Good

Black Country Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAJ20	Hallam Street Hospital	**Place of Safety suite (adjoins Friar Ward)**	B71 4NH
TAJ	Quayside House	**Crisis Resolution and Home Treatment Team**	B69 2DG
TAJ52	Penn Hospital	**Place of Safety suite**	WV4 5HN
TAJ52	Penn Hospital	**Crisis Resolution and Home Treatment Team**	WV4 5HN

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

Summary of findings

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

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We changed the rating for mental health crisis services and health based place of safety from requires improvement to good because:

- During our last inspection in November 2015 we asked the trust to make improvements to care plans. We asked that care plans were holistic and recovery orientated. We also asked the trust to ensure health checks were carried out and physical health needs were being monitored.The trust had made significant improvements by the time of our October 2016 inspection. Care plans had improved. They were holistic, patient led and included patient preferences. Staff carried out weekly audits of care plans to improve quality. Staff were supported by psychology in developing the care planning skills through training and reflective practice.
- During our last inspection in November 2015, we asked the trust to ensure that care and treatment was provided in a safe way for patients. By the time of our October 2016 inspection, the issues identified had improved. For example, staff carried out environmental risk assessments and developed plans to reduce any risks identified. Risk assessments were completed and regularly reviewed and updated.
- During our last inspection in November 2015, we asked the trust to improve the method of transporting medication to patients in the community. By the time of our October 2016 inspection, we found that the trust issued staff with lockable medication bags, which was a safe way to transport medications to patients in the community. We also asked the trust to ensure emergency equipment was available to staff at the Crisis Resolution Home Treatment Team in Oldbury and this had been implemented.

However:

- At the time of our October 2016 inspection, patient records were still in electronic and written form and kept in a number of different trust locations, which meant that they were still not accessible to all.
- During our November 2015 inspection, we told the trust they should ensure that there were arrangements in place to monitor adherence to the Mental Health Act and Mental Capacity Act to ensure that it was being applied correctly. At the time of our October 2016 inspection, there were still errors and omissions in the recording of information. The trust Mental Health Act administrator audited the information, but the results of the audits did not appear to filter down to clinical staff.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The rooms that constituted the Hallam Street HBPoS had a number of environmental risks that could not be adequately mitigated against by using 1:1 observations. For example, there were a number of ligature risks in the bathroom at the health based place of safety and patients could lock themselves in the bathroom.
- Staff at Penn Hospital could not easily access emergency equipment from the ward, which was kept three locked doors away and as such could delay their response in a medical emergency.

However:

- The environments were clean and well maintained with appropriate furnishings. Staff followed infection control principles and there were infection control audits to ensure standards were being met.
- Staffing levels were appropriate for level of service and managers could manage their staffing resources to suit their service needs.
- Mandatory training compliance rates were high and above the trust target.
- Staff assessed and managed risk to patients and staff using evidence based tools and interventions. There were crisis plans in the care records and staff could respond to sudden deterioration in patient's health.
- There was a lone working policy and local lone working procedures in place to keep staff and patients safe.
- There were good medicines management practices and staff had lockable portable medicines bags to carry out their role safely while in the community.

Are services effective?

Good

We rated effective as good because:

- Staff were prompt in their assessment of needs and planning of care. Care records showed staff took a strengths based, holistic and recovery orientated approach to planning of care.

Summary of findings

- There was a strong focus on delivering psychological therapies recommended by NICE. Psychologists used evidence based tools and were committed to developing staff skills to work effectively with the patient group.
- Patient's physical needs were assessed and met by medical staff and supported by specialist resources available in the community, for example, lithium clinics ran by the community mental health teams.
- Staff worked with external and internal organisations to help patients with their recovery. For example, there was recovery academy and agencies linked to services to support patients with social needs, housing and benefits.
- Staff used recognised rating scales and measured outcomes. This helped them evaluate the progress patients had made while in treatment.
- All staff were involved in the delivery of audits and monitoring to help improve the effectiveness of what was delivered.
- The trust had introduced a health record to help improve patient experience, recording and monitoring at the health-based places of safety. This was a new initiative that had not been fully embedded at the time of inspection.

However;

- Information about patients was recorded and stored in various places. For example, electronic records and written records were stored across locations. This meant this information could not always be easily accessed by all staff that might need the information.
- The trust were not fully compliant with the revised Mental Health Act Code of Practice for both the health based places of safety at Penn Hospital and Hallam Street Hospital. The trust had updated their local protocols, which meant they were using the most up to date guidance. They were also working with the police to update the policy as soon as possible.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with kindness, dignity and respect. We observed compassionate interactions and supportive care.
- Staff involved patients in the care they received and provided them with copies of their care plans.

Summary of findings

- Staff involved patients in making decisions about what might happen in future in the event that they had to access services while in crisis.

However:

- Patient feedback forms to help improve services were not formally followed up. Managers told us they were working with commissioners to improve the content of the feedback forms and to introduce a new system to gather and evaluate the information.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Staff consistently assessed patients within their target times set by commissioners. There were no waiting lists. Urgent referrals were prioritised and teams were accessible 24 hours a day, 7 days a week.
- Staff were proactive with hard to engage patients and were flexible in their approach. Patients were given an emergency contact number, which they could use at any time and could speak with a member of the team straight away.
- Patients could make a complaint or raise a concern. Staff tried to ensure a local resolution in the first instance, however, supported patients through the formal complaints, compliments process if necessary.

However:

- At the Hallam Street Hospital health-based place of safety, patients could be disrupted during their stay by staff accessing a kitchen to make drinks for themselves of patients on the main ward. This could mean that a patient's dignity and privacy was not respected.
- Privacy and dignity for patients using the health-based places of safety was an ongoing issue. The suite at Hallam Street Hospital was attached to a clinic room with a window that had no privacy screening. There was no soundproofing and conversations between people in the room could clearly be overheard.

Are services well-led?

Good

We rated well-led as good because:

- Staff had responded well following our last inspection and addressed many of the issues we that we identified.

Summary of findings

- Staff were familiar with the vision and values and they told us that these values related well to the team's objectives.
- Managers were approachable and staff told us they could share issues or concerns with them. Senior staff listened to the concerns of teams and we saw this evidenced in for example the trust risk register.
- Managers worked with commissioners to ensure that they met their targets and to improve patient experience.

However:

- Staff recorded information on a computer system and in written notes and stored the information in various places across the trust. This meant not all patient information was always accessible to professionals who might need it.

Summary of findings

Information about the service

The crisis resolution and home treatment teams were based at Quayside House in Oldbury and Penn Hospital in Wolverhampton. These services were for people experiencing severe mental health crisis. The teams operated 24 hours, seven days a week and provided both an assessment and treatment service. The teams provided assessment and short term interventions. They were responsible for receiving referrals and would carry out a triage; assessment and providing care and treatment. The teams worked using a multidisciplinary approach to support patients in their own homes to reduce inpatient admissions and facilitate early discharge from hospital.

The health based places of safety (HBPoS), also known as section 136 suites, were based at Penn Hospital and Hallam Street 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 could be assessed to see if they required treatment. The health based places of safety were managed by staff from the crisis resolution and home treatment team and staff from the adjoining acute wards. Both teams worked with the street triage services. A qualified mental health professional worked alongside the police to provide an immediate assessment of anyone that presented as possibly having a mental health problem.

Our inspection team

Our inspection team was led by:

Head of Inspection: James Mullins, Head of Hospital Inspection (Mental Health), Care Quality Commission.

The sub team that inspected this core service comprised of one CQC inspector, one Mental Health Act reviewer and two specialist mental health nurses.

Why we carried out this inspection

We undertook this inspection to find out whether Black Country Partnership Trust had made improvements to mental health crisis services and health based places of safety since our last comprehensive inspection of the trust on 16 – 20 November 2015.

When we last inspected, we rated mental health crisis services and health based places of safety as requires improvement overall. We rated the core service as requires improvement for safe, requires improvement for effective, good for caring, good for responsive and requires improvement for well-led.

Following this inspection we told the trust that it must take the following actions:

- The care and treatment of patients must be appropriate, meet their needs and reflect their preferences. Patients in crisis and resolution home treatment team did not have care plans that were holistic or recovery orientated. Health checks were not carried out and physical health needs were not monitored.
- Patients must be treated with respect and dignity. The management of potential risk from ligature points in the health based place of safety did not respect patients' privacy and dignity.
- Care and treatment must be provided in a safe way for patients. Environmental risk assessments to include ligature risk had not been carried out for flats used as crisis beds at 'P3. Risk assessments were not always completed for patients and regularly reviewed and updated. The trust did not have appropriate arrangements for the safe management of medicines at Quayside House. There was no access to emergency equipment at Quayside House.

Summary of findings

- Systems or processes must be established and operated effectively to ensure compliance. Records were not well organised, lacked detail and different team members could access patients' records when needed. The governance systems and processes were not effective enough to monitor all areas of quality and safety.

We also told the trust that it should take the following actions to improve:

- The trust should ensure that portable appliance tests are carried out to all electrical equipment used to ensure they are safe to use.
- The trust should ensure that the kitchen area at Hallam Street Hospital health based place of safety does not have open access to boiling water from the instant water boiler fitted to the wall.
- The trust should ensure that staff receive regular supervision and have regular staff meetings.
- The trust should ensure that staff in charge of the place of safety should receive special training for that role.
- The trust should ensure that there are arrangements in place to monitor adherence to the Mental Health Act and Mental Capacity Act to ensure that it was being applied correctly.
- The trust should ensure that staff participate in quality improvement and innovative practice initiatives.
- The trust should ensure that patients are given copies of their care plans and sign their and care plans.
- The trust should ensure that staff are aware of how to access advocacy services for patients.
- The trust should ensure that all teams have information leaflets specific to their teams on how the services are run.

We issued the trust with four requirement notices that affected mental health crisis services and health based places of safety. These related to:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
- Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
- Regulation 12 HSCA 2008 (Regulated activities) Regulations 2014 Safe care and treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance

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 families and carers at one focus group.

During the inspection visit, the inspection team:

- visited both health based places of safety; one at Penn Hospital and one at Hallam Street Hospital
- visited two crisis resolution home treatment teams; one team based at Penn Hospital and the other team at Quayside House
- spoke with six patients who used the crisis resolution and home treatment team service
- spoke with two team leaders and three clinical managers
- spoke with two psychiatrists, two clinical psychologists, three nurses, three healthcare support workers and an approved mental health professional
- attended and observed one handover meeting.
- looked at 16 treatment records of patients
- carried out a specific check of the medication management

Summary of findings

What people who use the provider's services say

Patients told us that staff treated them with respect, that they were polite and that they felt listened to.

Patients told us that they were encouraged to involve their relatives and carers in their treatment and care if that was what they wanted.

Patients told us they were given an information wallet, which contained lots of useful information on what to expect from treatment. It also contained information on what resources were available to help them with their recovery.

Patients told us that staff always visited them during their allocated time slots. That staff were flexible if an alternative slot was requested. Patients also told us they had a choice to meet with staff at different venues if it was more convenient.

Patients said they were given an emergency contact number for the team. If they telephoned the service, staff answered the phone or they had the option to leave a message. Patients felt comfortable to ring the team when they needed them.

One patient told us they were not given the opportunity to be involved in developing their own care plan; instead, they were given the completed care plan to sign.

Good practice

Action the provider MUST take to improve

- The trust must ensure that potential risks to patients using the bathroom in the Hallam Street Hospital health based place of safety.

Action the provider SHOULD take to improve

- The trust should ensure that all areas visited by patients for their clinical reviews have accessible emergency equipment such as automated external defibrillators and oxygen.
- The trust should ensure that a patient's privacy, dignity, and confidentiality should not be compromised while at the HBPoS. For example, patients should not be overheard or seen by other patients on the adjoining ward at Hallam Street Hospital.
- The trust should ensure that there are clear systems of records management so that records are well organised and different team members can access patients' records when needed.
- The trust should ensure they are fully compliant with the revised Mental Health Act Code of Practice for the HBPoS.
- The trust should ensure there is an effective system in place to evaluate patient experience and make improvements through service user feedback.

Areas for improvement

Action the provider MUST take to improve

Action the provider SHOULD take to improve

Black Country Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Place of Safety (adjoins Friar Ward)	Hallam Street Hospital
Crisis Resolution and Home Treatment Team	Quayside House
Place of Safety	Penn Hospital
Crisis Resolution and Home Treatment Team	Penn Hospital

Mental Health Act responsibilities

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

The health based place of safety was an ageless service and accepted children and young people as well as adults.

Staff from the child and adolescent mental health services(CAMHS) service supported the admission of children and young people aged 16 and 17. Psychiatrists from CAMHS were on call to undertake Mental Health Act assessments of children and young people.

Staff in charge of the health based place of safety had the opportunity to shadow other staff. Staff learned about the use of section 136 in their general Mental Health Act training; there was no specific training course in the use of section 136.

Staff at both places of safety reported explaining to patients their rights under the Mental Health Act. Nursing staff knew about the rights of patients detained under section 136, such as their right to refuse medication.

Detailed findings

Staff knew how to contact the Mental Health Act team for advice when needed. This meant that staff could get support and legal advice on the use of the Mental Health Act when needed.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training records indicated that all staff, except one who was booked on to receive it, had received training in the Mental Capacity Act.

Discussions with staff demonstrated a variable understanding of Mental Capacity Act and the five statutory principles. However, we saw clearly documented in care notes that capacity was assessed when needed. Staff were aware of the policy on Mental Capacity Act and knew who to contact in the trust to get advice. Arrangements were in place to monitor adherence to the Mental Capacity Act through weekly records audits.

Staff understood that patients should be supported to make decisions independently before they were assumed to lack the mental capacity.

When patients lacked capacity, decisions were made in their best interest. Staff gave examples of when this happened. Staff recognised the importance of patient wishes, feelings, culture and history and this was documented in patient care records.

Patients had access to an independent mental capacity advocacy service (IMCA). IMCAservices provide independent safeguards for people who lack capacity to make certain decisions and have nobody, such as friends and family, to support them.

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

Crisis Resolution Home treatment Teams (CRHTT)

Penn Hospital and Quayside House

Safe and clean environment

- There were reception areas at Penn Hospital and Quayside House, which allowed access to the teams. Both sites had signing in facilities.
- The sites that we visited were visibly clean, had appropriate wipeable furnishings and were well maintained. Domestic staff on site maintained the standards of cleanliness. There were completed cleaning records to ensure that standards were met.
- Staff followed infection control principles including handwashing. Staff received mandatory infection control training and were supplied with hand washing gels. There were regular recorded infection control audits carried out by qualified staff to monitor that standards were being met.
- Clinic room equipment was well maintained, clean and calibrated. Calibrationis the process of eliminating or minimising factors that cause inaccurate measurements. For example, ensuring accurate blood pressure readings on a blood pressure monitor.
- Environmental risk assessments were undertaken on an annual basis or when there were changes to the environment.
- Staff had access to pin point alarm systems and nurse call systems. Alarms were tested regularly to ensure they worked properly.

Safe staffing

- At the time of inspection, the crisis resolution home treatment team (CRHTT) in Wolverhampton comprised of 21 whole time equivalent (WTE) qualified nurses and seven WTE nursing assistants. There was one qualified nurse on secondment and no other nursing vacancies. At the CRHTT in Oldbury, there were 27 WTE nurses and six WTE nursing assistants. There were no vacancies at the time of inspection. Vacancy rates for qualified nurses were lower than the trust average in the 12-month period up until 31 July 2016.
- Each crisis service managed a team caseload, which averaged 30 patients. This meant the whole team had an overview of all patients. Clinical staff were responsible for care co-ordination of a proportion of patients whilst they were under the care of the team. Allocation of patients would be dependent on staff skills and patient need. Team leaders were able to adjust staffing levels daily to take account of case mix.
- Each team had a shift co-ordinator who had an overview of staffing resources and would manage the caseloads and allocate visits for the day. They would have information of any staff sickness or shortages, which meant that they were able to ensure that the service would continue to function with minimal disruption.
- The crisis services did not operate a waiting list. All patients referred were seen within 24 to 48 hours, dependent on their needs and risks.
- All teams in this core service had sickness rates higher than the trust average at 8% at 30 June 2016.
- The trust used a safer staffing tool to estimate the number and grade of nurses required. Safe staffing levels were based on population, referrals and caseload. The manager at Oldbury CRHTT told us that although staff were always accessible, there were not enough and that establishment levels were not correct. The issue of under-establishment at the Oldbury CRHTT had been identified on the trust risk register. There were plans in place to review the establishment levels for the team. This meant that the trust had identified this as a problem and were planning to make improvements.
- Bank and agency use in this core service had changed over the 12-month period. Shifts filled by bank staff dropped from a peak in December 2015 with 99 shifts filled, to 27 shifts filled in April 2016. Teams used agency and bank nurses when they were short staffed. At CRHTT in Wolverhampton, the manager told us they had block booked two agency nurses from 1st March 2016 on a seven-month contract for continuity and to ensure the nurses were familiar with the team.
- Two full time consultant psychiatrists covered the services and were accessible when needed. There were out of hours and on call duty staff when required outside normal working hours or in the absence of the substantive medical staff.

Requires improvement

Are services safe?

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

- Overall, the core service had a mandatory training compliance rate of 91%, which was above the trust average.

Assessing and managing risk to patients and staff

- The teams used a threshold assessment grid. This was a short, quickly completedassessmentof the severity of an individual's mental health problems. This helped staff to plan patient care at assessment, reviews and transfers between services.
- The Sainsbury risk assessment tool was used where more complex risk was a feature. We looked at 11 sets of patient care notes and all of them had an initial risk assessment. Two of the risk assessments were not up to date, which meant that staff might not have the right information to keep a patient safe.
- We saw evidence of multi-disciplinary crisis plans in all 11 care records we reviewed. The plans indicated patients were involved in making decisions and plans about what to do if they were in crisis in the future.
- Staff could respond to a sudden deterioration in patient's health. This was identified through contact with the patient and other people involved in their care, for example, family members. Patients were discussed during multi-disciplinary team meetings and decisions were made as a team about whether a patient's health had deteriorated.
- Staff responded promptly to referrals to the teams and there were no waiting lists.
- Teams achieved 75% for the mandatory safeguarding adults' level 3 training. Those staff that had not completed the training were booked to attend or were awaiting training dates to become available.
- There were accessible local and trust wide safeguarding leads for guidance and staff told us they knew how to access them. Staff spoke to patients about safeguarding issues and discussed as a team before making decisions about raising safeguarding alerts. From 1 July 2015 to 30 June 2016, the core service made 11 adult safeguarding referrals and two child safeguarding referrals.
- Staff utilised the trust lone working policy. Patients were risk assessed in advance of home visits or lone working. All new patients were seen for their first appointment with two members of staff.
- There were good medicines management practices in place, for example, weekly stock checks and audits, involvement of pharmacy and lockable portable medicines bags for transportation in the community.

Track record on safety

- Between July 2015 and June 2016, there were four serious incidents recorded for this core service; three of the four investigations were still ongoing at the time of inspection. The fourth was closed to the trust and allocated externally to another NHS trust by local commissioners in October 2016.

Reporting incidents and learning from when things go wrong

- Staff that we spoke with knew what to report and how to report incidents when things went wrong.
- The trust used an electronic incident reporting system. The information from the system was collated and themes were shared with the teams through team meetings. There was a lessons learned aspect to discussions at team meetings. Staff also worked alongside partner agencies, for example, the police, in looking at incident themes and learning lessons.
- Staff were open and transparent and explained to patients if and when things went wrong. One nurse explained the process that they would follow to make sure patients were kept involved in the incident process.
- Staff received feedback from investigation of incidents in the form of reports during meetings and supervision. There were also debriefing sessions when appropriate. Managers and a representative from human resources were sometimes involved in feedback from incidents. We saw this evidenced in supervision records.
- A CRHTT psychologist was part of a trust wide working group looking at post-incident debrief. The trust recognised that there were a lot of serious incidents trust wide and they looked to learn from these incidents through formal processes.

Health Based Place of Safety

Hallam Street Hospital and Penn Hospital

Safe and clean environment

- There was a secure, fenced area outside the health based place of safety (HBPoS) at Penn Hospital, where patients could smoke or access fresh air. The HBPoS at Hallam Street Hospital also included an external fenced area. However, patients could climb the fence if they were unescorted as the fence was low and accessible enough to do so. This was mitigated against using one to one observations.

Requires improvement

Are services safe?

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

- Each HBPoS had a lounge with comfortable, easy-clean furniture and a television set, boxed in for safety. There were some anti-ligature fittings, for example, collapsible curtain rails. This was to eliminate points where an item could be used to create a point of ligature. A ligature is an item used to tie or bind something tightly which may result in self-harm or in extreme cases, loss of life.
- At Penn Hospital HBPoS, patients had access to a wet room and toilet with anti-ligature fittings. The door opened outwards to prevent patients barricading themselves in the wet room. There was a kitchen area with a shutter to restrict access to hazards such as boiling water.
- At Hallam Street Hospital HBPoS there were a number of other identified risks that could not be adequately mitigated against by one to one observations. For example, the bathroom door could be locked from the inside. There had been an incident prior to the inspection where a patient locked themselves in the bathroom and staff could not access the patient immediately. The manager told us they were planning to remove the lock from the bathroom door to prevent this happening in the future.
- Staff at the HBPoS at Hallam Street Hospital had a well-equipped clinic room. There was an examination couch and emergency equipment that was checked regularly to ensure that it was in good working order. At Penn Hospital, patients would have to access a fully equipped clinic room for the adjoining ward.
- Each HBPoS had access to emergency equipment. Staff at Penn hospital had access to emergency equipment from the wards, which was kept three locked doors away. This meant it could not be easily accessed in an emergency.
- Staff at the HBPoS had access to appropriate alarms and nurse call systems, which would help them in the event that they needed assistance. Staff could use landline telephones in the adjoining clinic and office rooms if needed.
- Staff were trained in the principles of infection control and audits were completed in order to ensure that staff met recommended standards.

Safe staffing

- There were at least two members of staff, either police officers or health staff, within the HBPoS during an admission. The police remained until the patient was settled. This meant that patients were supported by a number of skilled staff while on the unit. There were always staff allocated in advance to cover the HBPoS.
- Staff accessed local authority duty approved mental health professionals (AMHP) who were responsible for arranging the attendance of medical staff to carry out assessments at the HBPoS. Outside of normal working hours, the HBPoS relied on the local authority emergency duty team AMHP.
- There were no dedicated medical staff at HBPoS. Medical staff were available on site during working hours and outside of normal working hours. There was an on-call system to ensure that patients had rapid access to a doctor when needed.
- Managers and staff told us that agency staff were not used to cover the HBPoS. These shifts were covered by experienced and skilled substantive staff.
- Staff received mandatory training in their substantive posts on the wards. There was no specific mandatory training related to working at HBPoS, however only staff with previous experience of working the HBPoS were used to cover this specialist service.

Assessing and managing risk to patients and staff

- Staff carried out a joint risk assessment with the street triage team for every patient on admission. Before admission, a nurse liaised with the street triage team to ensure that patients were physically well enough to be received at the HBPoS.
- Staff did not administer medication at the HBPoS. The powers under Section 136 of the Mental Health Act would not allow this.
- Staff would call emergency services to respond to any deterioration of a patient's physical health while they were at the HBPoS.
- Staff assessed the patient's risk to self and others. The police remained at the HBPOS until the completion of a risk assessment and for as long needed to ensure the health and safety of patients and staff. The police were expected to stay for at least an hour to help manage the person and to complete paperwork and hand over.
- Staff had access to policies and procedures for use of observation such as minimising risk from ligature points. All patients received one to one observations whilst in the HBPoS and staff were able to mitigate against the risk of ligatures.

Requires improvement

Are services safe?

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

- The consultant told us they would follow the trust policy for rapid tranquillisation, which followed NICE guidance, should it ever needed. The consultant had no recent examples of this being a requirement in the HBPoS.
- Staff used restraint only after de-escalation had failed. Staff were trained in using management of actual and potential violence (MAPA) techniques. These techniques allowed staff to respond with minimal force to a situation. There were no recorded incidents on either HBPoS in the six months prior to inspection relating to restraint.
- Staff had personal alarms and could use the phone in the adjoining offices to call for non-urgent assistance.
- Staff were trained in adult and children's safeguarding and knew how to make a safeguarding alert and did this when appropriate. Safeguarding training rates for the core service were 75% at the time of the inspection. Staff had access to a local safeguarding lead for guidance and discussed any issues relating to safeguarding in meetings, supervision and handovers.

Track record on safety

- There were no recorded serious incidents relating to either HBPoS at the time of inspection or in the six months prior to inspection.

Reporting incidents and learning from when things go wrong

- Staff used the trust electronic incident reporting system to record incidents. The trust recorded one incident at HBPoS at Penn Hospital in the six months prior to our inspection. This related to a physical health issue and was dealt with appropriately.
- Staff told us that if there were incidents they were supported by their line managers, they were offered debriefing and they could access psychology for one to one support.
- Senior staff attended a multi-agency group which is where they discussed any issues with HBPoS. We saw recorded minutes relating to these groups were incidents had been discussed and changes were made to make improvements

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

Crisis Resolution Home treatment Teams

Penn Hospital and Quayside House

Assessment of needs and planning of care

- The CRHTT's were able to undertake assessments seven days a week, 24 hours a day and these assessments were carried out within 24 hours to ensure staff had access to the most up to date information.
- Information needed to deliver care was stored securely in filing cabinets which were locked and the keys kept in a secure key lock storage box.
- Across both services, patient information was recorded and stored in various places. For example, the consultant psychiatrists had access to electronic records but also kept written records in paper form. This meant this information could not always be easily accessed by all staff that might need the information.

Best practice in treatment and care

- All staff were trained and supported by a psychologist in the team to deliver psychological therapies. These therapies were recommended by TheNational Institute for Health and Care Excellence (NICE), for example, brief cognitive behavioural therapy (CBT) skills and solution focused therapies. Psychologists used a number of evidence-based tools to assess patients. A psychologist gave examples of where they assessed someone with lower IQ and worked with staff to look at how to change their language to best suit the needs of the patient.
- Medical staff followed NICE guidance when prescribing medication. We saw this evidence in the care records and in discussions with the consultant.
- Staff had access to standard operating procedures relating to medication in care records. This meant that staff had information available on a patients file about how to use medication specific to them.
- The consultant psychiatrist could carry out physical examinations at assessment if required. There were clinic rooms available to carry out physical examinations.
- Patients could access clozapine and lithium clinics ran by the community mental health team at Sandwell Hospital. In addition, teams worked closely with general practitioners to ensure that patients physical health needs were met while they were in the community.
- Staff worked closely with a number of organisations to support patients with their social needs, for example, housing and benefits. A member of the CRHTT was trained to work with patients with issues relating to benefits and there was a referral pathway for those who requested help from external agencies.
- Staff used recognised rating scales to assess and record severity and outcomes such as health of the nation outcomes scales (HoNOS) which was used as a measure of the health and social functioning of people with severe mental illness. Staff also assessed patients using threshold assessment grid (TAG), which is a short, quickly completed assessment of the severity of an individual's mental health problems.
- Managers and nurses at all levels carried out audits. For example, clinical notes and infection control audits on a regular basis. We saw evidence of audit cycles and discussions with staff about audit outcomes in staff supervision notes.

Skilled staff to deliver care

- The teams consisted of a full range of mental health disciplines such as psychiatrists, psychologists, social workers and nursing staff. All staff were experienced and qualified.
- There were induction packages for agency staff and trust induction for new staff. Staff in the teams had received a local and trust induction.
- Staff received mandatory training and there were a number of elearning opportunities open to staff to assist in professional development. Other training was on offer for those staff who had identified this in their appraisal.
- Staff were regularly supervised and appraised. Appraisal rates for the period of 1 July 2015 to 30 June 2016 were 100%. This was above the trust target of 95% and an improvement on completion rates from the 2015 inspection, which was 87%.
- Staff were supported by a psychologist in regular reflective practice and supervision specifically addressing their skills in using cognitive behaviour therapy and solution focused therapy. Staff were offered reflective practice sessions weekly. Staff received clinical supervision every six to eight weeks and there was a supervision log.
- The trust had a capability policy in order to support managers dealing with poor performance. At the time of the inspection, there were no performance issues being handled within the teams.

Are services effective?

Good

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

Multi-disciplinary and inter-agency team work

- There were regular and effective multi-disciplinary meetings. These meetings involved all staff. They explored issues relating to work with patients, learning and development, risk and engagement issues.
- There were good handovers systems in place to ensure work was communicated by staff between each shift and further assess the needs and planning of care for those patients. There were three handovers a day within each team at the end of each shift. We observed one handover. It was task orientated, identified risks, addressed working with families, and highlighted the need for a referral to a support group. Staff discussed patients in a respectful manner.
- Staff worked closely with other teams when patients were discharged from CRHTT. For example, if patients were discharged to other services within the trust, there were joint visits and multi-disciplinary team meetings. If patients were discharged to their GP or another mental health service, staff would complete a standard discharge letter.
- There were effective working relationships with teams outside of the organisation, for example, local authority social services and working alongside general practitioners.
- Managers in the CRHTT managed access to acute inpatient beds. A post had been approved to go out to advert for a bed manager to support bed management in the team.
- Each CRHTT included an approved mental health practitioner. They were allocated to the team on a full time basis in agreement with the local authority.

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

- Staff knowledge and understanding of the Mental Health Act (MHA), and the guiding principles varied. The trust employed a specialist practitioner to deliver MHA training on 1 April 2016. At the time of inspection, the training had not been fully rolled out or embedded. However, the trust saw MHA training as a priority, and staff were booked in to receive the training.
- The trust employed a Mental Health Act administrator and there was an approved mental health practitioner available to support staff for specific queries related to the Mental Health Act.
- Patients could access independent advocacy and were given information in their induction pack, which included contact details. There were leaflets and posters on display in the waiting areas with contact details for advocacy.
- The Mental Health Act office carried out MHA audits and presented the findings at senior group meetings and in the form of spreadsheets and reports.

Good practice in applying the Mental Capacity Act

- Staff knowledge and understanding of Mental Capacity Act (MCA) 2005, in particular the five statutory principles was variable. We were advised by staff that Mental Capacity Act training had been introduced further to our last inspection. Trust records indicated staff received training in the application of the Mental Capacity Act as part of their safeguarding adults training, of which, they had achieved 75% compliance.
- There was a trust policy on Mental Capacity Act including DoLS, which staff were aware of and could refer to on the trust intranet. Staff could also discuss any MCA matters with the approved mental health practitioner and medical staff.
- Staff recorded whether there were any issues identified relating to capacity in crisis/care plans. This meant that staff were considering issues relating to capacity when working jointly with patients to develop care and crisis plans.
- Staff understood that patients should be supported to make decisions where appropriate and if they lacked capacity. They also recognised the importance of the person's wishes, feelings, culture and history. There was a section in patient care records that specifically asked about religious and cultural needs.
- All staff were involved in auditing care records which included auditing whether capacity was considered at assessment. Team leaders told us that where there were omissions they would discuss in supervision with staff and there were weekly one to one development sessions with psychology to help develop skills in for example, assessment, and care planning.

Health based place of safety

Penn Hospital and Hallam Street Hospital

Assessment of needs and planning of care

- In September 2016, the trust had introduced a Section136 suite health record. This included an

Are services effective?

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admission form, a Section136 MHA monitoring form, clinical risk tool, a modified early warning chart (a tool to monitor patients' physical health), clinical record observation record form and continuation sheets.

- The policy set a target of for the time spent in the Place of Safety of 4-6 hours but noted there would be delays in the assessment of patients admitted under the influence of drugs or alcohol.
- The average stay at a HBPoS was very short and as such staff did not produce specific care plans. Records were kept up to date, securely stored during a patient stay on the HBPoS and followed patients to their destination. This meant staff had access to the most up to date information about the patient to support them with future care planning needs.

Best practice in treatment and care

- Patients admitted to HBPoS had physical health checks completed by the street triage team in advance of admission. If a patient required physical health interventions, they were transferred to accident and emergency by ambulance.
- The trust introduced a pilot record keeping system for the HBPoS at both locations on 1 October 2016. This took the form of a "Health Record" booklet, which included a health monitoring chart (NEWS), a risk assessment tool, a fluid and food record. This meant that staff had tools to monitor changes in a patient's presentation.
- The MHA does not allow a person to be treated with mental health medication whilst detained on a S136 at a HBPoS unless they provided informed consent. The consultant we spoke with told us that they would follow National Institute for Health and Clinical Excellence (2005) (NICE) guidance and Royal College of Psychiatrists' (2011) guidance when working with patients medical needs in the HBPoS.

Skilled staff to deliver care

- Staff from the CRHTT and nursing staff from the adjoining acute wards covered staffing of the HBPoS. When patients were admitted to either of the HBPoS, they were also met and assessed by a doctor and an approved mental health professional.
- Staff learned about the use of section 136 in their general MHA training; there was no specific training course in the use of section 136. Managers used qualified and experienced staff to work at the HBPoS, often alongside a health care assistant. All staff who worked at the HBPoS had an opportunity to shadow an experienced member of staff to learn how to work within the suite. This meant that staff skills were developed to work within this specialist service.
- All staff working on the HBPoS were trained in de-escalation techniques. Staff from adjoining wards who worked at the HBPoS were 'management of actual and potential aggression (MAPA) trained but staff from the community team were not. If police and staff believed a patient posed greater risk of violence and aggression, the trust arranged for two MAPA trained nurses to staff the HBPoS.
- Staff who worked at the HBPoS were substantively employed to work on the wards and community teams. This meant that they received training, development, appraisal and supervision to support them in providing effective care to patients. Poor staff performance would be addressed by managers were they were normally based.

Multi-disciplinary and inter-agency team work

- Each team had a handover meeting at the end of every shift. There was a health record booklet to share important information between staff at the change of shifts. This meant that the new team had the most up to date information relating to the patient using the HBPoS.
- Depending on the time of admission, the handover might include a number of disciplines working with the patient. For example, the police, crisis team nurses and medical staff.
- A multi-agency group meeting was held on a bi-monthly basis to discuss good practice, learning and to ensure effective partnership working. The group included representatives from the trust, police, ambulance service and the local authorities.
- There was a joint inter-agency policy and local protocols in place for the teams to work effectively as a joint undertaking. Managers and representatives from the police told us that they were committed to multi-agency working and when difficulties occurred, all parties worked proactively to resolve them. There were records for each of the bi-monthly interagency meetings and we could see that issues were discussed, addressed, and resolved.
- Managers told us and we saw in recorded minutes, that they discussed issues relating to patients detained on

the suite at the monthly Multi Agency Group (MAG). Attendees included the HBPoS team leader, the service manager, triage service sergeant, and crisis team representative.

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

- The police, ambulance services and the trust had not updated the joint Place of Safety policy since the introduction of the revised Mental Health Act (MHA) Code of Practice. This meant the policy did not reflect changes to the way in which services should care for patients detained under section 136. The policy set out the areas the trust and partner agencies should audit in order to meet the guidance in the MHA Code of Practice and other best practice guidance, such as that issued by the Royal College of Psychiatrists.
- The trust introduced new protocols, which reflected the revised MHA Code of Practice for both the HBPoS at Penn Hospital and Hallam Street Hospital. This meant that while they were waiting for the joint updated policy with the police and other stakeholders, staff had access to the most up to date MHA Code of Practice information.
- Staff also had access to an information folder in the HBPoS to consult. For example, it included a copy of the Section 136 Suite Standard Operating Procedure", local protocols for HBPoS, contact numbers for relevant agencies and information from MHA Code of Practice (although some was from previous Code). This meant that they had information to support them while they worked with patients in the HBPoS. Staff we spoke with knew and understood the principles of the MHA Code of Practice and its guiding principles.
- Staff stored Section 136 monitoring forms which contained important information about the use of Section 136, in three separate locations. Storage of the information was dependent on whether the patient was admitted to the ward, discharged to the local area, or discharged to an area outside the trust. This meant auditing records was difficult.
- Patients who were assessed were provided with information explaining their rights under section 136 Mental Health Act. There were a team of professionals on hand to support the patient in understanding the process and their rights.
- The trust had a Mental Health Act office and the administrator was responsible for collating and monitoring information to make sure patient's rights were protected. The administrator told us they presented the findings to trust senior management groups. This meant the findings were shared with trust staff.
- Staff kept hourly observation records as well as progress notes documenting the admission and care of the patient in the Place of Safety. We saw three examples of this booklet. These included information about how staff had met the needs of patients. It also included contact with patient families, the provision of food and drink as well as the circumstances of their admission. This showed staff thought about the guidance in the MHA Code of Practice, particularly the guiding principles in Chapter 1.
- The duty senior nurse told us that qualified staff completed the Section 136 monitoring form, which recorded factual information about the patient's admission. It included time of arrival, police and ambulance involvement, risk assessments, time of Mental Health Act assessment and time of discharge. Either a nurse or a health care assistant would complete the information in the health record booklet.
- We looked at 10 Section 136 monitoring forms. Staff had not accurately completed all areas of this form, including some required by the Mental Health Act and the Code of Practice. These included, the time of arrival in the first Place of Safety was incorrect or missing in five cases. This information is a legal requirement.
- Staff had not accurately recorded the time of discharge from Section 136. Information was either incorrect or missing in five cases. This information should be recorded according to the Mental Health Act Code of Practice.
- Staff had wrongly calculated or omitted the total time spent in the HBPoS in all cases. However, there was no evidence that any patient had been in the HBPoS for more than the 72 hour legal time limit.
- In three cases, there was no evidence staff had informed patients of their rights under Section 136 as the Mental Health Act Code of Practice states should take place.
- In six cases, the staff had not correctly identified or omitted to record which HBPoS was used. In six cases, health staff had not completed their section of the risk

Are services effective?

Good

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assessment. In one case, staff had not recorded any information about the approved mental health professional involved in the Mental Health Act assessment.

- Records showed that Mental Health Act assessments took place within the trust targets of 4-6 hours, except where the patient was under the influence of drugs or alcohol. This was in line with their policy.
- The HBPoS accepted children and young people as well as adults. Staff from the child and adolescent mental health services (CAMHS) service supported the admission of children and young people aged 16 and 17. Psychiatrists from CAMHS were on call to undertake Mental Health Act assessments of children and young people. We saw records and staff told us there were plans for a HBPoS specifically for children and young people.

Good practice in applying the Mental Capacity Act

- Staff were trained in understanding the Mental Capacity Act and the five statutory principles. At the time of inspection, the core services were achieving 75%, which was within the trust target.
- Staff had good knowledge of the Mental Capacity Act and five statutory principles and understood the principle of giving patients every possible assistance to make a specific decision for themselves before they were assumed to lack mental capacity.
- There was a trust policy on the Mental Capacity Act which included Deprivation of Liberty Safeguards. Staff told us they were aware of the policy, where to find it and could refer to it if needed. Staff also told us they could discuss any concerns regarding capacity with the approved mental health practitioner and consultant.
- Capacity to consent was assessed and recorded appropriately for people using a common assessment tool and we saw this in all patients care records. A care records audit was carried out weekly to check that staff have assessed capacity if needed.
- If a patient under the age of 18 years was admitted, the child and adolescent mental health services team would support the admission. This meant there were trained professionals with knowledge to support young people if there were capacity issues.

Good

Are services caring?

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

Our findings

Crisis Resolution Home treatment Teams

Penn Hospital and Quayside House

Kindness, dignity, respect and support

- We attended a home visit and observed staff interactions with patients. Staff displayed compassion, kindness, and supportive care.
- We attended a handover where patients were discussed. Staff were responsive, respectful, and sought ways to offer support and improve patient circumstances.
- The patients that we spoke with told us that staff were supportive, treated them with kindness and that they were caring. One patient we spoke with told us that their mental health had significantly improved because of the support and engagement they had with the team.
- Staff discussed confidentiality with patients. Staff gained consent to information sharing and this was recorded on the Sainsbury's risk assessment.

The involvement of people in the care they receive

- We looked at 16 patient care records, 14 of which contained an up to date care plan with patient involvement. Two of the care records did not include the patients views.
- We spoke with six patients about care planning. Two of the patients we spoke with told us they signed their care plans but they were not asked for their opinions or what they thought should be in their care plans. The remaining four patients told us they were involved in the care planning process and they were offered a copy.
- Patients were given feedback forms to report on their care received. Managers told us that this information was not formally gathered or used to help improve the services. One manager told us that they were working with commissioners and patients to adapt the forms to make them easier to use. This was a work in progress at the time of inspection.
- Staff involved carers and families where appropriate. We saw evidence of family and carer involvement in care and treatment in care records. At assessment, patients were asked if families and carers should be involved in their treatment and where indicated, they were referred to the carers' team.
- Patients could access advocacy if they needed it. There were leaflets given to patients in their induction packs and leaflets available in waiting rooms.

Health Based place of safety

Penn Hospital and Hallam Street Hospital

Kindness, dignity, respect and support

- There was a difference in the quality of the physical environments of both health based places of safety (HBPoS). The HBPoS at Penn hospital was a dedicated place of safety and self-contained. There was a separate entrance used to respect the patient's dignity when they came on to the suite. The suite was also separate from the adjoining ward and maintained the patient's privacy.
- Patients at the HBPoS at Hallam Street Hospital did not have their privacy and dignity maintained. The suite was attached to a clinic room, which was used by patients on the ward. There was no soundproofing and you could clearly hear conversations between people in the clinic room. There was also a window that looked in to the suite from the clinic room, which meant that patients on the suite could be seen by anyone in the clinic room.

The involvement of people in the care they receive

- Staff documented patient involvement in progress notes. We saw three examples of patient involvement recorded in their personalised health record booklet. This included information about how staff had contact with patient families, their food and drink preferences, and cultural needs at admission.

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

Crisis Resolution Home treatment Teams

Penn Hospital and Quayside House

Access and discharge

- Referrals came to the crisis resolution home treatment teams (CRHTT's) from a range of professionals, for example, GPs, and other health care workers via a single point of contact. Staff triaged new referrals then prioritised them using a screening tool, which determined risk and identified needs. Data provided to us by the trust in the period from December 2015 to May 2016 showed that staff would assess urgent referrals on the same day and any referrals that came in out of hours were prioritised and non-urgent referrals seen the following day.
- The target for seeing new patients referred for assessment was 85%. Data shared with us from July 2016 to October 2016 indicated that teams were consistently above their targets.
- The CRHTT worked with patients for up to six weeks. However, staff told us that they care co-ordinated patients for longer if their needs required this. Staff and patients gave us examples of when this happened.
- There were no patients waiting for assessment and teams did not have a waiting list. The teams discussed, monitored, and responded to patients' needs in a way that took account of the level of risk presented by patients. Urgent referrals to the teams were prioritised based on risk. Assessments were carried out the same day or the next day if the referral was not urgent and received out of hours. Staff prioritised all urgent referrals to be seen within a three-hour period.
- Managers and staff told us they responded appropriately to patients who required crisis interventions and routine care. The teams were accessible 24 hours every day. The teams operated with night staff that worked from 10pm to 8am and were responsible for responding to all out of hours calls. Patients were seen in their homes and they could be seen at the teams' bases.
- Staff were proactive and flexible with patients who were harder to engage. Patients were offered opportunities to be seen where they felt most comfortable such as at home, the team base or at their GP surgery.
- Staff told us that they provided patients with a time slot for home visits rather than an exact time to allow for flexibility with patient visits. Patients could request changes to their visiting times and staff would accommodate this. One patient told us that they had to ask for this to be changed and that staff were flexible and could attend at an agreed convenient time if they asked for it.
- When patients' missed their appointment or were not at home, staff would re-allocate the visit to later in the day and would attempt to make contact over the telephone. This would also apply if staff had to re-arrange a patient visit.
- Patients were seen largely at home. There was flexibility to see patients at a mutually convenient place. Staff told us that revisited or rescheduled patient visits if they were unavailable.
- On occasions, teams had to cancel or reschedule home visits if there were not enough staff.
- All patients we spoke to told us they were given a 24 hour 7 day a week contact number and could speak with a member of the team straight away.

The facilities promote recovery, comfort, dignity and confidentiality

- Staff could access rooms and equipment to support treatment and care at both Penn Hospital and the Quayside House. However, patients were generally seen in their own homes.
- The rooms accessed on site were clean, comfortable and soundproofed to ensure patient confidentiality.
- There were rooms and facilities at both sites to facilitate one to one sessions with patients. At Penn Hospital there were consultation rooms which were comfortable and situated on a corridor away from the public area of the hospital.
- Patients had access to a wide range of accessible information. New patients were given an information pack full of information about what services were on offer to help them in their recovery. For example, a leaflet outlining the principles of theRecovery College. The Recovery College aims to support patients in their recovery. The trust have a website dedicated to the Recovery College where patients can access timetable and events information.

Meeting the needs of all people who use the service

Are services responsive to people's needs?

Good

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

- Each building was accessible to those who required disabled access or had mobility issues.
- Patients were given an induction wallet with information about their treatment and care, resource leaflets, for example, the recovery college which offered a range of activities to support their recovery.
- Patients could access leaflets to help them make complaints, comments, or compliments. Information leaflets were available in a number of languages, for example, English, Punjabi, Gujarati, Turkish, Bengali, Polish and Hindi. Staff said these were the languages most often spoken in the area. However, there were no easy-read information leaflets, or information for deaf or visually impaired patients.
- Staff told us that interpretation services were available from an external agency. We were unable to confirm this because none of the patients whose records we reviewed needed an interpreter.
- In the care records we looked at, we could see that at assessment and during care planning, staff asked patients about what their strengths were and what their cultural and religious needs were. This meant that staff considered meeting a wide range of patient needs while they were in service.

Listening to and learning from concerns and complaints

- Patients were given patient advice and liaison service(PALS) leaflets if they wanted to make a complaint or raise a concern. This was confidential advice, support and information on health-related matters. Staff also gave information regarding patient concerns to managers and issues were discussed. Where possible, a local resolution was sought in the first instance.
- The core service received nine complaints during the period 1 July 2015 to 30 June 2016; five of which were made in relation to the crisis resolution and home treatment team in Oldbury.
- Two complaints were partially upheld and none were referred to the ombudsman. We saw from trust data that the complaints had been investigated and outcomes and actions were agreed. For example, two of the complaints referred to unprofessional behaviour. Managers introduced customer care discussions at team meetings to highlight the importance of professional behaviour.
- The core service received 15 compliments during the period 1 July 2015 to 30 June 2016; eight of these were for the crisis resolution and home treatment team in Wolverhampton.

Health Based place of safety

Penn Hospital and Hallam Street Hospital

Access and discharge

- The health based places of safety (HBPoS) were accessible to patients 24 hours a day, seven days a week. There was an average of six detained patients received at the HBPoS each month.
- Records we looked at showed that MHA assessments took place within the trust targets of 4-6 hours except where the patient was under the influence of drugs or alcohol. This was in line with their policy.
- There were at least two members of staff, either police officers or health staff, within the Place of Safety during an admission.
- Police officers informed the duty senior nurse (DSN) before bringing patients to the HBPoS. The DSN arranged for one health care assistant (HCA) from the adjoining ward, and one qualified nurse to support patients during their stay. The police remained until the patient was settled.
- If the DSN had other responsibilities within the hospital requiring their attention, the HCA would be able to contact them if necessary. Staff had personal alarms and could use the phone in the office or clinic room to call for non-urgent assistance.
- If the HBPoS was occupied, patients would have to be taken to A&E for assessment.
- Staff reported that they could arrange for doctors with expertise in child and adolescent mental health services (CAMHS), learning disabilities and autistic spectrum disorders to take part in assessments if the individual needs of the patient required such input. Staff and police officers told us that since street triage team was in place, the health-based places of safety were rarely used for patients with these particular needs.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a separate entrance to the HBPoS so that patients did not have to pass through public areas of the hospital. This maintained their privacy and dignity.

Are services responsive to people's needs?

Good

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

- Patients detained in the health based places of safety (HBPoS) had access to a toilet and washing facilities. Both had a working television set. There was comfortable furniture, although, if patients wanted to sleep at the HBPoS in Wolverhampton, there was no bed and only a sofa.
- Each HBPoS had access to a clinic room. At Hallam Street Hospital HBPoS the clinic room was an adjoining room. At Penn hospital HBPoS, patients could access the clinic room in the main hospital.
- Patients at Hallam Street Hospital HBPoS could be overheard if the adjoining clinic room was being used by other patients. There was inadequate soundproofing. This would impact on confidentiality and dignity.
- Patients had access to an outside space, but the outside space at the HBPoS in Oldbury was overlooked and did not afford patients privacy.
- Staff kept sandwiches in the fridge, which they replaced every day for patients using the HBPoS. Alternative sandwiches were available on request, as was hot food during the day. Staff told us they were able to meet specific dietary requests for cultural, religious and health reasons. Hot and cold drinks were available.
- The Hallam Street Hospital HBPoS had a small kitchen, which was kept locked; however, it was where ward staff made hot drinks for inpatients on the acute ward. We observed staff using this facility to make patients hot drinks. The police told us that staff accessed this facility while detained patients were in the suite. This meant that detained patients may not be afforded privacy while in the suite. There was also the potential for risk of scalding while transporting hot drinks.

Meeting the needs of all people who use the service

- The HBPoS at Penn Hospital was purpose-built on the ground floor. Both HBPoS were accessible to people with a disability.
- Each HBPOS was accessible to those who required disabled access or for those with mobility issues. This meant if they had mobility concerns they could use the facilities, for example the bathrooms were accessible to those with a wheelchair.
- Information leaflets were available in languages spoken by people who used the service. For example, patients were given a pack with information about Mental Capacity Act to help them understand how to stay in control of their choices while they are accessing services.
- Patients could access leaflets on how to complain about, comment on or compliment the service. At the back of the leaflet there was a guidance section and a support number in a number of languages to help patients access further information in their own language.
- Staff told us they made sure there was a female staff member in the Place of Safety when a female patient with a history of being abused was admitted.
- Rights information leaflets were available in English; Punjabi; Gujarati; Turkish; Bengali; Polish and Hindi. Staff said these were the languages most often spoken in the area. However, there were no easy-read information, or information for deaf or visually impaired patients.
- Staff told us that interpretation services were available from an external agency. We were unable to confirm this because none of the patients whose records we reviewed needed an interpreter.
- Patients detained under section 136 are not eligible to access the independent mental health advocacy service (IMHA).

Listening to and learning from concerns and complaints

- From July 2015 to June 2016, the core service received nine complaints, none of which were made in relation to HBPoS.
- Staff told us that they knew and understood the complaints process for patients on the ward but were unable to give us examples of when patients who were admitted to the HBPoS could make complaints or any shared learning. Staff did attend a multi-agency group and we saw in the bi-monthly meeting minutes that issues and concerns were discussed with a view to learning.

Are services well-led?

Good

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

Our findings

Crisis Resolution Home treatment Teams & Health Based Places of Safety

Vision and values

- The teams displayed the vision and values of the trust on the walls and notice boards in staff areas. Staff agreed and were familiar with the trust's values. They told us that these values related well to the team's objectives.
- Staff demonstrated an understanding of their team objectives and how they linked in to those of the trust.
- Staff knew who their senior managers were and told us that they visited the teams.

Good governance

- The governance systems and methods to assess and monitor performance around quality, safety and risk were improved since the last inspection. For example, there were a number of audits carried out by staff at all levels. Audit cycles were recorded, monitoring and shared with staff through email, team meetings and we saw discussions recorded in supervision notes.
- Crisis resolution home treatment teams (CRHTT) introduced portable, locked medication bags to ensure safe transport and storage of medication.
- Managers were given the independence to lead the service and had administration staff to support the teams.
- Staff told us their managers were approachable and they could share issues or concerns with them.
- There was evidence of concerns being placed on the trust's risk register, for example low establishment levels at the CRHTT in Oldbury.
- Mandatory training compliance was above the trust and national average of 75%.
- Staff appraisal rates were 100% and staff were supervised. However, the trust was still working towards an electronic centralised system to collect and collate this data.
- There were incident reporting systems in place. Staff knew how to report incidents. The information from incidents was monitored, collated and used to highlight changes needed in practice. We saw this evidenced in new agenda items on team meeting minutes.
- Service user feedback forms were provided but there was no formal process in place to gather and use the information to help make improvements to the service.
- Managers shared key performance indicators (KPI's) inconsistently across services, for example, the CRHTT manager shared KPI's with staff through team meetings, supervision and displayed them on board for staff to view them. At Wolverhampton CRHTT, staff told us they would like access to KPI's, they requested them but they were not consistently accessible. This could mean that staff are not always aware of what their targets were.
- Staff were compliant in safeguarding training; Mental Health Act and Mental Capacity Act training had been rolled out.

Leadership, morale and staff engagement

- We looked at three months sickness rates from CRHTT. August sickness rates were 0.7%, September there was no recorded sickness and October sickness rates were just below 4%. This would suggest consistently low levels of sickness during this period and that they were below the national average
- At the time of our inspection, there were no grievances and no allegations of bullying or harassment.
- Staff told us that they were aware of the trust's whistleblowing policy and could raise concerns with their managers.
- Staff told us that they were supported by their line managers and were encouraged to access clinical and professional development courses. However, due to lack of funding, they were not always in a position to access bespoke training or external courses.
- Staff told us the board informed them about developments through emails and intranet and sought their opinion through the annual staff survey.
- Managers shared key performance indicators at the CRHTT in Oldbury through team meetings and we saw evidence in supervision notes of discussions relating to targets and outcomes.
- Managers consistently shared information with commissioners, for example, response times and worked with commissioners and service users to develop service user feedback forms.
- All staff, at all levels were involved in audits. We saw this evidenced in supervision records and audit outcomes documentation and meeting minutes.
- Managers and staff told us they were aware of duty of candour and being open and transparent when things

Are services well-led?

Good

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

go wrong. Senior staff took responsibility for meeting with patients or sharing information with patients when things went wrong. This followed a formal process and staff followed protocol when an incident had occurred.

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 Care and treatment must be provided in a safe way for patients. The bathroom located at Hallam Street Hospital health based place of safety had a lockable door. This door could be locked from the inside, where there were a number of ligature risks.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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