Good

Plymouth Community Healthcare CIC

Mental health crisis services and health-based places of safety

Quality Report

Local Care Centre
Mount Gould Hospital
Plymouth
Devon
PL4 7PY
Tel: 08451 558100
Website: www.livewellsouthwest.co.uk

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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)
1-297652203	Plym Bridge House	Plym Bridge House CAMHS place of safety	PL6 5ZD
1-297635140	Glenbourne Unit	Glenbourne Unit adult health based place of safety	PL6 5AS
1-297622270	Plymouth Community Healthcare CIC	Home Treatment Team	PL4 7PY

This report describes our judgement of the quality of care provided within this core service by Plymouth Community Healthcare CIC, also known as Livewell Southwest. 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 Plymouth Community Healthcare CIC and these are brought together to inform our overall judgement of Plymouth Community Healthcare CIC.

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?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Plymouth Community Healthcare's home treatment team and health based places of safety as good because:

- There was a separate place of safety for adults and young people. Staff manged risk well, including environmental risks and safeguarding concerns.
- Care records showed that patients received care based on their needs. Staff had completed risk assessments and care plans that reflected the patient's individual needs.
- The places of safety had a clear policy on how the patient pathway was set out. There had been a gradual reduction in the use of police custody for section 136 purposes for adults and since the introduction of the place of safety for young people, there had been no use of police custody for this patient group.
- There was evidence of good multi-agency working including shared forums for reviewing issues, strategic meetings, addressing continued service improvements and positive relationships within operational services.
- Patients mostly gave positive feedback on the service and said that staff were supportive and listened to them. When we spoke with staff, they reported feeling well supported by their management team.

However:

- There were some environmental issues with the places of safety, including a missing clock which meant that the patient could not maintain awareness of time and the quality of the environment in the suite for children and young people.
- The caseload for the home treatment team (HTT) was higher than normal due to having community mental health team (CMHT) patients on their caseload. This was due to their concerns over the quality of service that the four CMHT's provided. This placed additional pressures on the team impacting on the frequency of both management and clinical supervision available to staff and the frequency of team meetings.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- The layout of both health based places of safety enabled staff to observe patients safely whilst in the suites. We saw that ligature risk assessments were undertaken and risks were mitigated by the presence of staff at all times, who were able to safely observe the patient.
- Safeguarding training was mandatory and up to date within all three teams. Staff were able to explain how to make a referral. The safeguarding leads' contact details were visible on staff noticeboards. Staff were able to talk about different categories of abuse and they told us that they discussed safeguarding issues at the multi-disciplinary meetings.
- There was a lone working policy for the organisation. All staff we spoke with were clear about how they kept themselves and colleagues safe. They explained what they would do if a colleague hadn't returned at the proposed time, and that they risk assessed all situations and visited in pairs if the risk identified that this was needed.
- There were monthly multi-agency 'problems in practice' meetings which discussed many shared issues between the police, the emergency department, the ambulance service and the organisation, including sections 135 and 136. Any significant incidents were reported to the meeting and investigated.
- Risk assessments were completed and reviewed in all records that we looked at.

However:

- There was no clock available for patients in the adult place of safety.
- The toilet in the shower room of the child and adolescent place of safety appeared both stained and looked institutional.
- Mandatory training levels of the child and adolescent mental health inpatient team (CAMHS) were 76% overall, although safeguarding training was at 100%.
- Caseloads were higher than they should be for the HTT due to issues with the community mental health teams.
- There was no monitoring of the room temperature in the room where the medications were stored within the HTT. There was monitoring of the fridge temperature.

Summary of findings

Are services effective?

We rated effective as requires improvement because:

- There was no data available from the home treatment team (HTT) regarding the frequency of both management and clinical supervision available to the staff team. The manager told us that staff had informal clinical supervision within the team as issues or concerns arose.
- The policies for both adults and young peoples' places of safety had not been updated since the revised MHA Code of Practice had been introduced in April 2015.

However:

- We looked at 11 care records and found that risk assessments were comprehensive and regularly reviewed. Care plans were good, person centred and regularly reviewed. Progress notes showed good assessment of individual needs and planning of care.
- We were told that new staff were given an induction into the team and that all staff within the team were experienced. The manager told us that they gave an induction to bank staff and were continuing to attempt to recruit additional staff up to a full establishment.
- We checked the data available and most assessments took place within the health based places of safety (HBPoS) by the approved mental health professional (AMHP) and the section 12 approved doctor, where there were no clinical grounds to delay the assessment, within three hours. This complied with the MHA Code of Practice. However, we observed that some took longer than this.
- The health based places of safety had their own operational policy which clearly set out the steps from initial telephone notification to someone being brought in to the health based place of safety, the person's discharge from it. There was a flow chart that we observed on display in the offices. Both policies contained a local procedure for the use of the emergency department at Derriford hospital, Plymouth.
- Staff that we spoke with in the home treatment team and both places of safety were enthusiastic and motivated. The support workers at the adult health based place of safety stated they were well supported and trained to fulfil the role.
- We spoke to the pharmacist with the HTT who told us that the pharmacy technicians check the medication every day. The team had one nurse prescriber and we were told that two more nurses were training to do this. We were told that the technicians check the stock levels and remove medication that was not needed.

Requires improvement

Summary of findings

- Staff received regular training in de-escalation and the prevention and management of violence and aggression.

Are services caring?

Good

We rated caring as good because:

- We shadowed one visit and witnessed staff providing thorough, supportive and patient centred care.
- We attended a carers group and received positive feedback about the service.
- Staff treated patients who were brought into the places of safety in a caring manner and with respect. There were facilities to offer food, snacks and hot or cold drinks.
- We were told that all patients were offered a taxi home when leaving the place of safety to return to the community.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- There was an interim place of safety provided for young people.
- All Mental Health Act assessments in places of safety took place within 72 hours and most within three hours of admission.
- The teams provided patients with information leaflets on common mental health issues, medicines, rights and how to complain. The teams had access to an interpreting service if needed.
- The teams had clear referral pathways and set out clear lines of responsibility.
- Staff within the HTT rarely cancelled appointments. When cancellations did occur, patients were seen at the earliest opportunity. Staff maintained their appointment times and when they were running late, patients were informed.
- The HTT offered a 24 hour service with the team working seven days a week.
- Patients with both a learning disability and mental health issues could be seen by the HTT. There was a dual (mental health and learning disability) trained nurse in the team.
- There had been a gradual reduction in the use of police custody for section 136 purposes for adults and since the introduction of the place of safety for young people, there had been no use of police custody for this group.
- We found that regular audits of the use of the place of safety were completed. The multi-agency team also analysed audits

of section 136 usage and learned from these. The multi-agency team met monthly for the adult place of safety and less frequently for the child and adolescent mental health service place of safety due to its less frequent usage.

However:

- We found that the HTT had a number of ongoing cases which could be managed by the local community mental health team (CMHT) but due to concerns with the reduced number of care coordinators within the CMHT, the HTT had agreed to continue to provide a service in the best interests of the patient concerned. This resulted in higher caseloads and increased pressures on staff.
- The places of safety could be utilised by the neighbouring ward as an extra care area for the purposes of seclusion. Contingency plans were in place for this eventuality.

Are services well-led?

Good

We rated well-led as good because:

- Staff felt that they were listened to and supported by management.
- Managers we spoke with were enthusiastic and supportive.
- In the health based places of safety we saw thorough and robust interagency policies and procedures.
- The HTT had local leadership in place that was described as supportive and approachable by the members of the team we spoke with.
- Staff we spoke with in all services stated that morale was good and they enjoyed the challenge of their roles and were proud of the service they provided.
- Staff we spoke with told us they knew how to use the provider's whistleblowing process and that they would be comfortable raising any concerns or grievances with their managers, and felt them to be approachable and open.
- Governance systems were in place to ensure audits took place and were acted upon.

Summary of findings

Information about the service

Plymouth Community Healthcare CIC is an independent social enterprise providing NHS services for local people. The provider has two health-based places of safety, also known as section 136 suites. One is for adults and is located at the Glenbourne unit, Derriford, Plymouth. This was purpose built in 2015 with a separate entrance adjacent to two acute admission wards at Glenbourne.

The second is a child and adolescent mental health service (CAMHS) place of safety based at Plym Bridge House, Crownhill, Plymouth. This was a recent development and received young people from Devon, Torbay and Plymouth. It opened 30 March 2015 on an interim basis.

A place of safety is a place where people may be detained when they are subject to either section 135 or 136 of the Mental Health Act. Police officers have powers under section 136 to detain people believed to have a mental disorder in a public place and to take them to a place of safety to have their mental health and wellbeing assessed.

The provider has one home treatment team (HTT) which is based at Riverview, Mount Gould Hospital. The home treatment team provide short term mental health crisis support to help people remain at home, where they might otherwise be admitted to hospital. The team also help facilitate early discharge from hospital when support at home is appropriate. The HTT provides a 24 hour seven days a week service.

Our inspection team

The inspection team was led by;

Chair: Andy Brogan, executive director of nursing, South Essex Partnership Trust

Head of Hospital Inspections: Pauline Carpenter, Care Quality Commission

Inspection manager: Nigel Timmins, Care Quality Commission

The team that inspected the mental health home treatment team and health-based places of safety consisted of an inspector and a mental health nurse, and a social worker.

Why we carried out this inspection

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

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 we requested and reviewed information about the health-based places of safety and home treatment team (HTT) provided by Plymouth Community Healthcare CIC.

During the inspection visit, the inspection team:

- visited the HTT and two health based places of safety

Summary of findings

- looked at the quality of the environments and observed how staff were caring for patients, at the time of our visit both places of safety were not being used
- spoke with three patients who used the HTT service
- spoke with one carer of a patient who used the service
- spoke with one patient who had been recently admitted to the adult place of safety
- spoke with 10 staff members including team leaders, nurses, a referral co-ordinator, support workers and a pharmacist
- attended and observed a carers group
- looked at 15 treatment records
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We received mainly positive comments from people who used the services. Staff were described as good listeners and were respectful. One patient who had recently accessed the adult place of safety told us that they felt safe there and that staff were respectful, polite and caring. We received one negative comment from one individual who accessed the home treatment team about one staff member. We raised this with the team manager at the time of the inspection and she told us she thought this had been addressed to the satisfaction of the patient. The team manager told us that they would check with the patient to ensure they were satisfied with the response they had received at the time. This individual gave positive comments otherwise.

Good practice

Areas for improvement

Action the provider MUST take to improve

- The provider must update their policies for both adults and young peoples' places of safety in line with the revised MHA Code of Practice had been introduced in April 2015.

Action the provider SHOULD take to improve

- The provider should ensure that all statutory and mandatory training is completed by staff.
- The provider should ensure that staff are receiving regular supervision and appropriate records are being kept.

Plymouth Community Healthcare CIC

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
Adult Place of safety	Glenbourne Unit
CAMHS Place of safety	Plym Bridge House
Home Treatment TeamHome Treatment Team	Mount Gould 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.

- Staff in the Home treatment team and the places of safety could refer people for Mental Health Act (MHA) assessments as required.
- We saw that data was collected about how long people spent in the health based place of safety suite, and what the outcome of their assessment was.
- There appeared to be good adherence to the MHA and the Code of Practice. MHA documents appeared to be in order. However, the policies for both adults and young peoples' places of safety had not been updated since the revised MHA Code of Practice had been introduced in April 2015.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act (MCA) was a mandatory training requirement for all clinical staff working in the organisation. Staff who we spoke with had a good knowledge of the act including the five guiding principles.
- All staff had received training in the MCA and knew where to go for further advice if necessary. Capacity and consent were addressed in the MHA assessment conducted by medical staff and the AMHP in the records that we looked at in the places of safety. The home treatment team demonstrated a good understanding on the recording of capacity and consent to a decision specific issue.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

Mental health home treatment team

- The home treatment team (HTT) was based in Riverview, Mount Gould Hospital. There was space on the ground floor where staff could interview people using the service. We were told that staff had access to an alarm for this area. Most people using the service were seen in their own homes, this was risk assessed and two staff members would undertake the home visit if necessary.
- The team offices were cramped and some staff had to share computers to access care records. We were told that the size of the building was on the risk register.
- We observed a locked medicines fridge and daily temperature checks were completed. We did not find that the room temperature was recorded where other medicines were stored.
- We were told that there was no emergency equipment available but there was equipment for first aid and physical observations.
- The environment appeared dated but was clean and tidy.

Health based places of safety

- All staff in both of the health based place of safety (HBPoS) carried alarms linked to the adjacent ward(s). We saw that staff responded quickly to an alarm which was accidentally triggered at the place of safety for children and adolescents.
- The layout of both places of safety enabled staff to observe patients safely whilst in the suites.
- We saw that there were ligature risk assessments undertaken and risks were mitigated by the presence of staff at all times. We observed on the risk assessment at the Glenbourne HBPoS that access to the shower was considered to be high risk but was mitigated by staff observation whilst patients used this room. Anti-ligature measures were in place.
- Staff practiced good infection control procedures such as hand hygiene to ensure that patients and staff were protected against the risks of infection.
- The adult HBPoS had robust and practical furniture available which was aesthetically pleasing. There was a ceiling mounted television projector which enabled viewing of DVD's and television programmes. The adult HBPoS did not have a bedroom but had seats that could be used to lie down on and bedding would be provided.
- We found that the CAMHS HBPoS shower room had what appeared to be a replacement steel toilet which appeared stained. We also found that the CAMHS HBPoS television screen cover had been damaged. We observed a clock in the office of the CAMHS HBPoS which was visible from outside. There was no clock in the adult HBPOS.
- There were facilities available to make drinks and for snacks and food to be available in both HBPoS.
- Both of the HBPoS had timely access to resuscitation and emergency equipment located within the adjacent inpatient wards.
- Support workers in the adult HBPoS were supported by the referral coordinators and out of hours were supported by an allocated band six nurse from one of the wards.

Safe staffing

Mental health home treatment team

- The team consisted of two whole time equivalent team managers (band seven) and 15 whole time equivalent band six staff who were mostly registered nurses with one occupational therapist. There were two band 6 vacancies. There were three band five staff and a single vacancy at this level. There were six community support workers at band three. There were two medical secretaries (one based at Glenbourne) with two team administrators and a team secretary. We were told that a recent advert for band six posts did not attract any applicants but further attempts to recruit were ongoing.
- The medical cover for the home treatment team (HTT) was an acting consultant psychiatrist, a registrar and a junior doctor. Access to psychology was by referral to the community mental health team (CMHT).
- The team worked on minimum numbers of five on the early shift and six on the late shift with a mix of registered and non-registered staff. Both team managers were supernumerary, enabling them to undertake management duties. There was one band six nurse

working 7.30 pm until 7.30 am who, after handover, was based at Derriford hospital accident and emergency department and there was an additional on call team member available if needed, which could be any member of the team.

- We were told that bank and agency staff had been used to cover both vacancies and sickness. The data showed sickness levels had been high in 2015 (10% between 1 June 2015 – 31 May 2016), but had recently improved. Staff said that the staff that were off work due to sickness were reviewed and supported to return to work as soon as possible. The manager said that they ensured that staff who worked in the team had a week's induction, which was supernumerary. They used staff who had worked in the team before or extra shifts were offered to the existing team, particularly to part time staff.
- One of the team managers was a nurse prescriber who was able to adjust the dosage of the medication prescribed by the doctor. We were told that the wards completed annual medicines administration competency assessments but this was not completed in the HTT.
- Staff reported there was always access to medical cover if needed.
- All mandatory training courses were up to date or booked for staff to attend. Additional training in suicide prevention, nurse prescribing and personality disorders was available. One staff member told us that due to work pressures it was difficult to be released for additional specific training.
- The caseload was shared across the team and the manager told us that the ideal number of cases was 35-40 for the team. On the day of the visit it was 55 cases open cases and this had been 60 the previous week. Staff told us that this was putting additional pressure on the team but that sickness levels had reduced and the provider continued to attempt to recruit to vacancies. One member of staff told us it was a manageable workload.

Health based places of safety

- The Plym Bridge House child and adolescent mental health services (CAMHS) inpatient unit had a larger staff team to enable the HBPoS to be staffed by a nurse 24 hours a day. The area used as a place of safety could also be used as an extra care area where seclusion may be used for patients on the ward. The manager stated this had occurred on one occasion prior to the inspection. During the inspection we observed that the area was used to manage an individual in seclusion. The manager told us that a person would be taken to the emergency department if the HBPoS was occupied at the time and would be transferred to the HBPoS as soon as possible. The HBPoS had two bedrooms and we were told that it was used either for HBPoS or seclusion but would only be used by one person at any one time.
- We found that all staff had up to date disclosure and barring service (DBS) checks, and training was up to date in level three children's safeguarding. We were told that there was access to trained CAMHS doctors and nurse at all times.
- The training records of the CAMHS inpatient team were 76% overall, with safeguarding at 100%, but 34% for mandatory training and 57% for attendance at the corporate mandatory day, which included fire training, diversity, information governance, infection control and customer care.
- The sickness rate for the CAMHS inpatient team that covered the HBPoS at Plym Bridge was 6%.
- The adult HBPoS was staffed by a team of seven staff including two referral coordinators. There were five support workers who would be working in the HBPoS and they would be allocated to one of the wards if the facility was not in use.
- We were told by the manager that sickness levels were variable as there had been some long term sickness. We were told that contingency plans were in place to cover sickness including the training of some bank staff to fulfil the role. We observed that the sickness rate supplied in the data pack 1 June 2016 to 31 May 2016 was 3.5%. However we requested further information and had a breakdown of the team sickness statistics. The annual rate of sickness was 5%.
- The provider gave us information before the inspection which stated that 77% of the adult HBPoS team were up to date with mandatory training. The manager said and demonstrated that this was not accurate and that most of the staff were up to date or had training planned to achieve this.
- Staff working in the place of safety had alarms to alert colleagues to any concerns and staff from the neighbouring ward(s) would respond.

Assessing and managing risk to patients and staff

Mental health home treatment team

Good

Are services safe?

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

- We reviewed 11 care records and all had an up to date risk assessment. Staff told us that a risk assessment was completed at the first contact and was then updated as required.
- The team had three daily handovers at set times where staff told us they discussed risk and made changes to risk assessments if required.
- Safeguarding training was mandatory and all staff that we spoke with were able to explain how to make a safeguarding referral. The safeguarding leads' contact details were visible on staff noticeboards. Staff we spoke to were able to talk about different categories of abuse and supposed that they discussed safeguarding issues at the multi-disciplinary meetings.
- There was a lone working policy for the organisation. All staff we spoke with were clear about how they could keep themselves and colleagues safe. They explained what they would do if a colleague had not returned at the proposed time, how they risk assessed the situation and visited in pairs if needed.
- The pharmacist technician visited daily to check medicines management arrangements. The staff stored and transported medicines in accordance with their policy although they did not monitor the room temperature where medicines were stored.
- We were told that the team would be able to offer three to four visits a day depending on the complexity of the visit. The team had clinical reviews twice a week where risk was reviewed. These reviews were jointly managed with staff from the relevant community mental health teams.

Health based places of safety

- We looked at four care records in the HBPoS and we found that the documents that were used addressed risk management and risk assessments were detailed and were reviewed.
- Staff had access to electronic records on patients referred to the place of safety. The police would contact the HBPoS to alert staff of an admission prior to arriving at the HBPoS. This enabled staff to familiarise themselves with the patient's situation and any identified risks prior to their arrival at the HBPoS. The manager told us that the provider was planning to provide this role 24 hours a day. All staff had training in the management of challenging behaviour. This was called 'physical intervention' training and this included annual updates which included de-escalation skills training. The police, who we were told remain at the HBPoS for at least one hour, were required to remain or return to the HBPoS whenever aggressive behaviour was encountered. All staff had received training in basic life support skills.
- Staff were trained in safeguarding arrangements and all the staff we spoke with knew how to recognise the signs of abuse and how to raise safeguarding alerts.
- The manager told us that the majority of patients were transported to the HBPoS by ambulance rather than police car.
- We observed in the CAMHS HBPoS that staff were changing from paper records to the use of electronic records, 'System One'. The unit manager told us they were piloting the new system and some staff were still completing paper notes. We found that some information had not been uploaded onto the system. We were able to find information required in either written or electronic formats.

Track record on safety

Mental health home treatment team

- There was one serious incident reported, the death of a patient using the service. We were able to view the incident report relating to this.

Health based places of safety

- We were told that there had been no reported serious incidents that had required investigation in either place of safety in the previous 12 months.

Reporting incidents and learning from when things go wrong

Mental health home treatment team

- The HTT 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. This included reporting when they were short staffed which we were told was more of an issue in 2015 due to high sickness levels and some vacancies.
- Staff were offered individual work stress assessments and support was given to manage this period whilst attempts to fill posts and manage staff return to work continued.

Good

Are services safe?

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

- We were told of a medicines management incident that had resulted in the team discussing the issue and learning from it.
- Staff said that the incident reporting system used a filter system and the incident form was forwarded to the appropriate managers and other relevant professionals. We were told that any medicines management issues they reported were automatically forwarded to the pharmacist as well as to their managers.
- Staff discussed learning from incidents at their team meetings which the manager stated were supposed to be held every two weeks. We were told that meetings did not always go ahead due to the additional caseload that the team had. We reviewed minutes of meetings dated 31 March 2016, 19 May 2016 and 14 June 2016.
- Staff said they were de-briefed and supported after a serious incident.

Health based places of safety

- The electronic reporting system was available to staff working in the HBPoS.
- There were monthly multi-agency 'problems in practice' meetings which discussed many shared issues between the police, the emergency department, the ambulance service and the organisation, including sections 135 and 136. Any significant incidents were reported to the meeting and investigated.
- We were told that managers fed back learning from incidents to team members and that staff were offered debrief sessions and support after serious incidents.

Are services effective?

Requires improvement

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

Mental health home treatment team

- We reviewed 11 care records and found that risk assessments were comprehensive and up to date. We found that care plans were good and were person centred. We found that patient's progress notes on the electronic system were of good quality and showed risk updates and treatment progress.
- The manager said that an audit of care plans found that there were areas of improvement that they felt were related to the team's workload and that care plans did not always reflect the assessed risk. We found that the care plans that we reviewed did reflect risk.
- We were told that assessments were completed the same day and this was what we found within the care records that we looked at.
- Information was stored on the electronic system which we were told was accessible across all of the provider sites.

Health based places of safety

- We checked the data available since the child and adolescent mental health service (CAMHS) place of safety (HBPoS) opened in March 2015. We found that 78% of 37 assessments were completed by an approved mental health professional (AMHP) and the section 12 approved doctor within three hours. This was compliant with the Code of Practice.
- The adult HBPoS had 280 assessments within the last 12 months and we found that 74% of them were completed by the AMHP and the section 12 approved doctor within three hours.
- However, we observed that some took longer than this. We observed in the minutes of the 'problem solving monthly meeting' forum that during the meeting in January 2016 it was highlighted that there was a shortage of AMHP's which was delaying assessments. We also were made aware that some delays were caused by intoxication, delays in locating a section 12 approved doctor or the need for medical treatment.

Best practice in treatment and care

Mental health home treatment team

- We spoke to the pharmacist who told us that the pharmacy technicians check the medicines every day. The team had one nurse prescriber and we were told that two more nurses were training to do this. We were told that the technicians check the stock levels and remove medicine that was not needed. The team doctors prescribed medication and the nurse prescriber could adjust the dosage.
- The team did not have a psychologist and we were told that they referred to the community mental health team (CMHT) if this was required.
- There were good links with other agencies. We were told that three AMHP's were attached to the developing crisis team and some social care staff had joined the CMHT. We spoke to the manager of the developing crisis team who stated that the changes were part of the Crisis Care Concordat to support improvement in accessing support prior to a crisis point.
- Patients who required support for issues such as employment, housing or benefits would be supported and referred to the appropriate agency.
- Patients using the service were encouraged to see their own general practitioner to monitor their physical health but this was overseen by the team. Two of the support workers were phlebotomy trained and the team took basic physical observations. Nurses administered depot preparations where necessary.
- The team used clinical audits to improve practice and completed health of the nation outcome scales. The manager told us that this was sometimes delayed due to the increased workload of the team.

Health based places of safety

- We reviewed four patient records and found that all documentation was completed appropriately.
- The places of safety had their own operational policy which clearly set out the steps from initial telephone notification of someone being brought in to the HBPoS, to the person's discharge from it. There was a flow chart that we observed on display in the offices. Both policies contained a local procedure for the use of the emergency department at Derriford hospital, Plymouth.
- The provider had a HBPoS record form which was used from the time of arrival. It contained information about the patient, information from the police about the incident, time of arrival and departure of the police officers, searches, explanation of rights, and details of the MHA assessment.

Are services effective?

Requires improvement

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.

Skilled staff to deliver care

Mental health home treatment team

- We observed the records kept by the manager and that 95% of the team had received an appraisal in the year before the inspection.
- Team meetings, management and clinical supervision with staff were infrequently completed due to work pressures but there was no data available. Staff had informal supervision within the team and discussed issues or concerns as they arose. One staff member told us that they had management supervision every two months but they could approach the manager with any concerns at any time and stated this was the same for staff that they line managed.
- No staff were under performance management at the time of the inspection. However the manager provided evidence of two staff that had previously been performance managed and on both occasions we were told it led to positive change for the individuals and the team.
- New staff were given an induction into the team. The manager told us that they gave an induction to bank staff, who worked as a supernumerary member of staff in the team until the manager was satisfied they were able to safely fulfil the role. They were continuing to attempt to recruit additional staff up to a full establishment.

Health based places of safety

- The support workers at the adult HBPoS stated they were well supported and trained to fulfil the role. They had received additional training and had the support from the referral co-ordinators during the day and by an allocated band 6 nurse out of hours. Nursing support for clinical issues was available at all times.
- The CAMHS HBPoS was staffed by the inpatient CAMHS unit team that had a larger establishment to be able to provide a nurse at all times when required.
- We were told that 97% of staff within the CAMHS inpatient team had received regular supervision including group and individual. We were told that this was not routinely recorded as this was not a policy requirement. We were told that 91% of the team had received an appraisal in the last year and that 76% of the team were up to date with mandatory training.
- Staff who we spoke with told us that there were sufficient staff at the CAMHS inpatient unit to effectively staff the HBPoS as and when required.

Multi-disciplinary and inter-agency team work

Mental health home treatment team

- The home treatment team (HTT) had three handovers a day at 8am, lunch time and before the night shift. We observed staff discussing patients during our visit and these discussions were detailed and person centred.
- Staff held multi-disciplinary clinical review meetings twice weekly, with each locality reviewed weekly. We were told that members of the local CMHT would attend these reviews.
- We spoke with the manager of the newly formed crisis assessment team who stated that when the service was operational, referrals from HTT to the crisis team would be allocated automatically. The AMHP's were dividing into two teams namely the crisis assessment team and the complex case/hospital discharge team. All AMHP's were part of the duty AMHP rota. AMHP's were the point of contact for police related street triage enquires from Monday to Friday 9am – 5pm. This function would ultimately sit within the crisis assessment team. The manager told us there was a minimal street triage service linked to custody diversion, which we did not have the opportunity to visit.

Health based places of safety

- There were good working relationships with other agencies. There was a monthly meeting entitled 'problems in practice' involving the police, emergency department, ambulance and organisational representatives. We looked at minutes of these meetings which highlighted good inter agency working.
- There was also a criminal justice liaison meeting with commissioners where themes, issues and needs were discussed.
- The provider was part of the Devon emergency mental health steering group. This was a strategic, multi-agency partnership group between all stakeholders involved and responsible for the provision of mental health services in Plymouth, Torbay and Devon. The forum met monthly and was responsible amongst other things for the delivery of the Crisis Care Concordat action plan, the delivery of a single point of access for mental health emergency/crisis and improved access to psychiatric liaison in acute hospitals across Devon.

Are services effective?

Requires improvement

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.

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

Mental health home treatment team

- We saw evidence that training on the MHA was provided to team members on the 19 May 2016 during a team meeting and we were told that training on the latest MHA Code of Practice was contained within the mandatory training programme.
- HTT would often be the referrers for a MHA assessment and that the consultant in the HTT would often be the first doctor. This supported the HTT to manage admissions to inpatient beds.
- Occasionally patients were subject to a community treatment order (CTO) but not at the time of the inspection.
- We were told that the team had good links with the Mental Health Act office for advice and training.

Health based places of safety

- The policies for both adults and under 18's places of safety had not been updated since the revised MHA Code of Practice was introduced in April 2015. The adult HBPoS policy had received minor amendments following a CQC visit in September 2015. However, there appeared to be good adherence to the MHA and the Code of Practice. MHA documents we reviewed were appropriately completed.
- There was evidence in the records that patients on section 136 were given an explanatory leaflet and had their rights explained. We observed rights leaflets for section 135.
- We also found comprehensive AMHP reports in place.
- Staff we spoke with 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 MHA when needed.

Good practice in applying the Mental Capacity Act

Mental health home treatment team

- Training records showed that all staff had received training in the MCA as part of their mandatory training.
- The manager told us that during 2015, an extra training session was presented by a solicitor discussing MCA and deprivation of liberty safeguards. Staff that we spoke with had a good understanding of the MCA including the principles of the act.
- The provider had a MCA policy which was available on the intranet.
- We found evidence of consent being obtained within the care notes and in the sample of records that we looked at we found that staff had judged if a person had capacity which was decision specific.

Health based places of safety

- Staff received training in the MCA and knew where to go for further advice if necessary. Capacity and consent were addressed in the MHA assessment conducted by medical staff and the AMHP in the records that we looked at.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

Mental health home treatment team

- We observed a home visit and saw staff were caring and respectful. They were thorough, supportive and patient centred. It was clear that the patient was known to the nurse who discussed issues including medication, housing, risk of pressure areas to the body and discharge planning.
- All people who used the service we spoke with gave positive feedback. One person made a negative comment about an individual staff member. We shared this information with the team manager who stated they were aware of the issue and thought it had been resolved. They stated they would speak to the individual and take any necessary action.
- We observed a carers group which was well attended and we heard positive comments from the participants. Staff available at this meeting included nursing staff, the mental health crisis manager, therapy leads, the service user experience manager and the lead for the carers group.
- All staff we spoke with understood the need to maintain confidentiality and to keep information secure.

Health based places of safety

- One patient said that they had felt safe at the adult HBPoS and that the staff were respectful, polite and caring. The patient had medical equipment at home which the police collected and brought to the HBPoS for the patient.
- Anyone admitted to any of the places of safety would be offered food and a hot or cold drink. The units had spare clothing if needed.
- We were told that all patients were offered a taxi when leaving the HBPoS to return to the community.
- The policy advised that where possible an ambulance should be used as the preferred mode of transport rather than police transport. We were told that this happened for the majority of times and we found evidence of this in minutes of meetings
- The entrance to the adult HBPoS was separate to the main building. However, the entrance to the children and young person HBPoS was through the main building. We were told that when used the team took measures to maintain the privacy and dignity of the individual. They closed off the corridor leading to the HBPoS and closed blinds so that the patients cannot see who was brought into the unit and the young person can't see the patients on the ward. The manager told us that there were plans to develop a permanent purpose built unit in the future but she was not aware of a time frame.
- We reviewed over 50 incidents forms that showed staff had mostly written about incidents with patients comprehensively and in a way that conveyed compassion and respect. However, we saw in one report that staff had referred to the outside enclosed area of the adult HBPoS as a cage.

The involvement of people in the care that they receive

Mental health home treatment team

- The manager told us that care plans were printed off to be given to the patient but the team needed to encourage the patient to sign their care plan more often. We were told that care plans were reviewed with patients and we observed that this occurred on the home visit that we attended.
- We were told that feedback from patients who use the service was obtained by the use of a survey called Meridian and that audits of this survey were completed. We observed data over a 12 month period showing 26 responses to the survey which highlighted a largely positive response from individuals.
- Patients told us that they felt listened to and respected and that they had got a copy of their care plan which they were involved with when it was written and reviewed.

Health based places of safety

- We observed a number of leaflets available with pertinent information available in the office area of the places of safety.
- The managers told us that when individuals were brought into the suite they were given an opportunity to make phone calls, using the unit's portable phone if necessary or their mobile phone. Families were allowed to come into the suite if appropriate.
- We were told that feedback from patients who use the service was obtained by the use of a survey called Meridian and that audits of this survey were completed. We observed that in the patient records that we scrutinised that there was evidence that this survey was

Good

Are services caring?

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

sent to patients to obtain their feedback. We observed data over a 12 month period showing nine responses to the survey which highlighted a largely positive response from individuals.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Mental health home treatment team

- There were no waiting lists and people referred to the service were seen on the same day. At the time of the inspection there was a crisis team being established which would assist the home treatment team (HTT) to fulfil its commissioned role.
- We found that the HTT had a number of ongoing cases which could be managed by the locality community mental health team (CMHT) but that due to concerns with the number of care coordinators within the CMHT, the HTT had agreed to continue to provide a service in the best interests of the patients concerned. This resulted in higher caseloads and increased pressures on staff.
- The manager told us that the average length of service for HTT should be 4-6 weeks however due to the limitations of the CMHT; this was at the time of the inspection several months prior to discharge from the team. The manager stated that staff workloads had increased but they were able to assess new referrals promptly.
- Patients in need of crisis resolution could only access the HTT through referral by their general practitioner, or via the community mental health team. People could only self-refer if they were already known to the service. We were told that the forensic service could also refer to the HTT.
- The HTT offered a 24 hour service with the team working seven days a week. Most people were assessed at home and the manager told us that occasionally appointments were delayed or had to be cancelled due to traffic issues. There was one HTT team covering four locality CMHT teams. The manager stated that this delay or cancelation would be communicated to the individual as soon as possible and that a rearranged time would be organised as soon as possible.
- The HTT were the gatekeepers for the inpatient acute mental health beds at the Glenbourne unit. They liaised daily with inpatient services and the referral co-ordinators/bed managers.
- Staff said each referral received was triaged quickly and efficiently. However, caseloads were higher due to having community mental health team (CMHT) patients on their caseloads.

Health based places of safety

- We found that regular audits of the use of the place of safety (HBPoS) were completed. The multi-agency team also analysed audits of section 136 usage and learned from these. We read examples in the minutes of monthly meetings which highlighted individual issues that were raised and were followed up by a representative from each of the multi agencies involved.
- The manager of the adult HBPoS told us that the use of the police cell as a place of safety had reduced and was now between two-three times monthly. We read statistics which highlighted that the police cell was used as a place of safety on 211 occasions in 2014, 65 occasions in 2015 and 12 times by the 31 May 2016. The manager highlighted that there was a low conversion rate to a Mental Health Act (MHA) section and we found that for a 12 month period from May 2015, there were 280 times that the adult HBPoS was used and 35 of those resulted in informal admission to hospital and 24 in detention in hospital under the MHA. There was one patient transferred to another hospital and one occasion when the police removed the person from the health based place of safety to a police cell. On all other occasions the individual was discharged.
- The use of the child and adolescent mental health service (CAMHS) HBPoS was significantly less. Since it opened in March 2015 as an interim measure it had been in used 37 times by 34 people. However, we were told that since its introduction the police cell has not been required as a place of safety for young people. We were told that if the HBPoS was already occupied or if someone had significant medical problems, the young person would be taken to Derriford hospital emergency department, which was a backup HBPoS for young people.
- We were told that prior to our visit the CAMHS HBPoS had only been used once for seclusion purposes, therefore the incident that occurred during our visit was the second occasion. We were told that if the CAMHS HBPoS was occupied and was required then the patient would be taken to the emergency department but would return as soon as possible.
- One patient told us that when they were taken to the adult HBPoS by the police they had to wait for an hour in the car as the HBPoS was occupied on their arrival. The manager of the adult HBPoS told us that they would benefit from a second adjacent HBPoS due to the

Are services responsive to people's needs?

Good

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

demand for it but there were no plans to do this. We read the policy for the adult HBPoS which stated that when this scenario occurs, then the police station would be used but consideration should be given to the time required to wait for the HBPoS to be vacated and if transfer to custody would cause unnecessary distress or delay to the assessment. It also stated that the emergency department should be used if medical assessment/treatment was required.

- The CAMHS HBPoS policy identified the emergency department as the alternative place of safety to be used, if the facility was not available at the time.

The facilities promote recovery, comfort, dignity and confidentiality

Mental health home treatment team

- The HTT were able to see patients within the building where they were based and facilities there were appropriate and safe. However, most appointments were held in the person's home.

Health based places of safety

- In the adult HBPoS we observed a purpose built facility that was well equipped. There was a small enclosed outside area where individuals could access fresh air.
- The CAMHS HBPoS had a larger enclosed outside area where individuals could access fresh air.

Meeting the needs of all people who use the service

Mental health home treatment team

- Patients with both a learning disability and mental health issues could be seen by the team. There was a dual (mental health and learning disability) trained nurse in the team.
- There were leaflets about the HTT service and there was access to online feedback of the service on the organisation website. There was access to a translation service.

Health based places of safety

- We were told that the only exclusion criterion to the HBPoS was significant risk of violence.
- A wide range of information leaflets were available within each HBPoS which gave patients and carers information about services available. The only information available was in English. However, the managers told us that they had access to a translation service. We were told that there were no leaflets in easy read format.
- The places of safety could accept individuals with mobility issues.

Listening to and learning from concerns and complaints

Mental health home treatment team

- The HTT received five complaints during the last 12 months, two were under investigation and none had been referred to the ombudsman.
- Staff we spoke with told us that they would refer complaints to the team manager or to the PALS department.
- The manager told us that the team received feedback on the outcome of investigations of complaints and staff discussed this in team meetings to learn from this. One nurse told us that learning had occurred over a medication administration error and that a new system was implemented successfully.

Health based places of safety

- We saw an example within the adult place of safety where they investigated a complaint regarding an external agency which was judged to be unfounded. The manager explained this to us and it was referred to in minutes of meetings that we read.
- There were no reported complaints specifically for the CAMHS HBPoS.
- The managers told us that any lessons from complaints would be shared with team members to learn the lessons when appropriate.

Are services well-led?

Good

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

Our findings

Vision and values

Mental health home treatment team

- Copies of the organisation's vision and values were on display in the home treatment team (HTT) office area.
- Staff told us that the organisation's values were simple and easy to understand. They guided the work of the organisation. We were told that vision and values was part of the recruitment process.
- Staff said they felt committed to this work and said that they enjoyed it. Staff knew who their local managers were and they were aware of the chief executive.

Health based places of safety

- Copies of the organisation's vision and values were on display in the office in the place of safety (HBPoS).
- The staff we spoke with stated they had regular contact with their managers and attended regular meetings to discuss issues and objectives.

Good governance

Mental health home treatment team

- There was a risk register that detailed concerns about the suitability of the working environment, difficulties recruiting staff and the impact this was having on the staff team. There was a plan in place for these issues to be addressed; this included increasing the physical space available to the team in the office, recruitment of new staff and the monitoring of stress levels through the use of stress surveys. One staff member said that the managers were approachable and there was good team morale.
- It was apparent that staff in the HTT had community mental health team (CMHT) patients on their caseloads and that their case load was higher than would be expected. We were told that there were concerns about the functionality of the CMHT and the HTT preferred to sometimes not discharge patients back to the CMHT in the patient's best interests. This appeared to be admirable based on the needs of the individual but it was evident that the team were not having regular management and clinical supervision. Team meetings were sometimes missed and staff were working under more pressure.
- Governance systems were in place to ensure audits took place and were acted upon.
- There appeared to be adequate administrative support for the team.

Health based places of safety

- We saw good policies and procedures and interagency agreements.
- Both places of safety were staffed differently and there was a significantly higher usage of the adult place of safety which was used most days. The team operating the adult HBPoS were managed as a team and were appraised and given supervision accordingly. The staff providing input into the CAMHS HBPoS were part of the inpatient team and were managed as part of that team.
- Staff we spoke with appeared confident and able to work in the HBPoS and they stated they had been well trained. The support workers in the adult HBPoS had received guidance and support from the MHA Administrator.

Leadership, morale and staff engagement

Mental health home treatment team

- We were told by the managers that their office door was always open and this approach was reflected by what staff told us and the impression that we had based on observations during the inspection.
- We were not made aware of any bullying or harassment cases during the inspection.
- Staff we spoke with told us they knew how to use the provider's whistleblowing process and that they would be comfortable raising any concerns or grievances with their managers, and felt them to be approachable and open.
- Staff morale appeared to be good and staff were professional and enthusiastic in their discussions with us.

Health based places of safety

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- Staff we spoke with told us they knew how to use the provider's whistleblowing process and that they would be comfortable raising any concerns or grievances with their managers, and felt them to be approachable and open.
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Are services well-led?

Good

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Commitment to quality improvement and innovation

Mental health home treatment team

- The organisation was part of the Crisis Care Concordat to work in partnership to support improvement in accessing support prior to a crisis point. We were told that the planned crisis team will initially aim to establish a seven day 9am to 9pm service. The crisis team was being developed at the time of the inspection and was planned to take referrals in July 2016.
- The continuous improvement action plan to enable delivery of shared goals of the Mental Health Crisis Care Concordat within Devon is signed by 14 organisations.

Health based places of safety

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This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The policies for both adults and young peoples' places of safety had not been updated since the revised MHA Code of Practice had been introduced in April 2015 This is a breach of Regulation 17 (1)(2)(a)(b), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014