Requires improvement

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Date of inspection visit: 21 – 24 March 2016
Date of publication: 12/07/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRE58	George Bryan Centre	Health-based place of safety	B78 3NG
RRE12	St Georges Hospital	Health-based place of safety	ST16 3AG
RREG4	Castle Lodge	Telford & Wrekin Crisis Resolution and Home Treatment Team	TF4 2HQ
Trust HQ	Friary Centre	East South Staffs, Crisis and Resolution Home Treatment Team	WS13 6EF

Summary of findings

RREX9	The Redwoods Centre	Crisis Resolution and Home Treatment Team, The Redwoods Centre.	SY3 8DS
RREX9	The Redwoods Centre	Health-based place of safety	SY3 8DS

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
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 mental health crisis services and health-based place of safety as Required improvement because:

- The level of cleanliness in the clinic room at Telford & Wrekin was of a poor standard and we saw that cleaning schedules were not always being adhered to.
- The lack of space in both the HBPoS at George Bryan Centre and St Georges hospital would influence the ability of staff to safely carry out physical interventions if necessary.
- The responsiveness of approved mental health practitioners and doctors attending the HBPoS following the admission of patients was variable.
- There was no disabled access to the toilets in the HBPoS' at George Bryan Centre and St Georges hospital.
- Within the Telford & Wrekin team, there was no robust process in place to discuss themes of incidents or to ensure that learning was consistently embedded.

However:

- Staffing levels were sufficient to ensure that safety was not compromised. We also saw that mandatory training completion was above the trust target.
- Skilled professionals saw urgent referrals quickly; staff responded as quickly as possible to any deterioration in patients' mental health.
- Care plans, risk assessments and physical health checks were of a good quality and there was clear evidence of patient involvement in their formulation.
- We saw evidence of effective inter-agency working in assessing and supporting patients detained under section 136 at the HBPoS.
- Patients and their families were complimentary about the attitudes of staff and the support that they received. Staff showed that they understood the individual needs of patients and could describe how they supported patients with a wide range of needs.
- Staff had good knowledge of the Duty of Candour. We saw written letters of apology were given patients and their families were things had gone wrong.
- Good governance arrangements were in place locally, which supported the quality, performance and risk management of the services. Key performance indicators were utilised in order to monitor performance.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as required improvement because:

- The level of cleanliness in the clinic room at Telford & Wrekin was of a poor standard and we saw that cleaning schedules were not always being adhered to.
- There were environmental risks identified at St Georges and at the George Bryan Centre HBPoS. Observation levels carried out by staff to manage the potential risk of ligature points compromised patients' privacy and dignity when using the facilities.
- The lack of space in both the HBPoS at George Bryan Centre and St Georges hospital would influence the ability of staff to safely carry out physical interventions if necessary.
- Staff were crammed in the offices used by Telford & Wrekin Crisis Resolution Home treatment Team. The environment was noisy with lack of privacy for staff on the phone and staff handing over. There was insufficient desk space, and workstations to effectively carry out their role.
- Within the Telford & Wrekin team, there was no robust process in place to discuss themes of incidents or to ensure that learning was consistently embedded.

However:

- Staff practiced good infection control procedures such as hand hygiene to ensure that patients and staff were protected against the risks of infection.
- All the CRHT teams were able to respond quickly to sudden deterioration in patients' health.
- Staffing levels were sufficient to ensure that safety was not compromised. We also saw that mandatory training completion was above the trust target.
- The health-based places of safety (HBPoS) were clean, tidy and mostly well maintained. Staff carried out brief risk assessments and physical health checks and all had access to emergency equipment if needed.
- CRHT had effective systems to monitor medication management including safe and secure transportation of medication to patients. Staff effectively adhered to lone working policies.

Summary of findings

- Staff had good knowledge of the Duty of Candour and we saw that written letters of apology were given patients and their families where things had gone wrong.

Are services effective?

Good

We rated effective as good because:

- CRHT teams were responsible for gatekeeping 100% of all acute inpatient beds, which they managed effectively. The teams had two bed managers working across in their geographical areas, which enabled this effective level of gatekeeping.
- Comprehensive holistic assessments and care plans were completed and reviewed in a timely manner.
- Patients physical health needs were routinely considered and discussed at the point of assessment.
- Patients could access short-term psychological therapies within CRHT teams and were referred to other specialist teams for longer-term therapies.
- Staff were involved in a range of clinical audits; the results of these were used to monitor the effectiveness and performance of the services
- There was effective inter-agency working in assessing and supporting patients detained under section 136 of the Mental Health Act at the HBPoS.

Are services caring?

Good

We rated caring as good because:

- We observed good interactions between staff and patients. Staff were polite, kind, respectful and compassionate. Staff we spoke to were aware of the need to maintain patient's confidentiality.
- Staff gathered the views of patients through surveys. Patients were involved in their care and treatment and were aware of their care plans. Staff encouraged patients to involve relatives and friends in care planning if they wished.
- Patients and their families were complimentary about the attitudes of staff and the support that they received. Staff showed that they understood the individual needs of patients and could describe how they supported patients with a wide range of needs.

Summary of findings

- All the teams had a comprehensive welcome pack, which provided a variety of information on the available resources and how to access them. Information on independent advocacy was available and promoted across the teams to support the involvement of patients and carers.
- Patients had been involved in recruitment of staff and sat on interview panels.

Are services responsive to people's needs?

Requires improvement 

We rated responsive as requires improvement because:

- The responsiveness of approved mental health practitioners and doctors attending the HBPoS following the admission of patients was variable.
- There was no disabled access in the toilets at the George Bryan Centre and St Georges hospital.

However:

- Skilled professionals saw urgent referrals quickly; staff responded as quickly as possible to any deterioration in patients' mental health.
- The purpose-built facilities at Redwood HBPoS had been designed with safety and comfort in mind. It was appropriate for the service that was being delivered.

Are services well-led?

Good 

We rated well-led as good because:

- Staff were aware of the trusts vision and values.
- Operational leads supported their staff well; they were accessible and available to their staff that valued and respected them.
- Good governance arrangements were in place locally, which supported the quality, performance and risk management of the services. Key performance indicators were used to gauge performance.
- There was generally good morale and effective team working. Staff had access to developmental opportunities and could progress with their careers.
- Staff knew how to use the trusts whistle-blowing process. Staff told us that they felt able to raise with the trust any concerns they might have about patient care or treatment.

However:

Summary of findings

- Some staff told us they only had contact with senior managers when things had gone wrong. They had not received positive feedback when they had worked under pressure and done a good job.

Summary of findings

Information about the service

There were four Crisis and Resolution Home treatment (CRHT) teams operating across South Staffordshire and Shropshire Healthcare NHS Foundation trust. We inspected three of the teams. Telford & Wrekin CRHT team was based at Castle Lodge in Telford. East South Staffs CRHT was based at St Michaels Hospital in Lichfield. Shropshire CRHT was based at the Redwoods Centre. The teams operated 24 hours seven days a week. The main function of the CRHT teams was to provide home treatment for people whose mental health crisis was so severe that they would otherwise have been admitted to an inpatient ward. The teams worked using a multi-disciplinary approach to support patients in their own homes to reduce inpatient admissions and facilitate early discharge from hospital.

Shropshire CRHT received referrals from community mental health teams, general practitioners, A&E and local out of hour's general practitioners; "shropdoc". It was not a self-referral service. Telford & Wrekin and East South Staffs CRHT received their referrals from community mental health teams. Most of the referrals coming from the single point of access (SPA) Monday to Friday between 9am - 5pm and direct referrals after hours. The teams also provided psychiatric liaison cover out of hours. East South Staffs CRHT provided the psychiatric cover from 2pm.

The teams also worked with the street triage services that included a qualified mental health professional who worked alongside the police to provide an immediate assessment of anyone that presented as possibly having a mental health problem.

There were three 136 suites/health based places of safety (HBPoS) in the trust. These were based at George Bryan Centre in Tamworth, Redwoods Centre in Shrewsbury and St Georges Hospital, in Stafford. Patients were brought to the places of safety by police officers if there was concern that they had a mental disorder and should be seen by a mental health professional. Patients were kept in the suites under section 136 of the Mental Health Act (MHA) so that they could be assessed to see if they required treatment. Staff from West and East Wing wards managed the 136 suite at George Bryan Centre. The 136 suite at St Georges hospital was managed by staff rotating from Chesbey and Brockton acute wards, on a monthly basis, between 8am – 8pm. Night cover was provided by staff from Norbury ward, a psychiatric intensive care unit (PICU). Patients were cared for in the HBPoS for up to 72 hours until they could be assessed by a psychiatrist and an approved mental health professional (AMHP).

Our inspection team

The inspection team was led by:

Chair: Vanessa Ford, West London mental health NHS foundation trust

Head of Inspection: James Mullins, Head of Hospital inspections, CQC.

The team that inspected this core service was comprised of a CQC inspector, a psychiatrist, a mental health act reviewer, a social worker and a mental health specialist nurse.

Why we carried out this inspection

We inspected this core service as part of our ongoing 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?

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information. We carried out an announced inspection at the three Crisis Resolution Home Treatment (CRHT) teams at Telford & Wrekin based at Castle Lodge, East South Staffs based at St Michaels Hospital and Shropshire team based at The Redwoods Centre. We also visited the three health based places of safety (HBPoS) run by the trust located at George Bryan Centre, Redwoods Centre and St Georges Hospital to review the quality of the environment and to observe how patients were cared for by staff.

During the inspection visit, the inspection team:

- visited the three patients in their own homes. We observed how staff were caring for patients;
- spoke with 16 patients who were using the service and five of their relatives;
- spoke with one service manager;
- spoke with the four operational leads and one clinical lead;
- spoke with 28 staff members; including doctors, nurses, nursing assistants, student nurses and social workers;
- Spoke with one approved mental health professional;
- Spoke with the one police officer with responsibility of section 136;
- Spoke to one mental health police liaison officer;
- Spoke with one ambulance crew member;
- spoke with two members of the single point of access;
- spoke with three general practitioners;
- attended one case review meeting;
- attended one mental health act assessment;
- attended and observed three handover meetings;
- looked at 12 care records of patients;
- looked at 22 assessment records in the 136 suite;
- carried out a specific check of the medication management in the home treatment teams;
- 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 spoke with 16 patients who used the service and five carers of the patients.

Patients were complimentary about the support they received from the staff and felt staff provided the help they needed. They told us staff treated them with respect, listened to them and were compassionate. Patients said that staff kept them informed and gave feedback about things that had gone wrong.

Most patients told us that appointments ran on time and staff kept patients informed if there were any unavoidable changes. However, three patients reported that staff had not always been on time and they had not been kept informed.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must ensure that the cleaning standards of the clinic room at Telford & Wrekin Crisis and Resolution Home Treatment team are maintained. The clinic room was not clean and had ants, spiders and cobwebs. Cleaning records were not maintained.

Summary of findings

- The trust must ensure that assessments by doctors and approved mental health professionals for patients in the 136 suite are carried out in a timely manner

Action the provider SHOULD take to improve

Action the provider Should take to improve

- The trust should ensure that there is a robust system for learning from incidents in the Telford & Wrekin Crisis and Resolution Home Treatment team.
- The trust should ensure that where there are no clinical grounds to delay assessment, the AMHP and doctor attend the HBPoS within three hours. This is in accordance with best practice recommendations made by the Royal College of Psychiatrists.
- The trust must ensure that there are disabled access facilities in the HBPoS at George Bryan Centre and St Georges hospital.
- The trust should ensure that shower/washing facilities are available for patients at HBPoS

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Telford & Wrekin Crisis Resolution and Home Treatment team	Castle Lodge
Shropshire Crisis Resolution Home Treatment team	The Redwoods Centre
East South Staffs Crisis Resolution and Home Treatment team	Friary Centre
Health Based Place of safety – 136	George Bryan Centre
Health Based Place of safety – 136	St Georges 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.

Training records indicated that staff had received mandatory training in the Mental Health Act, Code of Practice and guiding principles. Staff showed a good understanding of the MHA and the Code of Practice.

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

The AMHP and doctor did not always attend within three hours as recommended in the MHA Code of Practice within the Health Based Place of Safety (HBPoS).

Detailed findings

Staff were aware of how to access and support patients to engage with the independent mental health advocacy when needed. Information on independent mental health advocacy services was readily available to support patients.

Patients had their rights under the MHA explained to them on admission to the HBPoS.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated a good awareness of the Mental Capacity Act 2005 (MCA) and the implications this had for their clinical and professional practice. They could apply the five statutory principles. Training records showed that staff had received training in the Mental Capacity Act.

Staff were clear about their ability to assess mental capacity and able to demonstrate examples of when to use the MHA and the MCA. We found evidence to show that staff followed MCA procedures.

Staff were aware of the policy on Mental Capacity Act and knew the lead person to contact about Mental Capacity Act to get advice.

Staff spoken with demonstrated that they understood the mental capacity act definition of restraint.

AMHP and doctors addressed capacity and consent issues in the Mental Health Act assessments.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

Crisis Resolution Home Treatment teams (CRHT)

Telford & Wrekin, East South Staffs and Shropshire CRHTs

Safe and clean environment

- There were staff in reception areas in each site that controlled access into the buildings. All staff and visitors were required to sign in and out, which provided a record of who was in the building in the event of an emergency.
- Staff did not routinely see patient's onsite. Visits were in patients homes. Staff had access to interview rooms used by the other community mental health teams on site if patients turned up to be seen. In order to mitigate any potential risks, patients who turned up to the offices were seen by two members of staff.
- We reviewed three clinic rooms and found them all secure. All were well equipped with emergency equipment such as automated external defibrillators and oxygen cylinders. Staff checked equipment regularly to ensure it was in good working order. Lockable cupboards were available for the storage of medication. There was a medications fridge and staff monitored temperatures regularly. The level of cleanliness in the clinic room at Telford & Wrekin was poor. Cleaning records indicated last clean was 8 March 2016 but there were no other records available prior to this date. The clinic had ants, spiders and cobwebs. Discussion with staff confirmed that in the last three months staff had raised this but no evidence of any clear actions. We raised this with the operational lead that was aware of the situation. We were told this had been raised with the trusts facilities and estates department.
- The CRHT offices we visited were clean and generally well maintained. The office used by CRHT Telford & Wrekin was not fit for purpose; staff were in a crammed office with insufficient desk space and workstations. The environment was noisy with staff on phone calls and lack of privacy within the working environment.
- Staff practiced good infection control procedures such as hand hygiene to ensure that patients and staff were protected against the risks of infection. There were antibacterial gels suitably located; gloves were available where required and clearly labelled sharps bins were available for staff to carry out on visits.

Safe staffing

- The staffing levels in each team were appropriate ensuring patient safety. Team leads told us they decided on their safe staffing levels, based on, referrals and caseload. The number of staff on the rotas matched the number of nurses, social workers and nursing assistants on shifts and we found that this was consistent.

Team:	Telford & Wrekin;	E. S. staffs;	Shropshire
Est levels: Nurses;	19 ;	16 ;	17
Est levels: HCA's;	5 ;	11 ;	8
Vacancies: Nurses;	0 ;	0 ;	0
Vacancies: HCA's;	0 ;	2 ;	1
Sickness rate:	4.8% ;	3.4% ;	5.5%
Turnover :	7.2% ;	21% ;	6.2%

- The teams had a Band 6 shift coordinator, whose role was to co-ordinate daily activities, communicate specific tasks and interventions to the other staff on the shift in order to maximise efficiency and safety. Shift co-ordinators were mainly office based. The shift co-ordinators reported that at times they were also required to go out on visits.
- Teams did not have an average caseload per care co-ordinator. The shift co-ordinator allocated cases to each individual per shift; case allocation to staff was based upon the most appropriate skill set to meet the individual needs. The shift co-ordinator told us that they allocated the same staff to the same patients where possible in order to provide consistency. The caseloads varied in each team. On 16 March 2016, Telford & Wrekin had 49 patients, Shropshire 31 patients and East South Staffs 13 patients on their caseloads.

Requires improvement

Are services safe?

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

- Staff discussed caseloads and case allocations were regularly assessed in staff handover meetings.
- There were no patients on the waiting list for allocation to staff.
- There were arrangements in place for the use of bank staff to cover staff sickness, leave and vacant posts to ensure patients' safety. The teams used their own staff on bank to cover most of the shifts; agency staff were rarely used.
- Access to psychiatrists varied across the teams. Telford & Wrekin and Shropshire shared the locum psychiatrist and associate specialist between the two teams. Shropshire were recruiting their full-time consultant with interviews scheduled in April 2016. East South Staffs shared their fulltime consultant psychiatrist with the acute wards at George Bryan Centre two days of the week. This was a temporary arrangement in place until the wards had their own psychiatrist. All teams accessed the on call psychiatrists out of hours. Staff said that during out of hours medical staff were available mainly for Mental Health Act assessment or admissions, so relied on general practitioners for prescribing medication.
- The average rate for completed staff mandatory training for Telford & Wrekin was 82%; East South Staffs was 89% and Shropshire 86%; the trust target was 85%.

Assessing and managing risk to patients and staff

- The teams used the Functional Analysis of Care Environments (FACE) risk assessment tool, which meet both Care Programme Approach and Health of the Nation Outcome Scales (HONOS) requirements. All patients in the 12 notes that we looked at had an up to date risk assessment.
- The records reviewed showed that patients had detailed crisis and contingency plans in place that informed staff what to do in the event of a crisis. Staff recorded advance decisions where appropriate.
- We observed interactions to show that staff responded promptly to sudden deterioration in patients' health and initiating contact and treatment accordingly. Staff demonstrated a good understanding of the needs and assessed risks of patients.
- There were no waiting lists in the CRHT teams and staff saw patients quickly, based upon risk. CRHT teams used white boards that staff updated several times a day in order to monitor patients referred to the service. Staff discussed patients' individual risks and personal support plans were reviewed on a continuous basis. The team used a red, amber and green (RAG) rating to review risk for each patient. High-risk patients were highlighted as red, medium risk as amber and low risk as green. Staff discussed risk levels for patients at handover meetings in order to detect any increases and take prompt action. In the 12 sets of notes we looked at, there was evidence of ongoing risk assessments. There were clear guidelines on how staff should respond and address the risks identified. The teams reported the ability to increase the frequency of their visits to up to two or three times a day if the person required an enhanced level of support. We saw from the assessments that people urgently requiring the services had either a face to face contact within four hours or a telephone contact within one hour.
- Training records showed that staff received safeguarding training. This training was updated annually and was monitored on an electronic recording system and overseen by team leads. Staff demonstrated a good understanding of how to identify and report any abuse. There was information about awareness and how to report safeguarding concerns displayed around the team bases. Staff knew who the designated lead for safeguarding was within their teams and in the trust. They knew how to contact them for support and guidance. We found evidence in care records and observed staff in handovers sharing information about safeguarding concerns. Patients and their relatives told us that they felt safe with staff.
- All staff were aware of the lone working policy and told us that they adhered to it. We observed on the day of our visit good personal safety protocols including lone working practice. Staff used the white boards to record their visits. The teams had established systems for signing in and out with expected times of return so that staff knew their team members' whereabouts at all times. Admin staff would contact the police if they were unable to get hold of staff on visits. Staff visited in pairs to see patients with high risk. All staff had work mobile phones and were given a choice to use the phones or the personal alarm devices to call for help if at risk in the

community; however, not all the staff in the teams used the alarms. East South Staffs team had created their own practices in ensuring staff safety on visits; staff would call the office to alert colleagues that they had finished their visit and were travelling to the next appointment. We observed staff calling the office after each visit.

- The teams had appropriate arrangements for the management of medicines. The medicines were appropriately stored in a locked cabinet in the clinic rooms. Staff consistently recorded the room temperatures of the clinic rooms. There was a safe and secure transportation of medicines procedure that was followed; staff used locked cases to transport medication to patients. Medicines stocks were consistently checked. We saw that medicines were safely stored and staff recorded when they removed medicines from patients' homes for safe disposal. Where staff supported patients to take their medication, this was clearly documented within care notes and followed-up.

Track record on safety

- Between March 2015 – March 2016, there were eight serious incidents (SI) reported within the core service. Five of the serious incidents occurred in the East South Staffs team; two in the Telford & Wrekin team and one in the Shropshire team.
- Changes in practice following SI's were evident. An action plan was formulated from the SI's in the East South Staff team where all discharges were to be a team decision; no single member could discharge patients from the caseloads. Another change implemented in the team, was that patients were to be followed up by band 6 nurses within 48 hours post-discharge from hospital. Prior to the incident where a patient had been discharged from hospital committed suicide, follow ups were completed by band 5 nurses.

Reporting incidents and learning from when things go wrong

- Between March 2015 – March 2016, there were 18 incidents reported by the Telford & Wrekin team, 14 incidents by the Shropshire team and nine by the East South Staffs team. The main theme highlighted from the incidents in the Telford &Wrekin Team was staffing levels. Changes were made to increase staff levels. A review of staffing then took place to ensure that temporary/secondment posts were formalised into permanent contracts.
- Staff were aware of the reporting system for incidents. Individual staff reported incidents via an electronic reporting form on their safe guard system. Staff that we spoke with knew how to recognise and report incidents through the reporting system.
- We saw that all the CRHT leads met on a monthly basis in their business meetings. Leads discussed improvements in safety at the meeting. Staff in East South Staffs met every two weeks for team meeting to discuss learning and themes. We saw evidence in team meeting minutes to suggest that both East South Staffs and Shropshire teams were discussing learning from incidents across the trust and locally in their respective team meetings. However, from examining supervision records and the team meeting minutes of the Telford & Wrekin team there was no evidence to suggest that they were discussing learning from incidents even though "learning the lessons" was on the team meeting agenda. Five staff spoken to confirmed that they did not discuss any lessons learnt from incidents. This suggested that there was no clear evidence of a robust formal process for the team to discuss learning and themes.
- Staff were open and transparent and explained to patients when something went wrong. Staff had good understanding of the Duty of Candour. Incidents were discussed with patients and their families. We saw that the East South Staffs had written letters of apology to patients and their families were things had gone wrong. Patients told us that staff had informed patients and given them feedback about things that had gone wrong.
- Staff debriefs and support varied across the teams following a serious incident. All staff from Telford and Wrekin team told us that only those staff involved in the incidents were offered appropriate support. Staff that had not been directly involved in incidents told us and we saw from their team meeting records that they had not been offered the support. Whereas this differed in the East South Staffs team, where all staff told us they were all offered debrief and opportunity to reflect following incidents. We reviewed team meeting records

that evidenced debrief sessions had been offered. The team met for clinical group supervision lead by the psychiatrist monthly. This helped staff look at how they might improve their practice following incidents.

Health Based places of Safety

George Bryan Centre, St Georges Hospital and Redwood Centre 136 suites

Safe and clean environment

- In the three HBPoS, we visited; there was a clear difference in the quality of the physical environments between the place of safety in the Redwoods Centre and the other services. The Redwoods was a newly purpose built facility with a separate entrance for section 136 admissions. There was a room with a built in bed where the detained person could rest within a separate sitting area. There was a separate toilet and an office area for staff. Staff used the office area to make phone calls and for the approved mental health practitioners (AMHP) and doctors to review clinical records and hold clinical discussions.
- The HBPoS at St Georges and George Bryan Centre were adapted older facilities. The rooms were not sufficient in size to comfortably accommodate staff to assess the patient.

The rooms appeared cramped for the number of staff based in those rooms. The lack of space in both the hallway and the sitting area would impact on the ability of staff to safely carry out physical interventions if required. This would pose risks to both patients and staff if the use of restraint were required. There were environmental risks identified; these were mainly ligature points on the toilet, taps and door handles. We saw that there were ligature risk assessments in place for identified potential risks. Staff reduced risks by constant observation of the patient. This had an impact on peoples' privacy and dignity when using the facilities.

- Staff working within the three HBPoS were issued with personal alarms which were linked to the associated ward and part of the overall emergency response process.
- The Redwoods centre HBPoS had access to a fully equipped clinic room within the 136 suite. St Georges and George Bryan Centre HBPoS' had access to a clinic rooms on the wards where resuscitation and emergency equipment was located. Portable appliance tests were carried out for any equipment used. It was checked regularly to ensure it continued to be safe to use and clearly labelled indicating when it was next due for service.
- Furniture in the Redwoods and George Bryan Centre was heavy duty, wipe clean finish and in good condition. At St Georges, the furniture was not fit for purpose; the sofa was not a wipe clean finish, which could influence infection control. The chairs and table were not fully appropriate for HBPoS because they were not sufficiently weighted and therefore unsettled patients could use them as weapons.
- The HBPoS locations we visited were visibly clean and generally well maintained. We looked at cleaning records and found they were up-to-date and maintained daily on the wards. The HBPoS' were assessed as part of the in-patient wards, scoring relatively well in recent patient-led assessments of the care environment (PLACE) annual assessment. The PLACE scores in relation to cleanliness were below the England average by 0.6%. For example, PLACE results from 2015 showed scores for St George's hospital were 96%; George Bryan Centre 98% and Redwoods Centre 98% respectively. The trust average was 97%.

Safe staffing

- The trust worked with commissioners to review safer staffing levels for the HBPoS. The trust had increased ward staffing establishment in order to appropriately staff the places of safety. We were informed that that there are always staff allocated to cover the HBPoS when required. If HBPoS was not in use, the staff would be working on the wards. We were informed by the managers that they do not use agency staff in HBPoS. However, on reviewing incident reports we found that in January 2016 two agency staff were working in the HBPoS at St Georges Hospital. The trust could not provide us with the number of shifts covered by agency staff in HBPoS.
- We saw evidence in rotas where specific staff were identified for the HBPoS. All the sites were managed by the hospital co-ordinator who received the initial call if a patient was being taken to the 136 suite and allocated staff from the wards. Qualified staff from West Wing and nursing assistants from East wing wards supported

Requires improvement

Are services safe?

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

George Bryan HBPoS; St Georges Hospital HBPoS was supported by staff rotating from Chesbey and Brockton wards on a monthly basis between 8am - 8pm. Night cover was provided by staff from Norbury ward. The Redwoods Centre was supported by the hospital co-ordinator along with a nursing assistant rotating from the wards. The trust ensured that the HBPoS was always staffed when needed. Police told us that they were never left alone with patients in the 136 and they were able to leave at the shortest possible time.

- Rapid access to psychiatrists was available when required. On call doctors, attended HBPoS for initial physical checks. Section 12 assessing doctors could be accessed by the AMHPs if needed for MHA assessments.

Assessing and managing risk to patients and staff

- The police notified the ward by telephone when they were transferring a patient to the HBPoS. This meant that the nurse would be able to prepare the room and check records for any available information. A registered nurse and nursing assistant would welcome the patient. Once admitted to the HBPoS, the police would stay to handover information about the patient and would leave after approximately 30 minutes to an hour. Nurses and police carried out a joint assessment of safety and risk. Staff reported they were able to call the police back if they felt they were unable to manage any violence or aggression.
- Patients remained on constant observations throughout the time they were detained in the HBPoS. The HBPoS were staffed with two staff at all times. We saw evidence of this this in practice at the Redwoods and George Bryan Centre.
- Staff had received training in safeguarding vulnerable adults and children. Staff we spoke with knew how to recognise a safeguarding concern. Staff were aware of the trusts safeguarding policy and knew how to raise safeguarding concerns.

Reporting incidents and learning from when things go wrong

- Between March 2015 and March 2016, there were four incidents at George Bryan Centre, 27 at St Georges and 69 incidents at the Redwoods Centre. The themes emerging from the incidents were two patients requiring the use of the 136 at the same time, patients that exceeded 12 hours before assessment and delays to deploy staff to the 136.
- There were monthly inter-agency meetings, which discussed many shared issues between the police and the trust; including sections 135 and 136. Any significant incidents were reported in the meeting and investigated. Staff told us that when there were concerns they could escalate them to their managers who fed any issues back to the meetings. An example of what was escalated was of individuals being bought to the HBPoS without police escort and the appropriate 136 paperwork. Staff told us that team leads fed back the findings from investigations in team meetings and supervision sessions.

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

Crisis Resolution Home treatment Teams

Telford & Wrekin, East South Staffs and Shropshire CRHTs

Assessment of needs and planning of care

- We found that urgent referrals to the teams were prioritised and assessment carried out within the four-hour target time. Between March 2015 and March 2016, teams met this target by 92%.
- We looked at 12 patient records across Telford & Wrekin and East South Staffs teams; ten of the records had up-to-date care plans and contained review dates that were holistic, recovery orientated and personalised. Care plans showed evidence of the involvement from people who use services and staff gave patients a copy of their care plan. Only two records did not address the needs identified in the assessment stage and lacked clear guidelines on how staff should support patients to meet their needs. In the Shropshire team, staff used carbonated care plans where they would complete care plans with the patient and leave the patient with a copy of the agreed and signed care plan.
- All the teams used the electronic RiO system. The teams also kept a paper copy of patient demographic details in order for staff to continue carrying out their visits even if the system failed or was slow. This information was stored securely in locked cabinets. Staff described that there were instances where they had difficulty logging on to the system and the system crashing. We observed instances of this happening during the inspection.

Best practice in treatment and care

- Staff followed National Institute for Clinical Excellence (NICE) guidelines when prescribing medication.
- Patients who required longer-term psychological therapies were directly referred to Improving Access to Psychological Therapies(IAPT) services. Staff were able to offer brief Cognitive Behavioural Therapies (CBT) as part of the treatment.
- East South Staffs and Telford & Wrekin teams had social workers who were also AMHPs allocated to them on a full time basis. Support for employment, housing and benefits would be addressed either by the staff or by their care co-ordinator in the community mental health team. Health of the Nation Outcome Scales (HONOS) was used primarily to ascertain care clusters for individuals. HONOS ratings determined future patient care pathways and treatments.
- The physical healthcare needs of patients within the CRHTs were routinely addressed. We saw that in each of the teams, they had physical health bags where staff carried them on home visits and monitored physical healthcare issues. The bags contained measuring and monitoring equipment that included blood pressure machines, glucose monitoring equipment and thermometers. Teams worked closely with general practitioners in feeding back any concerns.
- Staff carried out a range of clinical audits to monitor the effectiveness of the service provided. Operational team leads showed us audit records that included patient group directives (PGD), caseloads, care planning and risk assessments. Team administrators also carried out audits for referrals, discharges and response timescales. The teams used the findings to identify and address changes needed to improve outcomes for patients. We saw an example of improvements in the work being piloted by the East CRHT that included the creation of care documents specific to crisis teams, held within RiO for clinicians to access robust crisis plans for patients at visits and assessments. The East CRHT were also piloting a new information pack designed for carers.

Skilled staff to deliver care

- The teams had access to a range of mental health disciplines required to care for the patients. They included psychiatrists, nurses, support workers, occupational therapists, admin support workers, business support officers and social workers.
- When we looked at training records and spoke to staff, we found that staff were suitably skilled and qualified to carry out their work. All of the teams included staff that were trained as supplementary prescribers, with further evidence of other staff currently undertaking this training. We saw evidence of other staff on the training. Staff were trained to carry out venepuncture, physical health checks, baseline observations blood pressure, heart monitoring, oxygen saturation, temperature and urine testing.

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.

- Nurses were trained in patient group directions(PGD) in prescribing medication. PGDs were written instructions for the supply or administration of medicines by nurses to groups of patients who may not be individually identified before presentation for treatment. The trusts pharmacists had provided specialist training in PGDs for nurses. Nurse prescribers in the teams were the leads in PGDs; they audited and monitored stocks. Staff were only allowed to administer maximum three days' worth of medication and followed the trust policy guidance. The teams also used standard trust community prescriptions issued by consultant psychiatrists or general practitioners.
- New staff had a period of induction, which involved shadowing experienced staff before they were included in staff numbers. We saw an example of a recently appointed operational lead in the Shropshire CRHT on induction for three months whilst shadowing the operational lead from another team.
- The trust required all staff to undertake line management supervision every six to eight weeks but we found that teams did not consistently follow this. In nine out of the 10 supervision records reviewed at the Telford and Wrekin team, staff were not being consistently supervised. Team leads informed us that they were addressing this. The Shropshire CRHT were up to date and consistent with all staff supervision.
- The trust had implemented a Performance and Development Conversation (PDC) appraisal system. The percentage of non-medical staff that received PDC appraisal in the last 12 months at Telford & Wrekin was 77%, East South Staffs 71 % and in the Shropshire team 93%. The trust target was 85%.
- Teams monitored and measured performance using the trust wide Key Performance Indicators (KPI) and the performance scorecard. This meant that team leaders addressed poor team and staff performance promptly and effectively. All operational leads were aware of the procedures to follow and were able to competently describe what actions they would take when poor staff performance was identified. There were no staff performance issues identified at the time of the inspection.

Multi-disciplinary and inter-agency team work

- The teams we inspected had regular monthly team meetings. Staff we spoke with felt well supported in their teams.
- The CRHT teams were responsible for gatekeeping 100% of all inpatient beds, which they managed effectively across all teams. The teams maintained close working links with the community services and inpatient services, which enabled this high level of gatekeeping.
- The teams worked well with other services in the trust to ensure a seamless pathway of care for patients. They had developed strong working relationships with other community mental health teams and effectively shared information regarding patients who moved between services. We found that the teams were based in the same buildings with other community teams such as the Single Point of Access (SPA) team, adult community mental health teams and trusts Approved Mental Health Professionals (AMHP) teams. This meant that there was effective sharing of information and smooth transition of care.
- We observed three staff handover meetings across the teams. Staff were professional and shared information around patients' care, treatment, progress and risk. We observed good practice in the handover in the Shropshire team where all the staff on duty had access to RiO notes on their laptops. There were robust discussions and staff followed through the patient updates. However, only three patients out of a caseload of 20 home treatment patients were discussed in the afternoon handover in the East South Staffs team. Telephones ringing and people walking in and out of the office, talking and disrupting the handover, caused disruption.
- The teams had access to the trusts (AMHP) should they need to request a Mental Health Act assessment. We observed staff organise a Mental Health Act assessment where there was liaison with the AMHP and RAID teams.
- Clinical staff referred patients to the teams' Occupational Therapist (OT) following the initial assessment if staff identified that there was a need for their input. OTs wouldhelp patients with mental, physical or social disabilities to independently carry out everyday tasks or occupations.
- CRHT teams maintained contact with general practitioners, the police, housing groups, such the

Are services effective?

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Salvation Army Kip Project and other voluntary agencies. We spoke to the general practitioners linked in with the teams and they described a good working relationship. General practitioners were kept fully informed once they had referred a patient up until the point of discharge.

- Staff had access to general practitioner notes. We observed staff liaising with the general practitioners on blood tests and monitoring titration of medication.
- There was a suicide risk screener used by A and E staff. CRHT staff were involved in providing training to the A and E staff to use the suicide screening tool.
- The trust had two mental health police liaison officers from West Mercia and Staffordshire police who worked with the trust to co-ordinate care and treatment of people who made contact with the police and the trust. This had led to improved information sharing and good working relations between each organisation.

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

- Training records indicated that staff had received mandatory training in the Mental Health Act, Code of Practice and guiding principles. Information provided by the trust showed that 94% of staff in East South Staffs, 82% of staff in Telford & Wrekin and 90% of staff in Shropshire had received the training. Staff demonstrated a good understanding of the MHA and the Code of Practice.
- Information about independent mental health advocacy services was readily available within the teams. Staff across all teams demonstrated an awareness of how to access the advocacy services for their patients.
- CRHT teams did not specifically carry out MHA audits within the teams. Staff had access to the trusts MHA lead within the mental health act administration team for advice and support.

Good practice in applying the Mental Capacity Act

- Information provided by the trust showed that 86% of staff in the East South Staffs, 93% of staff in the team in Telford & Wrekin and 76% of staff in the Shropshire team had received training in applying the MCA. Understanding of the MCA was embedded within the teams; staff we spoke to all demonstrated a good understanding of the guiding principles of the act and how it affected their work with the patients they supported. Information on the MCA was also displayed within the teams' offices.
- We saw evidence of patients' capacity recorded appropriately in the notes we reviewed. We also observed discussions in handovers where capacity was being reviewed. Staff told us how they ensured they tested capacity when appropriate, recognising the importance of the persons wishes, feelings, culture and personal history.
- Staff told us that if they had any concern around capacity issues, they would discuss the matter within their teams in the first instance and then with the MCA lead from the mental health act administration team. The mental health administration team provided face to face adapted training for specific service areas where requested or where a concern was noted over practice.

Health Based places of Safety

George Bryan Centre, St Georges Hospital and Redwood Centre 136 suites

Assessment of needs and planning of care

- Nurses would immediately contact the AMHP once patients were admitted to the HBPoS. The AMHP would ensure they had two section 12 approved doctors to carry out the MHA
- Records relating to assessments in the HBPoS were maintained on RiO the trust wide electronic patient record system. Staff from any of their base locations could access the information. All reports were directly entered or scanned into the trusts electronic RiO system.

Best practice in treatment and care

- A clear assessment and physical health check was undertaken on arrival to the HBPoS by the accepting nurses and hospital duty doctors. If a patient required physical health intervention, the patient was transferred to accident and emergency by ambulance.

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.

- Patients who were being assessed in the HBPoS were provided with information explaining their rights under section 136. This ensured that patients understood where they were, what was happening to them and what the process was.

Skilled staff to deliver care

- Training on section 136 of the MHA was not covered in the trusts' mandatory training schedule, however the staff that worked on the acute wards and as such covered the suites were given were given an opportunity shadow experienced staff who had experience of working in the 136.
- It was a trust requirement that all staff who worked within the HBPoS maintained a working knowledge of the MCA and the Children Act 2004 and as such were given regular updated training. Staff training was monitored during supervision.

Multi-disciplinary and inter-agency team work

- A multi-agency group consisting of representatives from the trust, police, ambulance and local authorities met on a bi-monthly basis to discuss good practice, learning and to ensure effective partnership working. There was a joint inter-agency policy in place for the implementation of section 136 of the MHA; the trust, the local authority, the police and the ambulance service had agreed this. Managers told us they had a strong commitment to multi-agency working and when difficulties occurred, they worked proactively to resolve them. Where there had been incidents or disagreements between agencies; they were discussed within this forum.
- During our inspection, we saw effective inter-agency working in assessing and supporting those patients detained under section 136 at the HBPoS. Staff reported good working relationships with the police and with local AMHPs. However, despite links with the police in the operation of section 136 being good, staff reported that out of hours emergency duty team (EDT) would not refer to the AHMP until working hours. This was predominately an issue if any patient was referred after 10pm. This in turn meant that patients were left waiting in the HBPoS for long hours, prior to an assessment. During this time staff maintained continuous observations. Staff reported difficulties in maintaining the continuous observations for long periods when there were other observations on the ward taking place at the same time. Staff would report these as incidents.
- Staff could access their RiO system and liaise with the police as soon as calls came in. Data collation was not yet integrated between the agencies.
- The Police officer that we spoke with praised the role of street triage in reducing the use of section 136. The trust and police did not yet formally evaluate these figures.

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

- Staff had a good understanding of their responsibilities and duties when people were admitted under section 136 of the MHA; they ensured that they followed the Act, the Code of Practice and the guiding principles.
- Through our observation of practice, review of records and discussion with staff, we saw evidence that patients on section 136 or 135 had their rights explained. Patients and were given a copy of their rights.
- Patients had access to an independent mental health advocate (IMHA) in the HBPoS. Information about advocacy and independent mental health advocacy services (IMHA) was available to patients.
- Monitoring forms were used to record standard information about a patients' admission to the HBPoS. This information was to include the start and end times of the detention period. We looked at 22 forms in total. In seven cases, this information was missing; therefore, it was not possible to decide if these patients stayed in the HBPoS for longer than the legal limit of 72 hours. Only 13 of the forms were fully completed.

Good practice in applying the Mental Capacity Act

- Staff demonstrated a good awareness of the Mental Capacity Act 2005 (MCA) and the implications this had for their clinical and professional practice. They had received training on the MCA and had access to e-learning so they could update their knowledge. Staff were clear in their ability to assess mental capacity and were able to give examples of when to use the MHA and

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.

the MCA. Staff told us that if they had any concern around capacity issues, they knew how to access the MCA lead from the mental health act administration team.

- The Mental Capacity Act 2005 is not applicable to children under the age of 16. Staff demonstrated no knowledge of Gillick competence and confirmed that they had not received the training. Gillick competence is used for children under 16 to balance children's rights and wishes with the responsibility to keep children safe from avoidable harm. Between April 2015 - March 2016 there had been seven children under 16 admitted to the HBPoS across the trust. Staff informed us that of all the seven admissions none of them triggered Gillick competence. If specialist advice was needed, they would contact to CAMHS specialists.
- We noted from the records that staff were considering patients capacity in most cases. In one case, we found an excellent record of a patient's capacity assessment who had been discharged into the community where their wishes and beliefs had been clearly taken into account.
- Between March 2015 and March 2016, there were five restraints reported across the HBPoS. Four of the restraints occurred at the Redwoods Centre and one at St George's hospital. Three of the restraints related to staff assault. Staff spoken with demonstrated that they understood what type of actions staff viewed as restraint and knew situations when it was the right thing to do. Staff understood the MCA definition of restraint. Staff were clear on seeking support from the police if they felt they were unable to manage a violent or aggressive patient.

Good

Are services caring?

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

Our findings

Crisis Resolution and Home Treatment team

Telford & Wrekin, East South Staffs and Shropshire CRHTs

Kindness, dignity, respect and support

- Staff treated patients who used the service with respect and communicated effectively with them. They showed the desire to provide high quality and responsive care. We observed kind and respectful interactions between staff and patients.
- We spoke with 13 patients and 5 carers of patients who used the CRHT teams; either during our inspection or subsequently over the phone. All were very positive about how staff behaved towards them. Patients told us staff treated them with respect, listened to them and were compassionate.
- Some patients told us that they saw different staff at each visit. However, staff were well informed about the patients' particular needs and reasons for referral to the service. This meant that patients did not feel they were repeating their story on each occasion. Patients on home treatment knew which staff would be visiting prior to each visit.
- All the teams had a comprehensive welcome pack given to patients on their first or second visit. The packs provided a variety of information on the available resources and how to access them. Information on how to make a complaint, what to do if they needed more support or were not happy with their level of care and advocacy support groups, was also readily available.
- When staff discussed patients in handover meetings or with us, they discussed them in a respectful manner and showed a good understanding of their individual needs.
- Staff recorded when they had received a patients consent to share information with family and carers and they respected this. Consent was discussed in team handover meetings so the staff were clear about whom they could and could not share information with. They were aware of the requirement to maintain confidentiality at all times.

The involvement of people in the care they receive

- Patients told us they were involved in their care and treatment and were aware of their care plans. The Shropshire team had adopted using carbonated care plans and ensured that they left their patients with copies as soon as the care plan had been completed.
- Patients we spoke with felt that their mental health had improved because of the service they received.
- Information was available for patients on access to advocacy.
- Patients were involved in the recruitment of staff; we were shown examples of interview panels that patients had sat on for the recruitment of a consultant psychiatrist.
- The trust used user experience surveys to obtain feedback from patients. A bespoke questionnaire was developed specifically for the CRHT teams to use within the patient experience electronic system, which was implemented during March 2016. This was to ensure information collected was relevant to the CRHTs.
- East South Staffs and Shropshire teams developed an additional process of gathering feedback. Following visits with service users, the feedback was displayed on a board in the office to inform the team of any negative or positive comments that have been made informally.

Health Based places of Safety

George Bryan Centre, St Georges Hospital and Redwood Centre 136 suites

Kindness, dignity, respect and support

- The staff across the HBPoS explained to us how they attempted to build a rapport with the patient as soon as they could engage. We witnessed patients becoming less anxious and agitated once released from the custody of the police and staff supporting them to relax.
- One patient, who had been brought to the HBPoS on section 136 at George Bryan Centre, said that the staff were very professional and that they had been treated well. They told us the police had brought them in to the HBPoS at around 11pm and the patient was not seen by the AMHP until around 2.30pm the next day. They told us that, the staff had treated them with respect and dignity.
- Mental Health Act assessments took into account, as far as possible, patients' perspectives and information received from nearest relatives.

Good

Are services caring?

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

- Access of the HBPoS at George Bryan Centre was not suitable for the purpose for which it was being used. Patients walked through the acute ward to access the suite. It compromised patient safety, privacy, dignity and confidentiality of both the patient being taken in and the patients already on the ward.

The involvement of people in the care they receive

- The HBPoS at George Bryan Centre and Redwoods Centre were in use during our inspection. We spoke to a patient using the facilities who told us that since being admitted they felt safe and fully informed by staff in the hospital.
- There was some involvement of carers following patient consent. Carers were allowed to sit with their relatives whilst waiting for the assessment. Staff reported that this at times assisted in settling the patients in the HBPoS.
- Information was available for patients who used the HBPoS on access to advocacy.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Crisis Resolution Home treatment Teams

Telford & Wrekin, East South Staffs and Shropshire CRHT teams

Access and discharge

- Access to the CRHT teams was by referral from the patients' general practitioner, community mental health teams, SPA team, accident & emergency departments or other professionals. The teams will provide services to patients who had been assessed using the care cluster allocation tool.
- The teams met the key performance criteria by 92% in the last 12 months. This meant that most crisis referrals were contacted by telephone within one hour and face-to-face contact within two hours. An assessment would take place within four hours. Where teams had not achieved this, staff would communicate the reasons for delay and a plan documented.
- Out of hours, the teams would see patients from 16 year olds. Some staff described this as a challenge especially if they were unable to get child and adolescent mental health (CAMHS) psychiatrist to assess the patients with them. The CAMHS service in Shropshire and Telford & Wrekin is provided by a different Trust and uses a different electronic records system; this caused a challenge at times for staff accessing appropriate information. Staff told us that in most cases the CAMHS patients were offered a bed in the children's ward at the general hospital until the CAMHS staff were available to assess.
- Staff told us that they responded to a number of telephone calls from patients who used services regularly throughout the day and night. We observed a telephone call between a member of staff and a distressed person that staff managed sensitively and professionally.
- Following a referral, we observed that patients were given a degree of choice in the times of appointments on the first contact by the team. Staff would call their office base to arrange the next visit with a set time for their patients. We spoke with 16 patients who used the service and five carers of the patients. Most patients told us that appointments ran on time and staff kept them informed if there were any unavoidable changes. However, three patients reported that staff had not always been on time and staff had not kept them informed.
- All CRHT teams took a proactive approach to managing patients who did not attend appointments. We saw evidence that where there had been a failed visit, staff would repeat visits and consider options prior to requesting a welfare check from the police. Staff told us of cases where they would ask the police to accompany them on a home visit if they were concerned for the welfare of a patient.
- There were two band 4 bed managers in the East South Staffs and Shropshire teams. They had the responsibility of managing and gatekeeping all the adult acute beds across the trust including repatriation of patients who had been placed out of area. They liaised daily between the hours of 9am and 5pm with inpatient services to identify and manage available beds. Their responsibilities included organising transfers to and from out of area placements. We saw a system in place where the trust beds were rag rated daily. Bed managers would always try to find a bed in the trust first before going elsewhere. Bed managers would redirect clinical enquiries to the qualified nurses in the teams.
- East South Staffs and Shropshire teams had access to crisis houses as an alternative to hospital admission. The crisis houses provided short-term intensive support for individuals experiencing psychological or emotional distress. The East South Staffs team had access to Brendon house, in Cannock; Shropshire teams accessed Path House in Ludlow and Oak Paddock in Shrewsbury. The teams felt they had a good relationship with the crisis houses. They managed and gate kept the admissions from the trust.
- Discharge arrangements from the CRHT teams were discussed at the earliest opportunity so patients were clear that the service was a short-term crisis support measure. This meant that patients and their families were clear about the discharge process from the early stages of the involvement. Staff gave all patients a discharge plan. The teams worked well with staff in other teams and services to ensure a smooth transition for their patients.

The facilities promote recovery, comfort, dignity and confidentiality

Are services responsive to people's needs?

Requires improvement

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

- Most patients were seen in their own homes and not in office bases. The teams had facilities to see people in their premises if patients did present at the team offices.

Meeting the needs of all people who use the service

- The teams had a wide range of information leaflets available in English within each team base. Leaflets were available which gave patients and carers information on some mental health problems for example managing depression, details of services available, medicines, complaints process and service feedback. Staff told us that leaflets in other languages could be made available when needed.
- The teams had facilities with disabled access to see people in their premises if patients did present at the team offices.
- The teams had access to interpreters when needed.

Listening to and learning from concerns and complaints

- There were four complaints for the CRHTs during the 12 months prior to our inspection; one of which was upheld. None had been referred to the parliamentary health services ombudsman.
- The teams welcome packs we looked at contained a guide that informed patients who were using the service on how to complain. Staff told us that they knew how to handle complaints and that they would try to address patients' concerns informally within their teams as they arose.

Health Based places of Safety

George Bryan Centre, St Georges Hospital and Redwood Centre 136 suites

Access and discharge

- All ages were accepted in all the trusts HBPoS. The only exclusion criterion was significant risk of violence. If a patient was physically unwell, they would be taken to accident and emergency first and then brought to the place of safety after any treatment. We saw good practice on the involvement of the child and adolescent mental health service (CAMHS) with a young person admitted to the HBPoS in Redwoods Centre.
- The police notified the staff by telephone when they were transferring a patient to the HBPoS. This meant that the nurse would be able to prepare the room and check records for any available information. The patient would be welcomed by a registered nurse and nursing assistant.
- Each of the HBPoS could take one person for assessment at a time; when HBPoS were in use, patients were redirected to A&E as a place of safety. The trust had developed strong working relationships with the police. This helped in reducing and monitoring the numbers of patients assessed in police cells. Trust data showed that between April 2015 and March 2016; only one person was taken to the police cells.
- Information from the trust showed the AMHP and section 12 approved doctors did not always attend the HBPoS for assessment within three hours. This was not accordance with best practice recommendations made by the Royal College of Psychiatrists and as recommended in the MHA Code of Practice. We were told that this was happening mainly out of hours when emergency duty team (EDT) were providing cover. Trust target times had been set to three hours; during the inspection, we saw patients in the HBPoS kept for up to 15 hours. In the records we reviewed; 98 out of 162 assessments did not meet the three hour requirement across the HBPoS in the past 12 months.
- During the week of our inspection, the trust had closed Redwoods HBPoS to all admissions in order to accommodate a patient with complex needs whilst a suitable placement was sought. We were able to make further visits once they re-opened. The trust had made the required refurbishment changes in the suite so that it could be open once again. Staff told us that during the brief closure, patients had been redirected to Shrewsbury A and E and or other HBPoS within the trust. Staff informed us that the temporary closure did not disrupt services.
- Staff reported that the street triage (which operated from 3pm to 2am) had reduced the demand for the HBPoS. This was because the service was able to intervene, signpost and arrange an alternative outcome at an early stage.

The facilities promote recovery, comfort, dignity and confidentiality

Are services responsive to people's needs?

Requires improvement

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

- The facilities in the Redwoods Centre were modern and comfortable. Patients could use the two rooms provided to sit, walk, rest or sleep comfortably during assessment.
- There was no access to fresh air for patients in the HBPoS at St George's hospital. The hospital grounds were a no smoking area. However, we observed good practice were a patient using the facilities had requested to smoke and the staff had the on call doctor prescribe nicotine patches as an alternative.
- There were no shower facilities in any of the HBPoS. Staff told us they were able to use ward facilities if they needed. The toilets had no disabled access or facilities.
- There was no clock visible in to help avoid disorientation in time in any of the two HBPoS at George Bryan Centre and St Georges hospital. However, the trust told us that they ordered several clocks the week of our week of our inspection to address this. On a further visit to the HBPoS we noted that the trust had still not provided a clock at George Bryan Centre. Both suites had an examination couch and the sofa that would not be suitable for a patient to sleep on comfortably.
- There was no television or radio access therefore no form of entertainment in the HBPoS at the George Bryan Centre.
- All three HBPoS had access to refreshments such as hot, cold drinks and meals.
- There was accessible information for patients. They were given leaflets on their rights and how to make complaints.

Meeting the needs of all people who use the service

- Redwoods had a disabled accessible toilet with rails to assist patients with mobility issues. Staff told us they considered the risk to patients from these ligature points prior to allowing them to use the toilet unsupervised. However, there were no disabled accessible toilets at the George Bryan Centre and St Georges sites.
- Staff confirmed that they had access to translation services and interpreters where required.

Listening to and learning from concerns and complaints

- There was one complaint for the HBPoS during the 12 months prior to our inspection. This related to a patient not being given information on being sectioned and how long they would be held for. We saw in practice and were told that patients were given leaflets on their rights and Patients advice liaison service (PALS) leaflets on how to make complaints or provide service feedback. There were PALS posters displayed in the HBPoS at St Georges.
- Staff told us they tried to address patients concerns informally as they arose. Staff we spoke with were aware of the formal complaints process and knew how to handle them appropriately.

Are services well-led?

Good

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

Our findings

Crisis Resolution Home treatment Teams

Telford & Wrekin, East South Staffs and Shropshire CRHTs.

Vision and values

- Staff we spoke with were aware of the trusts vision and values. These were displayed in the services we visited.
- We saw team values displayed in the services we visited. Specific team objectives were in line with the trust vision and values.
- Staff knew their immediate line management structure up to the services manager and felt well supported within that structure with regular monthly business meetings. The services manager was accessible based themselves at each of the team sites throughout the week. Staff knew and had met their chief executive.

Good governance

- Staffs received mandatory training. The average rate for completed mandatory training for all CRHT's was 85%, trust target was 85%.
- Staffs appraisals clearly identified areas for development, career progression and they were supported in achieving their objectives.
- Good governance arrangements were in place locally, which supported the quality, performance and risk management of the services. Key performance indicators and other indicators were used to gauge the performance of all the CRHT teams. Team leads provided data on performance to the trust consistently. All information provided was analysed at team and directorate level to identify themes and this was measured against set targets. The teams captured data on performance such as referral time response, discharges, appointments and patient clusters. The performance indicators were discussed at monthly business meetings. The information was used as a way of improving performance in some areas identified. Service leads meet on a monthly basis where feedback was discussed and information then cascaded to individual teams to share learning. Staff were also congratulated on the areas where they performed well. The feedback was also included in an overall quarterly report to the Quality Governance Committee.
- Safeguarding, MHA and MCA procedures were followed and we saw that staff had a good understanding of application the principles in practice.
- Team leaders from across the services had monthly meetings to discuss issues. This provided an opportunity for learning and sharing of information across the middle management structure.
- There was evidence in the team meeting notes of discussions of incidents with staff in the East South Staffs and Shropshire teams. Staff received feedback following complaints and compliments. We saw evidence of these displayed at the team basis.
- Operational leads told us that they had enough time and autonomy to manage the services and administration staff to support the teams. They also said that, where they had concerns, they could raise them. Operational and team leads were respected by their teams and valued by the service manager.
- Team leads confirmed they could submit items to the risk register. There were local risk registers in place for all the CRHTs. They also said that, where they had concerns, they could raise them. Where appropriate the concerns could be placed on the trusts risk register.
- The teams used champions for areas such as safeguarding, physical healthcare, PGDs, carers, team educator, care cluster, risk management, drug and alcohol and mental capacity. Staff were clear on whom to get support from in these areas if required.
- Clear policies and procedures were in place to protect both staff and patients. Staff demonstrated a clear understanding of the key policies such as safeguarding, lone working and medication management.

Leadership, morale and staff engagement

- Staff we spoke with knew how to use the whistleblowing process they expressed they would feel confident to raise any concerns. The trust had a 'Public Interest Disclosure Policy' (PIDP) in place and staff were aware of it. The policy was available on the trust's website, ensuring that staff had a proper and widely published procedure for voicing their concerns. East South staffs gave us an example of where a PIDP had been raised and how the team was supported as a result of the concerns raised.

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.

- There were no bullying and harassment cases we were made aware of during inspection week. Staff said there was no culture of bullying within their teams and they felt empowered to raise concerns in the workplace if and when bullying occurred without fear of victimisation.
- The sickness rates in the 12 month period for the East South Staffs were 3.4% and Telford & Wrekin 4.8%. Both below the trust average of 4.8%. Shropshire was 5.5%. Where teams had high levels of sickness, team leads managed this effectively via the appropriate trust Human Resources policy.
- We observed good morale in the teams. Staff were all positively engaged in individual patient discussions. However, some staff told us they only had contact with senior managers when things had gone wrong. They had not received positive feedback when they had worked under pressure and done a good job.
- Team leads told us they promoted an atmosphere of transparency and candour. They did this by following the policy. Staff were open and transparent and explained to patients if and when something went wrong. Staff had good understanding of the Duty of Candour.
- Staff told us they were proud of the job they did and felt well supported by their team leads in their roles.
- Staff were offered the opportunities for clinical and professional development courses. There were promotional opportunities from bands 3 to 6. For example, band 3 support workers have a career progression pathway to band 4. The trust supported support workers to start nurse training. We saw band 5 nurses acting up in to a band 6 position. However, one member of staff told us that there were very limited opportunities for career development beyond band 7.
- Complaints, compliments and concerns were raised through the Customer Services/PALS team, which were fed back to the teams on a monthly basis through automated monthly reports sent to operational team leads.

Commitment to quality improvement and innovation

- All CRHT teams had been involved in the trusts Rapid Process Improvement Workshops (RPIW) over 2014/ 2015. Key to these was the involvement of the teams, gaining their feedback and ideas on what they could change and make improvements. Telford & Wrekin CRHT had piloted the crisis plan template, which aimed for clinician's access and complete robust crisis plans for service users within eight hours of referral. This was in line with the Crisis Care Concordat, 2014. There was also the introduction of the new carers' information pack, which was piloted by the East South Staffs CRHT.

Health Based places of Safety

George Bryan Centre, St Georges Hospital and Redwood Centre 136 suites

Vision and values

- Staff we spoke with were aware of the trusts values and vision. These were displayed in the services we visited.
- Staff were able to name their senior managers in the trust. Staff felt they were approachable and had visited the three HBPoS on several occasions.

Good governance

- There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act. This policy and procedure has been jointly agreed by the local police force and ambulance service.
- Staff received feedback the findings from complaints and incidents in supervision sessions.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment Regulation 12 (2)(h) HSCA 2008 (Regulated activities) Regulations 2014 Safe care and treatment The cleanliness of the clinic room at Telford & Wrekin Crisis and Resolution Home Treatment Team was poor. The clinic room was not clean, it had ants, spiders and cobwebs. There were no cleaning records maintained.