Care Quality Commission

Good

Solent NHS 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)
R1CF2	St James Hospital	Crisis Resolution Home Treatment Team	PO4 8FE
R1CF2	St James Hospital	Health-based places of safety	PO4 8FE

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

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

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the service and what we found	5
Information about the service	8
Our inspection team	8
Why we carried out this inspection	8
How we carried out this inspection	9
What people who use the provider's services say	9
Good practice	9
Areas for improvement	9

Detailed findings from this inspection

Locations inspected	11
Mental Health Act responsibilities	11
Mental Capacity Act and Deprivation of Liberty Safeguards	11
Findings by our five questions	13
Action we have told the provider to take	21

Summary of findings

Overall summary

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

- There was a range of psychological therapies available to patients using the crisis and home treatment service.
- Staff of the crisis and home treatment service told us they were well supported and had a good induction to the services. Patients we spoke with told us that the staff were respectful and staff reported morale as high.
- The crisis team had daily multidisciplinary meetings (Monday to Friday) to discuss patients and update risk assessments. Detail and quality was good in most of the care records we reviewed.
- The crisis team had access to a full range of mental health professionals and had non-medical prescribers.
- The crisis team had capacity to respond to routine and urgent referrals and all patients were visited within target times.
- The crisis teams were available 24 hours a day; seven days a week and staff gave patients known to the team a direct contact number.

However:

- The trust did not receive comprehensive data from the private ambulance service that served the health-based place of safety in a way that assured them of the safety and quality of care in the health-based place of safety. There was a lack of oversight by the trust of the service that they commissioned.
- Care records did not indicate that staff in the crisis and home treatment team gave patients copies of their care plans. The patients we spoke with and their carers told us they had not received copies of their care plans.
- No staff in the crisis team had undertaken recent training in the Mental Health Act training the number of staff with Mental Capacity Act and safeguarding adults training was low. There was no day to day monitoring of the use of the health-based places of safety.

Summary of findings

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

Are services safe?

we rated safe as good because:

Good

Mental health crisis team:

- The meeting area accessed by patients had suitable alarms and was effectively sound proofed.
- The facilities were clean and well maintained. Medicines were stored safely and the crisis team helped patients manage their medicine on a risk-assessed basis.
- We saw evidence of the trust apologising to patients when something had gone wrong and the trust was at fault.
- Staff felt supported following incidents

Health-based places of safety :

- The health-based places of safety was free from ligature points, had good lines of site via mirrors and a two-way communication system in place.

However:

Mental health crisis team:

- Compliance with safeguarding and mandatory training was low.

Are services effective?

We rated effective as good because:

Good

Mental health crisis team:

- Records had up to date goal orientated and had personalised care plans.
- The crisis team had access to a full range of mental health professionals and had non-medical prescribers.
- Staff had a trust and local induction and were "buddied up" for two weeks, with a more experienced member of staff.
- The team took part in clinical audits.
- The team held daily multidisciplinary meetings to discuss patient's care and treatment.
- Staff reported good relationship with other agencies.

However:

- The service did not use a recognised outcome measure to assess the impact of the team's interventions.
- Staff did not have training in the Mental Health Act and Mental Capacity Act.

Summary of findings

Are services caring?
we rated caring as good because:

Good

Mental health crisis team:

- Staff acted in a kind and respectful manner with patients. The patients we spoke with all said staff were supportive.
- All staff we spoke with were enthusiastic and caring.
- Patients were involved in recruiting staff.
- Patients could give feedback as part of a patient forum.

However:

- Care records did not indicate staff gave patients copies of their care plans. The patients we spoke with and their carers told us they had not received copies of their care plans.

Are services responsive to people's needs?
we rated responsive as good because

Good

Mental health crisis team:

- Responded to referrals promptly and visited patients within 24 hours.
- The crisis team was available 24 hours a day; seven days a week and staff gave patients known to the team a direct contact number.

However:

Health-based places of safety :

- The facilities in the health-based places of safety were stark. The furniture was uncomfortable, and there was little for patients to do.

Are services well-led?
we rated well-led as requires improvement because

Requires improvement

Health-based places of safety :

- There was no day to day monitoring of the use of the health-based places of safety.
- The trust did not receive comprehensive data from the private ambulance service in a way that assured them of the safety and quality of care.
- The trust had no oversight of care records. This meant it could not ensure the care complied with the Mental Health Act Code of Practice. Staff were using paperwork from a different trust and it did not reflect the care being provided.

Summary of findings

- Governance systems did not provide assurances that all incidents were reported using the trust system. Information was not always communicated effectively following an episode of care. The staff working in the health-based places of safety did not use, or have access to, the trust's electronic record system.

However:

Mental health crisis team:

- Senior managers had visited and responded to the team when needed.
- Staff felt confident in raising concerns.
- Morale was high and staff felt supported by their manager.
- The crisis team had a quality improvement plan.

Summary of findings

Information about the service

In February 2014, the publication of the Crisis Care Concordat placed mental health crisis care under the national spotlight. The Concordat committed its signatories to working together to improve the system of care and support, so that people in crisis are kept safe and are helped to find the support they need.

Crisis and home treatment teams aim to assess all patients being considered for mental health hospital admission, to offer intensive home treatment rather than hospital admission where possible, and to facilitate early discharge from hospital. Solent NHS Trust provides one crisis and home treatment team that covers the city of Portsmouth.

Section 136 of the Mental Health Act allows for someone believed by the police to have a mental disorder, and who may cause harm to themselves or another, to be detained in a public place and taken to a safe place where a mental health assessment can be carried out. Police can also take people detained under section 135 to a place of safety. Mental health professionals can use section 135 to take someone to a place of safety for a mental health assessment. A health-based place of safety could be a hospital, care home, or any other suitable place where the occupier is willing to receive the person while the assessment is completed. Police stations should only be used in exceptional circumstances.

Health-based places of safety are most commonly part of a mental health unit on a mental health hospital or acute hospital site, or part of an accident and emergency department in an acute hospital. Solent NHS Trust provides one health-based place of safety at St James Hospital. The trust subcontracts this service to a private ambulance service. The private ambulance service manage the service and provide the staff for the service while the patient is awaiting a Mental Health Act assessment, in addition to providing transport to and from the health-based place of safety. This commissioning arrangement differs from the rest of Hampshire where a qualified mental health nurse is provided by trusts to manage the patient's care once admitted to the health-based places of safety in conjunction with the staff from the ambulance service.

As the health-based place of safety is provided by a private ambulance service, we will not be reporting on this part of the core service in this report, other than in relation to the physical environment and the governance of the service.

Our inspection team

The inspection was led by Joyce Frederick, head of hospital inspection, Care Quality Commission.

The team that inspected the mental health crisis services and health-based places of safety comprised: two CQC inspectors and a specialist advisor for the mental health crisis services and two CQC inspectors for the health-based places of safety.

Why we carried out this inspection

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

Summary of findings

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?

During the inspection visit, the inspection team:

- visited the services and looked at the quality of their environment and observed how staff were caring for patients
- spoke with three patients who were using the services
- spoke with the managers of the services
- spoke with13 other staff members; including doctors and nurses
- attended and observed one multidisciplinary meeting
- looked at five medication records of patients
- reviewed 18 care 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 met two patients during crisis and home resolution team visits. They felt the team were polite and respectful, available when needed, and they did not cancel appointments.
- Patients advised us they had not received a care plan.

Good practice

The crisis and home treatment team has agreed to allow one of their non-medical prescribers to provide an appointment based service in a local GP surgery that offered patients the opportunity to:

- talk about the practical impact that mental health/ wellbeing difficulties they may be having
- assess and talk through psychological support needs and help address these directly or through referral to other specialists
- discuss self-help, therapy and treatment options, including medication
- offer short-term one-to-one support to help gain coping strategies relating to mental health

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must ensure that all staff received their mandatory training and that they have all received appropriate training for their work place.
- The trust must review the health-based places of safety standard operating procedure. It must receive the appropriate level of scrutiny and address every deviation from the multi-agency policy that covers the other health-based places of safety suites in Hampshire.
- The trust must ensure the governance systems in place to monitor care in the health-based places of safety are comprehensive and allow for effective monitoring of safety and quality.

Summary of findings

- The trust must ensure that all incidents that occur within the health-based places of safety are recorded effectively on the trust`s incident system and that relevant risk information is passed on as appropriate.
- The trust must ensure the safety of all staff working in the premises.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure they record that patients have been offered copies of their care plans
- The trust should ensure there is appropriate comfortable furniture and activities for patients in the health-based places of safety.

Care Quality Commission

Solent NHS Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Crisis Resolution Home Treatment Team	St James Hospital
Health-based places of safety	St James Hospital

Mental Health Act responsibilities

Mental health crisis team:

- The crisis team had no patients on their caseloads that were under a community treatment order.
- No staff had received Mental Health Act training. The manager advised us that this was because the trust only offered training on the Mental Health Act to inpatient services.

Health-based places of safety :

- Section 136 of the Mental Health Act 1983 allows police officers to detain someone who is in a public place and take them to a place of safety, if it appears that the individual is suffering from mental disorder and is in immediate need of care or control, and it is in the interests of that person or for the protection of others. Section 135 can be used by mental health professionals to take someone to a place of safety for a mental health assessment.
- Once section 136 has been applied, a person should receive transportation to a health-based place of safety via an appropriate vehicle, most likely an NHS ambulance but on occasion private vehicles may have to be commissioned. In exceptional circumstances, conveyance in a police vehicle may be required if other more suitable forms of transport are not available. A person should be taken to a designated health-based places of safety. The private ambulance service that provides staffing for the Solent NHS Trust health-based places of safety also has the contract for providing transport to and from the units across Hampshire.

Detailed findings

- The MHA Code of Practice states that there should be a jointly agreed local policy in place that governs all aspects of the use of sections 135 and 136. This should be maintained by a multi-agency liaison committee. A standard operating procedure was in place for the health-based places of safety (SOP). We saw a copy of this dated May 2016. It was not in agreement with the Hampshire-wide multiagency protocol for management of section136 that was the locally agreed policy between partner agencies in the Hampshire area, including the police, another NHS trust and other organisations. There was no evidence of the degree of scrutiny that the SOP had undergone.
- The Mental Health Act Code of Practice 2015, 14.86 recommends that: '"local recording and reporting mechanisms should be in place to ensure details of any delays in placing patients, and the impact on patients, their carers, provider staff and other professionals are reported to commissioning and local authority leads. These details should be fed into local demand planning", the records we saw did identify how long patients had been waiting for transport.

The trust had no day-to-day oversight of activity in the health-based place of safety, it was possible for patients to be admitted and discharged without coming to the attention of the hospital managers. The information provided by the ambulance service to the trust was not comprehensive; it did not provide information around how long patients waited to be collected from the police. In the information we reviewed we did not find any significant delays in accessing AMHP, although on the four occasions we identified patients being in the health-based places of safety for longer than 12 hours all were as a result of waiting for an AHMP. We did not identify any delays in patients being admitted to an inpatient bed. We did identify that two admissions to the health-based places of safety were not included in the figures provide to the trust and that there were gaps in the data provided where staff had not completed timings or where the timings were incorrect.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental health crisis team:

- Sixty-three percent of crisis team staff had received training in the Mental Capacity Act.

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 Crisis teams:

- The crisis team saw most patients in their own homes or at another venue of their choice. Staff could use a room with disabled access and a suitable alarm system to see patients if needed. The crisis team had a treatment room used to store medicines for patients being discharged from mental health wards. A passkey locked the clinic room and the keys for medicine cupboards were stored in a key safe. The team did not store any controlled drugs. There was no medicines fridge, or emergency equipment in the clinic room. Staff could access a fridge or emergency equipment via the wards in the building.
- There was no maintenance schedule for checking physical health monitoring equipment used by the crisis team, for example blood sugar testing kit. There were suitable clinical waste bins; we noted that on two out of three waste bins staff had not completed the information about date and time of assembly. There was gel for cleaning hands at suitable locations, for example, entry and exit to clinical areas. We observed staff using them.

Health-based places of safety :

- We inspected the trust's purpose built health-based places of safety. It comprised of two patient rooms and a reception area, as well as an office for staff. The patient areas in the place of safety were clean and well maintained. There were viewing panels on the doors and mirrors giving lines of sight to all areas of the rooms.
- There were no ligature points in the patient rooms. A ligature point is anything, which a patient could use to attach a cord, rope or other material for the purpose of hanging or strangulation. The service further mitigated ligature risk by constant staff supervision and observation. Trust managers told us that the trust had plans to alter the design of the suite to reduce the patient rooms to one (meaning there could be only one admission) and to create a kitchenette and seating area. The trust had not agreed a date for the completion of this work, at the time of our visit.

Safe staffing

- The staffing establishment at the time of inspection for the crisis team was 12.8 whole time equivalent (WTE) qualified nurses and 10 WTE unqualified nurses. There were no vacancies.
- The staff turnover rate for the past 12 months was 20%, four staff members and sickness was 4%.
- The current shift pattern was early, 08:00 – 17:45, three qualified nurse and two unqualified, late, 12:15 – 22:00 two qualified and two unqualified and night, 21:45 – 08:15 one qualified and one unqualified member of staff.
- The staff establishment was agreed in 2008 and the manager was unaware how the numbers were agreed. Since then the trust had increased the numbers by three qualified nurses, to its current level, due to taking on additional roles in hospital liaison.
- The team manager advised us that the service rarely had to cancel visits and would rearrange for later that day if needed to.
- If shifts needed to be covered, the service would try to use their own staff. They rarely used bank or agency. Between May 2015 and April 2016, bank staff filled 12 shifts and no shift were left unfilled.
- Seventy-nine percent of staff had completed all their mandatory training. Seventy percent of staff had completed fire and safety, seventy-three percent of staff had completed safeguarding children and health and safety training, Mental Capacity Act training had been completed by sixty three percent of staff and fifty seven percent of staff had completed safeguarding adult training.

Assessing and managing risk to patients and staff

Mental health Crisis Team:

Good

Are services safe?

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

- Staff advised us that all patients received a full risk assessment, by the crisis team, during the initial assessment. The team would review the risk assessment when there was a change for the patient or when there was a new initial contact. The service used the risk template on the electronic record system used by the trust. We reviewed eight case records and found that seven reflected this procedure. Staff told us that they discussed all options with patients and the least restrictive options were always encouraged.
- Staff developed a crisis plan and recorded any advanced decisions by the patient during the initial contact. In the eight care records we reviewed, we noted that the crisis plan was referred to and was embedded in the progress notes rather than being a standalone document. In two of the eight progress notes we reviewed there was no crisis plan present.
- At the time of our visit, the team had 22 cases open and no waiting list.
- The team followed the trust safeguarding policy. Staff members would discuss with the team manager before making a referral. The team did not know how many referrals it had made but were able to discuss the type of issues they would refer. For example, physical and financial abuse and they recognised their role in the safeguarding of children. Only 57% of team members had received safeguarding training.
- The team reviewed patient records to assess risk and always visited in pairs. During the day shift, all staff were expected to return to the office for the handover meeting, one person always remains in the office and staff must ring in following each visit. During the night shift staff follow the same protocols but they diverted the phone to the ward for them to check in, following a visit.

Health-based places of safety :

- The health-based places of safety was equipped with an alarm system that linked to the hospital wards. There was no established agreement between the trust and the ambulance service to when and if staff should respond to an alarm.

Track record on safety

- Between 3 January 2015 and 12 February 2016, there were three serious incidents that required review. Two related to unexpected or avoidable death and one to allegations of physical or sexual abuse

Reporting incidents and learning from when things go wrong

- The team manager told us that an investigation had identified that the service had not always filled out the documentation completely in the patient's files; the service now audited five patient records monthly. However, we found of the eight records we reviewed, that staff had not reviewed three risk assessments at initial assessment or updated one to reflect a recent incident. We saw two recent incident reports describing incidents reported to the trust; staff had followed the serious incident process.
- The team manager told us that all staff could enter incidents on the trust's electronic incident record system. All staff we spoke to were able to access the trust incident system. We were advised that staff would report any concern they had, which would include physical, financial or sexual abuse and near misses. Staff showed us how the service had reported medication errors even when the staff had identified the incidents prior to the patient receiving the medication (a near miss incident).
- Staff told us that they would apologise to patient in person and that they would record this in a letter sent to the patient. The manager showed us a letter sent to a patient. The letter included an apology and what action the service had taken to prevent the incident occurring again.
- Staff advised us that following an incident there would be a meeting during which senior trust managers were involved and would feedback and debrief the team. The team would have a local group debrief and any learning discussed in the team meeting and via email.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- The team completed a comprehensive assessment of the patient at the initial contact. The staff member would discuss with the patient what the team could provide.
- Of the eight records we reviewed, seven had care plans that were up to date and one had care plans that staff had not reviewed or updated for eight months. Seven records had holistic, goal orientated and personalised care plans.
- Out of eight care records, two documented that patients had received a physical health assessment on initial contact with the team. The crisis team relied on other services to conduct a physical health assessment. However, in five of the eight records we did see evidence of staff considering on going physical health issues, which included monitoring of antipsychotic medication. The team would assist people to manage their medicine on a risk assessed basis providing them with prescriptions or medication on a daily, weekly or monthly basis.
- All patient information was stored in an electronic record system, which was secure and accessible to team members when they needed it. The trust had recently issued staff with lap top computers, which would allow them to access records away from the base, reducing the need for staff to record assessments on paper, and then upload afterwards.

Best practice in treatment and care

- The service was able to offer access to psychological therapies such as, mindfulness, emotional coping skills, dialectic behavioural therapy and acceptance and commitment therapy. The service supported patients with a range of needs including employment, and housing.
- At the time of our visit, the service only used clustering (a way of gathering information that helps standardise what care is offered to patients with similar problems) and did not use a recognised outcome measure to assess the impact of the team's interventions. The team participated in audits such as infection control, medication monitoring and case note audits. There were no established CQUINs, (commissioning for quality and innovation payment framework); the CQUIN payment framework linked to the achievement of local quality improvement goals by healthcare providers.

Skilled staff to deliver care

- The crisis team had staff from different disciplines, including psychiatrists, nurses and psychologists; they did not have direct access to any occupational therapists. The team had access to pharmacist support. The team had two non-medical prescribers.
- The team had experienced staff. The team manager recognised there was few chances for staff to advance their career within the team but had supported staff to develop their role such as non-medical prescribers.
- Staff completed the trust's induction and the team had devised their own local induction procedure. New starters are "buddied up" with an experienced colleague for two weeks.
- The manager said that not all staff were supervised in line with the trust standards. The manager addressed this with the supervisors in their supervision, and they had a chart on the wall stating when each member of staff had been supervised. Staff we spoke to felt well support by the manager and their colleagues.
- At the time of our visit, none of the staff were being performance managed. The manager was able to explain to us what issues could lead to performance management and where they could get advice and support from if they need to.

Multi-disciplinary and inter-agency team work

- The team had a daily multidisciplinary team meeting to discuss the current patients on their caseload. We observed one meeting and all staff on duty, including the consultant, attended it. Staff recorded meetings directly into the case notes of patients including discussion around risk and team involvement. The team held had handover meetings between shifts.
- The team had good links with other services such as the inpatient service, local authority appointed mental health practitioner team (AMHP) and another crisis team

Are services effective?

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.

provided by a neighbouring trust. Staff gave us an example of where they had arranged for a patient to spend time in another area and for the local team to provide crisis management.

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

Please see earlier part of report.

Good practice in applying the Mental Capacity Act

Please see earlier part of report.

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

- We observed two episodes of care. Staff were polite and respectful in manner at all times. All the staff we spoke with expressed respectful and compassionate attitudes towards patients.
- The two patients we spoke with told us that staff treated them in a respectful manner

The involvement of people in the care that they receive

- The staff told us that they completed a crisis and contingency plan form with a patient, left a copy with them and transferred this information in to a plan on the electronic care record. In the eight patient records we reviewed staff had followed this process and left copies of the plans with patient. Care records did not reflect that patients had been given copies of their care plans and the two patients we spoke with told us they had not received a care plan.
- Staff asked patients what information they would like to share and recorded this on the electronic care system. Staff reviewed this with the patient at the beginning of each care episode.
- Crisis team will involve families, carers in the patients care with the consent of the patient, and they could attend a local carers group.
- Patients could give feedback about the service via a feedback form, which was given to patient with a prepaid envelope. There is a patient's forum that patients can join. The crisis team displayed patients' feedback on a notice board.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- The team had clear referral criteria. In order to be referred to the crisis team, patients needed to be at risk of admission to hospital or already be receiving support from mental health services. The team accepted referrals from a range of services. For example, the police, accident and emergency departments, mental health teams and general practitioners. The service did not currently accept direct referrals from patients or members of the public. The manager told us that the trust wanted to move to an open referral system and was in the process of reviewing this.
- The team had capacity to respond to urgent and routine referrals. Staff confirmed that they responded to referrals within four hours and visited patients within 24-hour hours.
- The crisis team provided a gate keeping function for admissions are able to access beds when needed.
- Staff were available 24 hours a day seven days a week. Patients were given a direct contact number.
- We were advised that if an appointment needed to be cancelled the team would always advise the patient that this had occurred and why.

The facilities promote recovery, comfort, dignity and confidentiality

- The crisis team visited most people at home, or in a place of their choice. The assessment room that used was clean and comfortable.

Meeting the needs of all people who use the service

- Staff had access to information leaflets in different languages and could access interpreters as needed.

Listening to and learning from concerns and complaints

- The service had received 10 complaints. The trust had not fully upheld any; the trust had partially upheld five and three were ongoing. At the time of our visit, one had been referred to the ombudsman.
- Staff gave patients information on how to complain and if they contacted the team with a concern, the manager would be give them the local patient advisory and liaison contact details.
- Staff received feedback following a complaint via team meeting and supervision.

Are services well-led?

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

- The staff were aware of the trust values. If they provided care in a way that reflected the trust values they would write it down and it was displayed on a notice board to encourage good practice trough out the team.
- The crisis team staff were aware of who the trust`s senior managers were. They had visited the service regularly.

Good governance

Mental health crisis team:

- The team manager had access to the trust governance systems that enabled them to manage their teams. Senior managers in the trust accessed the information generated through those systems.
- The crisis team measured their performance based on patients' length of stay on a mental health hospital ward, between seven – nine days, and the number of re-admissions within a 30 day period. The team reviewed any readmission within 30 days looking for any common themes that could help reduce the number of re-admissions within 30 day of discharge.
- The team manager felt they had the authority to do their job. There was no administration support for the team.
- The manager was able to submit items to the trust's risk register and had submitted the team's telephone system. The system in place at the time of our visit did not record conversations, provide an answering system or log calls. The new system is due later in the year.

Health-based places of safety :

- There were not effective governance arrangements in place. This meant that the trust lacked clear oversight of practice, risks, training, complaints, incidents and record keeping in relation to use of the health-based place of safety . The trust managed the contract with the private ambulance service via monthly meetings using statistical data on the use of the health-based places of safety but there was no day to day monitoring of care in the suite by the trust.
- There was a Hampshire wide multi-agency policy that had been agreed between partner agencies in the Hampshire area, including the police, another NHS trust and other organisations. A standard operating procedure was in place for the health-based places of safety provided by Solent NHS trust. We saw a copy of this dated May 2016. It was not in line with the Hampshire wide multi-agency protocol for management of section 136 and health-based places of safety suites.
- The Hampshire wide multi-agency policy described the role of the designated nurse and responsible practitioner. There was no designated nurse or responsible practitioner in the Solent operating procedure. The private ambulance service that provided staffing for the Solent NHS trust health-based places of safety also has the contract for providing transport to and from the units across Hampshire. The role of the private ambulance service in other parts of the county was to convey patients and to provide care in the suites under the direction of qualified nursing staff.
- Our review of patient records showed that there was a lack of senior oversight. Much of the documentation used was not trust specific, it was from another trust, and did not reflect the practice within the Solent trust's health-based places of safety. For example, there was a section for the nurse in charge to review the patient on admission, despite there not being a nurse to perform this role.

Leadership, morale and staff engagement

Mental health crisis team:

- Staff felt the morale was high and relationships between the team members were good. Staff told us they felt well supported by the manager.
- There were no bulling or harassment complaints and staff felt able to raise concerns without fear of being victimised as a result. Staff told us that the trust always responded well when concerns were raised. There were opportunities to do internal management/leadership courses but external courses were harder to access.

Health-based places of safety :

- The health-based places of safety lacked strong leadership from the trust at a local and a service level. There were not effective collaborative processes in place between the trust and the provider contracted to

manage the health-based places of safety. There were not effective governance arrangements in place. The trust did not have clear oversight of the quality and safety of care provided.

Commitment to quality improvement and innovation

- Displayed in the office was a quality improvement plan for the crisis team and a ‘how we are doing’ board that displayed the results of internal audits.
- The team was not currently working towards a recognised accreditation scheme such as The Home Treatment Accreditation Scheme (HTAS).

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 There was a lack of effective governance systems in place to assess, monitor and improve the quality and safety of services. This included monitoring of incidents, scrutiny of paper work, overall quality of records, the training records of staff working within the services and monitoring of overall activity data. The health-based places of safety had deviated from the multi-agency agreed policy, used throughout Hampshire and had adopted a standard operating procedure. The standard operating procedure had not under gone the same level of scrutiny as recommended in the Mental Health Act code of practice. **This is a breach of Regulation 17 (1) and (2a) and (2b) of the Health and Social Care Act 2008 (Regulated Activities)**

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 18 HSCA (RA) Regulations 2014 Staffing There was no established agreement between the trust and the ambulance service to agree a process when and if ward staff should respond to an alarm in the health-based places of safety . This places staff at risk. Staff had not been trained in the Mental Health Act at the crisis team. Seventy percent of staff had completed fire

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Requirement notices

and safety, 73% of staff had completed safeguarding children and health and safety training, Mental Capacity Act training had been completed by 63% of staff and 57% of staff had completed safeguarding adult training.

This is a breach of regulation 18(1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities)