. The remaining stock balance did not match the amount of medicine actually stored. We found that the medicine had been removed and signed out as 'handed to patient' before it had been given to the patient.

**Track record on safety**

- There was one serious incident of death in the last 12 months for home treatment team. This was still under investigation. The adverse events that were specific to these teams were discussed in the weekly trust summary of incidents held every Tuesday. Senior nurses would review the incident and share the information with the chairperson of patient and safety lead and the governance team. A root cause analysis investigation would be carried out if applicable. Any lessons learnt were shared with the team to ensure that actions were taken to avoid a reoccurrence. This process was managed by the Trust incident learning group, team meetings and learning lessons on intranet.
- The team told us that they had improved how they arranged their appointments as a result of the learning from a serious incident that had occurred over a year ago. Their appointments were now communicated with patients on time and had specific time slots that a patient would be seen. This helped to reduce the anxiety of patients waiting to be seen.

**Reporting incidents and learning from when things go wrong**

- All teams had an effective way of recording incidents, near misses and never events. Incidents were reported via an electronic incident reporting form. Staff knew how to recognise and report incidents through the reporting system.
- The teams had a clear structure which reviewed all reported incidents. Incidents sampled during our visit showed that investigations took place, with clear recommendations and action plans for staff and sharing within the team.
- We spoke with staff within the Access team who were aware of incidents which had been attributed to patients death. They told us they had been supported by the trust and had access to counselling when required. Staff said they were aware of the result of the root cause analysis reports which identified no recommendations as all relevant safety measures were in place.
- Staff were able to explain how learning from incidents was shared with all staff. Their responses indicated that learning from incidents was distributed to staff. Learning from incidents was discussed in staff meetings, handovers and through learning lessons newsletter.

Inadequate

# Are services safe?

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

- Staff were offered debrief and support after serious incidents.

# Are services effective?

**Inadequate**

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**

- 24 records viewed showed evidence that admission assessments had been carried out on initial contact on arrival to 136 suite. However, some details were not fully completed such as social history and family history. Physical health checks were carried out and any ongoing physical health problems were followed up appropriately. The Access and Raid teams also completed admission assessments in a timely manner. However, the Access team did not carry out any physical health checks. Staff from Access team told us that they did not carry out physical health checks on their initial assessment. They told us they would refer patients to GPs or the GP on call. The Access team did not have any medical equipment to carry out baseline physical health checks.
- The home treatment team did not complete admission assessments or update the assessments that had been carried out by other teams. All the records sampled showed that no assessments were updated by the team or carried out their own assessments when they received patients from other teams. The team relied on assessments that had been carried out by other teams. The team did not ensure that patients received care and treatment that was based on up to date assessment of their needs.
- Records read did not identify the involvement of patients in partnership with their health and social care professionals. For example; out of 27 records within the access team we found that 18 did not identify the patient's, their relative or carer's involvement in the care planning/management plan process.
- The Access, Raid and home treatment teams did not have care plans that were personalised, holistic or recovery orientated. The home treatment team did not have up to date care plans. The teams provided care and treatment that did not reflect person-centred care that was based on individual needs and preferences.
- Information and records of care were stored securely in locked cupboards and computers in the offices at Harplands hospital and Access team. However, at A&E there was no locked cupboard to store information securely for the Raid team. Only limited information was accessible via the online system 'Chips' by all teams. The Access team out of hours did not have readily available access to paper based records of patients known to other teams. To overcome this shortfall the records were scanned into the trust's "Y" drive. The section 136 paper records were held separately by the Mental Health Act team and not combined with patients' notes. Records were not well organised and different team members could not access patient's records when needed. This could not provide staff with easy access to deliver effective patient care.
- Staff recognised how important it was to keep the information up to date on the system. However, we found that staff within the Access team had to input the information twice onto the electronic system. We found there were no processes in place to monitor the information being duplicated onto the electronic system to ensure this was accurate. This meant that there was a risk that staff may have incorrect information to respond to patient risk.
- On occasions, the access team received phone calls regarding young adults aged between 16 and 18 years old. The manager told us they utilised the Davies structured interview for assessing adolescents in crisis and we saw a copy of the literature used. They told us all referrals were linked with the on-call psychiatrist.
- Individual assessments we reviewed took into account the reason for referral, patient's mental health presentation and past psychiatric history. However, we found that the risk assessments had not been regularly reviewed and updated within the Access team.

**Best practice in treatment and care**

- Patients could access psychological therapies recommended by National Institute for Health and Care Excellence (NICE) as part of their treatment through referral to a psychologist within the community mental health team.
- The teams offered practical support for patients with employment, housing and benefits. The home treatment and access teams were had links with employment officers, charitable organisations and housing schemes in order to support patients.
- Records in the 136 suite showed that physical healthcare needs were assessed and supported. There were monitoring arrangements in place for prescribed antipsychotic medication. There was no clear monitoring of physical health needs within the Access

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and home treatment teams. Health checks were not carried out and there were no care plans in place for patients with physical health needs to ensure that their individual needs were being monitored.

- All teams used the 'Warwick Edinburgh mental well-being scale'. The health based place of safety also used the modified early warning score as tools for measuring severity. These were used as part of the initial assessment only and were not repeated during treatment and care. There were no tools used to measure clinical outcomes for patients. This meant that staff did not have standard ways to monitor changes in a patient's presentation.
- There was no evidence that staff actively participated in clinical audits. This meant that staff had a lesser role in quality improvement of the services.

**Skilled staff to deliver care**

- The home treatment and Raid teams consisted of doctors, nurses and support workers. The Access team had nurses, support workers and social workers. The teams did not have psychologists, occupational therapists or pharmacists. Staff told us that these professionals could be accessed through referrals to the community mental health team. The home treatment team told us that a psychologist had been appointed to start in November and would be have 50% input to the team and the other 50% to in-patient wards.
- All of the teams had experienced and qualified staff. The teams were mostly made up of band six and seven nurses. The teams included nurse prescribers and nurses who were approved mental health professionals.
- We saw evidence from our observations of records that staff received appropriate induction which involved shadowing experienced staff before they could be given a caseload.
- We saw evidence from records that staff from the home treatment and Raid teams received supervision regularly. Staff could review their practice and identify training and continuing development needs. Staff from the Access team told us that supervision was not taking place regularly. However, the percentage of staff that had received supervision in last 12 months within this team was 79%.
- The percentage of non-medical staff that received an appraisal in the last 12 months was 100% for home treatment team, Access team 89% and Raid 44%. Staff in the home treatment and Access teams told us that they received annual appraisals.
- The nurses had regular staff team meetings to discuss operational issues. Staff said they felt that team meetings gave them an opportunity to share information together.
- Staff told us they had undertaken training relevant to their role. Staff were trained in cognitive behavioural therapy, solution focussed therapy, open dialogue and clinical risk assessment. Some staff within the Access team said they would
benefit from "psychotic presentation" training which they felt would enhance their experience in dealing with patients.
- Staff within the Access team said they would like role specific training due to the reconfiguration of the integrated teams
- Records showed that the average rate for completed staff mandatory training was 92% for Access team, 98% for home treatment team and 97% for Raid team. However, the records showed that the access team's clinical risk course compliance was low at 34% and fire compliance at 65%.
- Managers within the Access team and the Early Intervention team were aware of the new Care Act. They said they were in the process of ensuring that all staff were able to describe the patient's eligibility of a needs assessment to manage every day activities such as looking after themselves.
- The Access team had an Attention Deficit Hyperactivity Disorder (ADHD) nurse champion who was able to provide support within the team for patients with ADHD.
- The management within the Access teams said they monitored staff performance through regular informal supervision. However, we did not see evidence of this which meant that we could not ensure that they were able to address any issues promptly and effectively.

**Multi-disciplinary and inter-agency team work**

- There were no regular and effective multi-disciplinary team meetings taking place in Access, Home treatment and Raid teams. All records sampled showed that there

# Are services effective?

Inadequate

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were no discussions recorded as a multi-disciplinary team to address the identified needs of patients. Staff told us that there were no structured multi-disciplinary team meetings taking place. Assessments were multidisciplinary in approach, however, the care/ management plans did not include advice and input from different professionals involved in a person's care within the Access team records.

- There were effective handovers within the teams. We attended a handover meeting and the staff discussed each patient in depth about any changes in treatment plan and risk, patients' presentation, progress and details of family support. Staff demonstrated an understanding of their patients' needs and how they were to be supported.
- The teams had a good working relationship and shared information about patients likely to move between services. The Access team faxed all handover information to different teams in the morning regarding any patients that they had been in contact with out of hours. The other teams gave the Access team any information on patients that were high risk and likely to be in crisis. However, when patients were transferred between teams, there were no clear and detailed discharge plans in place.
- There was evidence of working with others including internal and external partnership working with in-patient services, GPs, police, acute hospital, independent sector and local authority. The trust held section 136, section 135 and conveyance forum every two months with the local authority, police, ambulance services, acute hospital and commissioners.
  The Access team worked closely with the Child and Adolescent mental Health Services (CAMHS) for children and young adults known to the service
- Staff in the community teams told us that multi-disciplinary working was good. Staff felt able to consult with their colleagues. The STR's in the Access team said they had links with the resource teams and had developed a good working relationship with the local church group and food bank group.
- There was communication with other services, appropriate information sharing, progress reviewing and decision-making about patients' care. The information was shared across different types of services involving both internal and external to the organisation.

**Adherence to the MHA and the MHA Code of Practice**

- We saw evidence in training records that staff had received training in MHA. Staff from health based place of safety, Access and Raid teams showed a good understanding of the Mental Health Act and the Code of Practice. However, staff in the home treatment team did not appear to know the required documents for consent to treatment for patients on community treatment order such as forms CTO 11 and 12.
- The documentation reviewed for patients' files in the health based place of safety was up to date, stored appropriately and compliant with the Mental Health Act and the Code of Practice. We were told that no patients were on Community Treatment Order.
- Consent to treatment and capacity forms were appropriately completed.
- Patients that used the health based place of safety had their rights explained and were given leaflets of their rights under the Mental Health Act.
- Staff knew how to contact the Mental Health Act team for advice when needed.
- Audits were not being carried out to check that the Mental Health Act was being applied correctly.
- Information on independent mental health advocacy services was not readily available to support patients. Staff were not sure of how to access and support people to engage with the independent mental health advocacy when needed.

**Good practice in applying the Mental Capacity Act**

- We saw evidence in the training records that staff had received training in the Mental Capacity Act.
- Staff demonstrated a fair understanding of Mental Capacity Act and were able to apply the five statutory principles.
- Patients' capacity to consent was assessed and recorded appropriately. These were done on a decision – specific basis with regards to significant decisions. Patients were supported to make decisions for themselves before they were assumed to lack the mental capacity to make those decisions. However, the records read showed that patient's assessments of mental capacity and best interest were inconsistent within the Access team. We were informed that patients had access to an independent mental

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capacity advocate (IMCA) when required. However, there was no literature available supporting this. An IMCA could speak to patients on issues relating to for example; health care and accommodation.

- Staff within the Access team said they explained patients' rights to them at regular intervals during their assessment. However, this was not recorded in the records viewed.
- When patients lacked the capacity, decisions were made in their best interest, recognising the importance of their wishes, feelings, culture and history.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. Staff spoken with demonstrated that they understood what type of actions could be viewed as restraint and knew situations when it was the right thing to do.
- Staff were aware of the policy on Mental Capacity Act and knew the lead person in the trust to contact to get advice.
- There were no arrangements in place to monitor adherence to the Mental Capacity Act.

Requires improvement

# Are services caring?

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

## Our findings

136 Suite Harplands Hospital; Access Team; Raid Team and Acute Home Treatment team

**Kindness, dignity, respect and support**

- Patients and their families were positive about the attitudes of staff and the support that they received. Our observations and discussions with patients confirmed that staff were friendly, polite and treated them with respect.
- We observed interactions between staff and patients both over the phone and also face to face. The language used was compassionate, clear and simple and demonstrated positive engagement and willingness to help.
- The interaction between patients and staff was positive and staff responded to patients with patience, kindness and ensured that they were treated with dignity and respect.
- We observed that confidentiality was not always maintained at the Access team and Raid team. The Access team shared an office with Healthy Minds, a separate team with a different role. As such, confidential conversations held with patients on the phone were not always private. Information on computer screens was also visible to the other team
- When staff in the home treatment team held discussions about people's care, they did this in a confidential manner and showed a good understanding of how to maintain information security.

**The involvement of people in the care they receive**

- Staff in the 136 suite and Raid teams discussed care and treatment with patients and involved them in the reviews. Patients told us that staff discussed their care and treatment with them on initial contact or when staff visited them on home visits. However, in home treatment and Access teams there was no evidence of patients' participation in care plans and care reviews. Patients in all teams did not have copies of their care plans. Patients in all teams told us that they were not given copies of care plans and were not aware of their written care plans. Our review of records and discussions with patients and staff confirmed that the home treatment team did not invite and involve patients in clinical review meetings. All clinical review meetings conducted by home treatment team had nursing staff only to discuss patient care and did not involve patients
- In all teams patients' carers were involved in the assessment and discussion of care and treatment on initial contact or when staff visited them on home visits where appropriate. Patients were encouraged to involve relatives and friends in care and treatment discussions if they wished. Families and carers were provided with support where it was appropriate. However, there were no formal carers' assessments carried out
- Staff in the home treatment team were not aware of how to access advocacy services for patients. Families, carers and patients were not given information about relevant local advocacy contacts. Patients and their families told us that they were not aware of how to access advocacy services when needed.
- The Access, Raid and home treatment teams did not have a structured way of getting patients involved in decisions about their service. There were no patient forums or meetings held or involved in recruiting staff. Patients told us that they were not actively involved or encouraged to take part in decisions about the service
- Patients in health based place of safety, Access and home treatment teams were given feedback forms to complete about the care they received. However, this information was not analysed into themes and trends to ensure that it is used to improve the services provided. Raid team had no structured way of patients giving feedback about the care they received.
- We saw no evidence within access team records of people being offered a preference for a male or female health or social care professional to conduct crisis assessments.
- Standard operating procedures within the Access team stated that should people need to wait before an assessment this is for no longer than 20 minutes after the agreed appointment time. The manager we spoke with said the team did not monitor or measure the outcome of whether they were meeting this.

# Are services responsive to people's needs?

Requires improvement

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

## Our findings

136 Suite Harplands Hospital; Access Team; Raid Team and Acute Home Treatment team

### Access and discharge

- The access team was the single point of contact for the crisis services. Referrals came from GPs, families, self-referrals and other health care workers. Following a triage referrals were prioritised according to risk and identified needs. The referrals were classified into three groups; rapid response to be seen within four hours, urgent to be seen within 24hours and routine to be seen in one week. The referral pathways were clearly outlined and set out clear lines of responsibilities, time frames and actions to be taken. The Access team operated a triage system and were responsible for appointments to carry out assessments. After assessment the team would handover patients to the home treatment team, in-patient wards, GPs, community mental health team or discharge. The access team acted as the gatekeepers. The team had met all its targets of responding to rapid response and urgent referrals.
- The Access Team had responsibility for bed management and we observed staff liaising with the hospital staff regarding the allocation of beds. The manager told us they did not have any measured outcomes to ensure the allocation of beds was effective. The review of the bed management process to identify blockages in system and the undertaking of a capacity and demand exercise was identified as an area of improvement in the trust quality priorities for 2015/16. We observed bed management was discussed during each shift handover. However, we noted that allocations of beds were not identified.
- The Access team provided a 24 hours service seven days a week. The out of hours, bank holidays and weekend services were provided by the Access team. The duty clinician role within the ICMHT's operated from 8am to 8pm with out of hours response being provided by the access team. Urgent referrals by the Access team were prioritised with contact made with the person the same day. Should they be unable to contact the person the procedure was to contact the referrer and follow that up with a letter. The Access team said they received between 400 and 500 referrals a month. This was confirmed in the analysis of daily referrals.
- We looked at the percentage of patients who were seen within four hours. The records showed that the Access team had achieved a target rate of 100% since November 2014 to April 2015. However, there were no records which measured the outcome of patients seen within 24 to 72 hours and 21 days. All routine referrals were seen within seven days, achieving higher than the target of 90%.
- The Access team were the gatekeepers for working age adult beds. If a bed was not available, they would access two crisis beds at Hill Crest working in partnership with a voluntary organisation Brighter Future. Patients could stay there for 72 hours until a bed was found. The team was the single point of access for all patients in crisis out of hours. However, could not facilitate admission or find a crisis bed for patients under 18 and those over 65 out of hours. These cases were referred to social services emergency duty team. Patients on community treatment orders were also referred to the emergency duty team.
- The Raid team assessed patients in mental health crisis arriving in the A&E or on the wards in the acute general hospital between 7am and 11pm. Patients seen and assessed were referred back to their GP, admitted to the general wards, admitted to a mental health ward, taken on by the home treatment team or referred to the community mental health team. Between 11pm and 7am the Access team would respond to patients arriving in A&E. The home treatment team received all of its referrals from a range of services including RAID, CMHTs, EIT and in-patient services
- In the last 12 months, the Raid team assessed 68% of the patients in A&E within one hour and 91% in A&E and other wards within four hours
- The health based places of safety section 136 suite received admissions from police officers. Only four out of 21 records reviewed showed that patients were seen for mental health act assessment within three hours. The main reason for delays was that approved mental health professionals and doctors were involved in other assessments. There was no data readily available to monitor the delays
- Patients were moved to police custody if the 136 suite at Harplands was occupied. Since April 2015 this happened seven times and occurred 52 times from April 2014 to March 2015. Since April 2015 there was an improvement from an average of this occurring once in

# Are services responsive to people's needs?

Requires improvement

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

three weeks from once every week. In situations where Harplands 136 suite was occupied, the duty senior nurse would provide support to detaining officer from Staffordshire police. The duty senior nurse would call other places of safety to find a vacant suite.

- The Raid team provided training for staff in A&E and community hospitals in risk assessment, dementia awareness, mental health awareness, self-harm and anxiety management. Staff from A&E and charitable organisation told us that the teams took active steps to engage and raise awareness to people so that it was easy for them to access services. The Raid team and A&E staff had identified patients who repeatedly reported to A&E in order to ensure that they received the right care at the right time
- The teams were taking the initiative in reducing 'did not attend appointments'. Most of the patients on the caseloads were seen in their own homes or GP surgeries. Follow up and cold calling appointments were made for those who DNA. Staff told us that they saw patients where they felt most comfortable
- The appointments were set up in such a way that showed flexibility to ensure that there was some access to patients who had the highest needs. Appointments were discussed with patients to check the best suitable times for them.
- Appointments were rarely cancelled and where there were cancellations, people were seen at the earliest possible opportunity. Patients told us that they were always seen on time and any cancellations were explained to them and seen at the next available appointment.
- The teams maintained their appointment times and when they were running late patients were informed. Patients told us that staff were reliable and arrived on time to their appointments.

**The facilities promote recovery, comfort, dignity and confidentiality**

- The health based place of safety had equipment such as defibrillators, oxygen cylinder and masks for emergency use and an appropriate place to examine patients.
- The home treatment team did not see patients on site and instead carried out assessments predominantly in patients own homes. The Access team saw patients on site but did not have equipment to support treatment and care or a room with facilities to examine patients. We were advised that the Access team were due to be moving to new premises but they were unsure when this was due to happen.
- The interview rooms at the Access team were appropriately designed and located for the purposes of clinical interviews. The patients in ward one complained that the noise that came from 136 suite was disturbing them. The door that separated the two areas was not robust enough to keep the noise away from the ward.
- Staff at A&E in Raid team did not have any lockable cupboards to store patient records and documentation. Instead, they had to leave a folder with confidential information on an open desk within a shared office. This posed an information security risk.
- Patients under the care of the Access team were not provided with accessible information on treatments, local services, patients' rights and how to complain. There was limited information given to patients about services from home treatment and Raid teams. Patients in the place of safety were provided with information on treatments, their rights and how to complain.

**Meeting the needs of all people who use the service**

- All the teams had an environment that had full disabled access.
- We saw that the assessment details did not address areas of disability and sexual orientation needs of individuals. These needs were not identified to make any reasonable adjustment to appropriately meet the needs of patients. The full analysis of equalities monitoring information was not captured
- There were no information leaflets available in different languages. Staff told us that information in other languages could be made available from patient advisory and liaison services.

**Listening to and learning from concerns and complaints**

- The home treatment team had received seven complaints through patient advisory and liaison services. The manager told us they had received a number of verbal complaints direct to the team but did not keep a record.
- Patients were not always provided with information about the ways that they could raise complaints and concerns regarding the service. Patients and their families told us that they were not given information on

# Are services responsive to people's needs?

Requires improvement

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

how they could raise complaints. The managers told us that complaints could also be raised verbally and tried to resolve them immediately. They told us that when patients raised their complaints they would act immediately but were not recording these complaints. The manager at the Access team said they worked closely
with the PALS service and were in the process of analysing all complaints received to report directly to PALS.

- Staff were aware of the formal complaints process and were able to tell us how to handle complaints.
- The teams did not record the complaints received verbally. The managers could not able to analyse the complaints for any themes and trends so that learning from complaints was used to improve services. We did not see that learning from complaints received within the teams were taking place and shared with the staff team. Learning that was shared with staff was from the trust wide complaints team.

# 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

136 Suite Harplands; Access Team; Raid Team and Acute Home Treatment team

**Vision and values**

- The teams had the vision and values of the trust displayed. However, staff were as yet unfamiliar with the trust's values. They told us that these values were new and they were not yet used to them
- Staff demonstrated a good understanding of their team objectives and how they linked in to the trust's values and objectives
- Staff knew who their senior managers were and told us that they visited the teams.

**Good governance**

- The managers felt they were given the independence to manage the teams and had administration staff to support the teams. They also said that, where they had concerns, they could raise them. Where appropriate the concerns could be placed on the directorate's and trust's risk register
- The teams did not have robust systems and methods to effectively assess and monitor performance around quality, safety and risk. The inspection team identified areas where improvements were needed. The areas that were not monitored effectively were risk assessments and management plans, comprehensive assessments, care plans, medicines management, learning from verbal complaints and staff participation in clinical audits.
- Managers provided data on performance to the trust consistently. All information provided was analysed at team and directorate level to come up with themes and this was measured against set targets. However, the teams were not capturing all data on performance, for example, patients seen for mental health act assessment within three hours, late appointments, did not attend and number of complaints received verbally were not available. The performance indicators were discussed weekly at directorate level and monthly in the quality and risk meeting. The measures were not in an accessible format but were discussed in staff meetings as a way of improving performance in any areas identified.
- The Access team pathway forms were inconsistent in their completion and the information recorded. There was no evidence of an audit tool to monitor standards. We found it difficult to ascertain how the Access team were managing the single point of access without the electronic recordings of live information on the patient's pathway of care.

**Leadership, morale and staff engagement**

- The sickness rate in the 12 month period for home treatment team was 8%, for Raid team 2% and for Access team it was 6%.
- At the time of our inspection there were no grievances being pursued within the teams, and there were no allegations of bullying or harassment.
- Staff told us that they were aware of the trust's whistleblowing policy and that they felt free to raise concerns. Two members of staff told us that they did not feel free to raise concerns as a result of fearing to be victimised
- Staff told us that they were supported by their line managers and were encouraged to access clinical and professional development courses. They told us that managers were accessible to staff, approachable, had an open culture and willing to listen
- Our observations and discussion with staff confirmed that the teams were cohesive with good staff morale. They all spoke positively about their roles and demonstrated their dedication to providing high quality patient care.
- Staff were open and transparent and explained to patients if and when something went wrong. Incidents were discussed with patients and their families. Patients told us that they were informed and given feedback about things that had gone wrong.
- Staff told us the board informed them about developments through emails and intranet and sought their opinion through the annual staff survey.

**Commitment to quality improvement and innovation**

- The Raid team produced a performance activity report for the period of April 2014 to March 2015. The report described the activity undertaken by the team, starting with a total of 3499 referrals. It also included number of case histories and patient stories to show the work of the team and analysis of sources of referrals, care

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clusters, where patients had been discharged to, response times and assessments conducted. This information was used make changes on how the team responded to referrals and deployment of staff to meet the needs of patients.

- Staff from the Access team had attended a quality workshop which resulted in the creation of an electronic log which we saw in use during handovers.
- The access team had recently won the trust "Reach" staff awards for 2015 which was for "difficult journey to overcome". The manager for the access team won two awards which were for "leading with compassion" and "the chairmans award".

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<br><br>Diagnostic and screening procedures | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>Regulation 9 HSCA 2008 (Regulated activities) Regulations 2014<br><br>Person-centred care<br><br>The care and treatment of patients must be appropriate, meet their needs and reflect their preferences. Patients did not have care plans that were up to date, personalised, holistic or recovery orientated. Patients did not actively participate in care planning and care reviews and did not have copies of their care plans. Health checks were not carried out and physical health needs were not monitored. The trust did not have regular and effective multi-disciplinary team meetings taking place.<br><br>This was a breach of Regulation 9(3) (a) |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>Regulation 10 HSCA 2008 (Regulated activities) Regulations 2014<br><br>Dignity and respect<br><br>Patients must be treated with respect and dignity. The trust did not always take into account the protected characteristics as set out in the Equality Act 2010. The |

This section is primarily information for the provider

# Requirement notices

assessment details did not address areas of disability and sexual orientation needs of individuals. The management of potential risk from ligature points in the 136 suite did not respect patients' privacy and dignity.

This was a breach of Regulation 10(2) (c)

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>Regulation 12 HSCA 2008 (Regulated activities) Regulations 2014 |

Safe care and treatment

Care and treatment must be provided in a safe way for patients. Risk and comprehensive assessments were not completed for patients and regularly updated. The risk management plans were not regularly reviewed and detailed enough to identify how staff were to safely manage patients. There were no detailed emergency plans in the event of a crisis and advance decisions were not recorded. The trust did not have appropriate arrangements for the safe management of medicines and controlled drugs were not stored following safe guidance for controlled drug storage.

This was a breach of Regulation 12(1) (2)(a)(b)(g)

| Regulated activity | Regulation |
| --- | --- |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>Regulation 17 HSCA 2008 (Regulated activities) Regulations 2014 |

This section is primarily information for the provider

# Requirement notices

Good Governance

Systems or processes must be established and operated effectively to ensure compliance. Records were not stored securely and well organised that different team members could access patients' records when needed. Confidentiality was not always maintained. Clinical audits were not regularly carried out and staff did not actively participate in clinical audits. Patients were not always provided with information about the ways that they could raise complaints and complaints received verbally were not recorded and analysed for any themes and trends so that learning from complaints was used to improve services. The trust did not have robust systems and methods to effectively assess and monitor that the service is performing well around quality and safety of the service. Risk assessments for staff home visits were carried out and staff did not have reliable systems to call for assistance when their safety was at risk on home visits.

This was a breach of Regulation 17(2)(a)(b)(c)(f)