Good

Cornwall Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ8X7	Trust Headquarters	Home Treatment Team - east	PL31 2QT
RJ8X7	Trust Headquarters	Home Treatment Team – west	TR15 3ER
RJ863	Longreach House	Health Based Place of Safety (136 suite)	TR15 3ER

This report describes our judgement of the quality of care provided within this core service by Cornwall Partnership 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 Cornwall Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cornwall Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

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

Are services safe?

Good

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

- Both east and west home treatment teams employed sufficient numbers of staff who were experienced, competent, trained and supervised in line with the trust policy. Staff morale was good across the two teams.
- Staff carried out comprehensive risk assessments of patients; which were updated regularly. Their assessments covered physical health risks where relevant. Patients had individual care plans which aimed to help manage risks. Care plans were person centred and contained the patients' views. Patients also had individual crisis plans.
- There was good multi-disciplinary working within both home treatment teams and within the wider health and police service in provision of the health-based place of safety.
- Staff teams contained a range of staff that included nurses, social workers and psychologists. Approved mental health professionals were integrated within the team
- Staff spoke with kindness and respect about patients and patients gave us positive feedback about how they were cared for
- Staff tried as far as possible to be flexible and deliver the service in a way that suited individual patients. As far as they were able they would try to meet patients where and when they wanted.
- There was good governance leadership across the home treatment teams. Staff felt supported by their managers. Team managers felt supported by the trust, able to raise concerns, and had regular contact with senior people within the trust.

Are services effective?

Good

We rated effective as good because:

- Care plans were personalised and of a very good standard. These included any physical health needs.
- There were clear crisis plans for every patient.
- There was good multi-agency working within home treatment teams and the HBPoS staff.

Summary of findings

- Home treatments teams now had psychiatry and psychology input.
- Approved mental health act professionals were integrated into the teams.
- There was good understanding and implementation of the Mental Health Act and the Mental Capacity Act.

Are services caring?

Good

We rated caring as good because:

- We observed staff to be warm, kind and caring in both home treatment teams. Handover discussions were directed towards providing the best care for individual patients. Patients were positive about the attitude of staff.
- Care plans and crisis plans were person centred and staff recorded patients' views. There was evidence of staff being as flexible as possible in the way they provided support.
- Patients were represented on an health-based place of safety working group which enabled the trust to incorporate patients' views into decision making.
- Staff could provide drinks, hot and cold food and spare clothes if necessary for patients in the health-based place of safety.
- Staff made additional support arrangements in the health-based place of safety for patients with a learning disability or young people.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Staff always saw patients within their target time.
- Staff were flexible about how they engaged with patients and willing to negotiate times and venues.
- The service worked with other agencies to minimise length of stay in the health-based place of safety.
- Staff were able to provide leaflets and services in other languages. The health-based place of safety was accessible for patients with a disability.

Are services well-led?

Good

We rated well led as good because:

- Staff were committed to delivering a high standard of care as a team.

Summary of findings

- There were good governance arrangements which ensured staff felt supported and adequately equipped to carry out their roles.
- Staff felt supported by their managers and the trust.
- Staff reported good morale within the team and an absence of bullying or harassment.
- Staff felt empowered to do their jobs effectively.

However

- The provider did not collate data on length of stay in the health based place of safety.
- Staff did not always records patients' hourly presentation in the health based place of safety.

Summary of findings

Information about the service

The home treatment service is split into two teams covering the east and west of Cornwall. It is managed as part of acute inpatient services. Both teams are located on the same sites as acute inpatient wards in Bodmin and Redruth and act as gatekeepers for admission into these wards.

The clinical model is based on each community consultant having their own geographical area and looking after patients across the pathway from acute inpatient admission to input from the HTT and community mental health team. The service has a part time psychiatrist in each team and approved mental health professionals integrated into the team.

The service operates 24 hours a day. The day shift is 8am to 8pm and provides crisis services and early discharge for working age adults and older people with functional mental illness. Overnight, the much smaller home treatment team works with all ages and patient groups across Cornwall, particularly on the provision of Mental Health Act assessments, and provides telephone advice to other health professionals.

The trust also has a psychiatric liaison service based at Treliske hospital, which provides a 24 hour service. It is able to assess people presenting in mental health crisis at A&E and provided support to acute inpatient wards.

The trust's health-based place of safety is located within the grounds of Camborne and Redruth Community Hospital and adjoins one of the acute mental health wards on this site. This health-based place of safety provides a service for people detained in the Cornwall or the Isles of Scilly. It has provision for two adults with no upper limit. The health-based place of safety also offers a service to young people under the age of 18. If a young person was being detained in the health-based place of safety, one space would be closed on the unit to ensure the young person was not detained with a detained adult patient. It is served by the Devon and Cornwall police force.

Should a person be detained by police on the Isles of Scilly the normal practice would be to transport the person to the Cornwall health-based place of safety. Although there is no mental health provision on the Isles of Scilly, a room is available for people detained under section 136 of the Mental Health Act at the community hospital to assist professionals in making arrangements for the care or transfer of a person for assessment.

This was our second inspection of crisis and health-based place of safety services. At our previous inspection in April 2015 the service was rated as requires improvement. We issued a requirement notice as we found that the provider had not carried out assessments that reflected patients' needs or ensured safety of the patients. This included lack of crisis plans and lack of physical health assessment.

At this most recent inspection, we found good assessments which included physical health and all patients had personalised crisis plans. We found that the provider had met this requirement notice.

Our inspection team

The inspection of Cornwall Partnership Foundation trust was led by:

Karen Bennett-Wilson, head of hospitals inspection.

The team that inspected this core service was led by Lesley Whittaker (inspector) and included two CQC inspectors and two specialist advisors. The specialist advisors were registered mental nurses with experience in crisis services.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited both home treatment teams at the two hospital sites,
- spoke with seven patients who were using the service and one carer,
- spoke with the managers or acting managers for each of the teams,
- spoke with nine other staff members; including doctors, nurses and social workers,
- observed a visit to a patient in their own home,
- attended and observed two hand-over meetings,
- visited the psychiatric liaison service based at Treliske hospital.
- looked at 16 treatment records of patients.
- carried out a specific check of the medication management at one service
- 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 seven patients and looked at some of the many thank you cards received by the team. Feedback from six of seven patients was very positive. Patients told us how staff had supported them and taken their views into account. One patient who wanted to see as few different staff as possible told us staff had done their best to accommodate this.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that their monthly monitoring reports for section 136 accurately collect the information on total length of stay, time to assessment and reasons for any delay in assessment or discharge/transfer from the health-based place of safety.
- The provider should ensure that staff are recording the presentation of people detained in the health based place of safety a minimum of hourly as per the trust's guidance.

Cornwall Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Home treatment team east	RJ8X7
Home treatment team west	RJ8X7
Health-Based Place of Safety (136 suite)	RJ863

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.

There was good adherence to the Mental Health Act (MHA). The team had approved mental health act professionals (AMHPs) who were skilled and experienced at working within the Act. The AMHPs acted as a resource and source of advice to other members of the team as well as carrying out assessments under the MHA. Staff told us they had received training in the Mental Health Act and there was additional support available from the trust.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff we spoke with had an understanding of capacity. Staff assumed patients had capacity to make decisions about their care and treatment. When staff assessed a patient as potentially lacking capacity to consent to treatment they contacted AMHP colleagues to assess under the Mental Health 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

Home treatment teams

- The service rarely saw service users on their premises. However, staff had access to the family rooms attached to the hospital wards on the sites where both west and east teams were based. Both of these rooms had alarms which had been regularly tested.
- The family rooms were clean and well maintained.

Health-based places of safety (HBPoS)

- The health-based place of safety (HBPoS) had two bedroom areas, a staff office and one communal bathroom with a toilet. There was an external entrance door where patients could be received into the HBPoS. This was located in a side area of the hospital site. There was a locked door directly from the HBPoS into an acute mental health ward.
- The HBPoS provided a service to men and women. This may present some dignity and privacy issues if a patient was disinhibited. There had been an incident where a female patient had to be restrained due to her disinhibition and concerns she was trying to access the area of the suite where a male patient who was also unsettled was being cared for. The report identified that staff had managed this appropriately. The patients had to share one bathroom and toilet and there was no lounge area, so they would need to remain in their room if a male and a female were in the suite at the same time and they did not wish to be in the company of someone of the opposite gender.
- The HBPoS had CCTV recording cameras with viewing screens in the office in the HBPoS or from the acute ward office. There was a sign on the external entrance door to inform patients of this. The CCTV did not allow all areas of a patient's bedroom to be seen if the door was shut. Staff were aware of this issue and did not rely on CCTV alone to monitor patients.
- There was up-to-date ligature assessment from December 2016. A ligature point is a fixture that a patient can attach a cord or similar to for self-strangulation. There were ligature reduced fixings in most areas of the ward. Staff were able to tell us of the ligature risk points in the HBPoS such as the doors, and that these were managed by observing patients. There were ligature cutters on the ward and staff also carried ligature cutters.
- The manager explained that as staff were usually on a one to one basis with the patient and also had access to CCTV they were confident that patients were being closely monitored. However there was no formal observations log for staff to indicate if a patient was observed to be breathing for example or grading of patient observations. The manager's expectation was that staff record their observations of the patient hourly in the progress notes. Staff did not always record hourly on records we reviewed and staff did not always record if a patient was breathing if noted to be asleep.
- Call alarms for an emergency response were fitted to the wall in all the rooms, staff also held a personal safety alarm. Staff confirmed that the alarm system worked well and the response team from the acute wards attended quickly if they sounded the alarm.
- There was no clinic room for the storage of medication as the HBPoS was not always in use. A clinic room was available on the acute ward if required. Emergency medical equipment was available in the HBPoS and records confirmed that this was checked in line with trust policy. A defibrillator was available on the adjoining acute ward.
- The HBPoS was clean and tidy. Records confirmed full daily cleaning unless the HBPoS was occupied, when nursing staff would undertake a clean. There were good furnishings and the HBPoS appeared well maintained.
- The bedroom doors were thick secure doors which could lock if shut from outside. The bedrooms could both be used as seclusion rooms if required. On the day of our visit one door had a faulty lock, the manager arranged for this to be repaired during the inspection.
- There was an up to date fire risk assessment and fire extinguishers had been checked in line with the schedule.

Good

Are services safe?

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

Safe staffing

Home treatment teams

- Both the east and west teams were integrated so the number of qualified staff included nurses, social workers and approved mental health professionals (AMHPs). East and west teams had twenty whole time equivalent staff and a part time psychiatrist and part time psychologist.
- Staff worked a two shift system with five qualified on a day shift and one support worker. Each shift had a minimum of one AMHP. Night shifts consisted of a minimum of two registered staff, one of which was an AMHP and a third member of staff who could be either a registered nurse or support worker.
- The west team had one band five vacancy for an occupational therapist. The service had previously failed to recruit into the post but planned to re-advertise. Two social workers were on AMHP training and these posts had been covered.
- The east team had 1.5 social workers on AMHP training and these posts were currently not covered however there was minimal impact on service delivery.
- Staff sickness rate 4% in 12 month period
- Staff turnover rate 4% in 12 month period
- The majority of shifts were fully staffed. Both team managers told us that occasionally short notice sickness could result in low numbers on shift but that they had been able to ensure all visits were made. Staff we spoke with confirmed this. Records showed that visits were, particularly for patients assessed as being high and medium risk, were not cancelled.
- The service had obtained cover for the social workers on AMHP training in the west team. Vacancies and cover for annual leave and sickness was provided by staff overtime or bank staff familiar with the service. Neither team used agency staff.
- Staff at both teams were able to access a psychiatrist when required. Following the last CQC inspection each team had recruited a part time psychiatrist. If the team psychiatrist was not available staff could request input from one of the psychiatrists employed in the locality. Staff told us the addition of a dedicated psychiatrist had been very helpful as they could arrange for patients to be seen quickly. The psychiatrist was also available at team handovers and meeting which enabled medical input into discussions of risk and treatment.
- Staff told us they had received mandatory training. However, the trust systems could not supply confirmation of this. Staff spoken with were evidently knowledgeable and demonstrated a good understanding of all aspects of their role. Some staff were due to update face to face safeguarding training, however there was a lack of sessions available. This was a trust wide issue. However this was mitigated within both teams as they were able to discuss safeguarding with social work colleagues and at morning handover meetings.
- We were told staff training included specialist training in supporting patients with a diagnosis of personality disorder, formulation, emotional focus formulation, clozaril and anxiety management. Records showed that this training took place and we saw evidence in patient records of formulation and delivery of appropriate interventions.

HBPoS

- The health-based place of safety (HBPoS) was only used when a person was detained there under section 136 or section 135 of the Mental Health Act. Staff worked two shift patterns of long days or night shifts. In the daytime an extra member of staff was employed on the adjoining acute ward for this purpose. At night time two extra staff were employed for this purpose. Staffing rotas indicated that there were always sufficient staff on duty.
- A patient would normally be received by an admitting nurse while the police were still present. If the patient was agitated, the police may remain for a period of time at the HBPoS until it was considered safe to leave. The nurse would normally handover to one health care assistant who would supervise the patient alone in the HBPoS. The health care assistants would change on an hourly basis. Dependent upon assessed risk the patient could be supervised by two or more members of staff. Staff confirmed that they felt safe and that if extra staff were required this was facilitated. The policy for the

Good

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HBPoS stated that one member of staff should always be present. If a second patient was admitted to the HBPoS then they would have additional staff allocated to care for them.

- Staff were trained in the management of violence and aggression. All staff would cover the breakaway level of this training on induction and would normally complete the full restraint training within two weeks of completing their induction. Staff could work on the place of safety whilst waiting for the full restraint training.
- If a young person under 18 was admitted then two staff would be allocated to supervise the young person. The local protocol indicated that staff must consult the local child and adolescent mental health services prior to receiving a young person into the HBPoS.
- Staff told us that they felt safe working in the HBPoS, and could call for extra help if required. However we did see an incident reported where the night staff on the ward had not known that a member of staff from the day shift was staffing the place of safety due to this not being handed over. The member of staff expressed concern that in the event of a fire or assault by a patient they would have had no assistance or help as they were not entered onto the staff board. As a consequence staff were reminded of the requirement to enter all staff on the staff allocation board when planning the shift.
- Agency staff were rarely used within the HBPoS and bank staff were usually full time staff doing overtime or bank staff familiar with the unit. Staff who had not worked in the unit before would be supervised on the acute ward for an hour before being asked to work alone in the place of safety.
- There was no access to a psychiatrist for patients in the place of safety other than when they attended for assessment with the AMHP. If a patient was in need of medication then the staff would need to call an on call GP to prescribe or arrange for a friend or relative to bring in someone's medication.

Assessing and managing risk to patients and staff

Home treatment team.

- We looked at 16 care records across both home treatment teams and found that all care records were of a very good standard.
- Staff risk assessed all service users on admission to the service and scored risk as high, medium or low. Risk assessments were updated frequently. Staff updated risk assessments following any risk incidents or reduced the assessed level of risk when patients' risk decreased. The home treatment teams assessed service users risk at every visit. The team was able to arrange a mental health act assessment quickly if needed and also to increase or decrease the frequency of visits as necessary.
- All of the records we looked at contained crisis plans. Service users who had been in services longer had more detailed plans. We saw evidence of some advance decisions, for example information about who to contact to care for pets if the patient became too unwell to do so for themselves.
- All staff had received safeguarding training. We attended morning handover at both home treatment teams and observed staff discussing safeguarding. Staff told us that they were always able to seek advice regarding safeguarding from their social work colleagues, the team manager or could discuss any concerns with the trust safeguarding team. Members of both teams knew how to make a safeguarding referral.
- We also visited the psychiatric liaison service based at Treliske hospital and noted staff discussing potential safeguarding.
- Both home treatment teams had clear safety protocols and lone working procedures. All new service users taken on to the team caseload had a first visit by two members of staff. Staff risk assessed both the service user and their environment and decided on the basis of this if it was safe for lone worker visits. Risk assessments clearly stated if the service user needed visits by two staff, or if they needed to be seen at a different location. Each team base had a white board which clearly displayed staff locations and visit times.
- There was minimal medication kept on the premises. Staff had completed medication charts correctly and documented the necessary physical observations in line with NICE guidance. Medicines were stored in a locked cupboard within the team office.

HBPoS

Good

Are services safe?

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- We reviewed six care records. In five of the six records a risk assessment was present and up to date. These were recorded using the screening tool on the electronic care record. Admission paperwork that the police completed asked them to communicate risks they may have identified. The Mental Health Act assessment by the AMHP and doctor was also entered on the electronic care record.
- Mental health crisis services and health-based places of safety had three incidents of restraint and two incidents of seclusion between 1 June 2016 and 31 May 2017.
- If people were secluded it was within the bedroom area. Once the door was locked to the bedroom, staff were able to observe through a window. There was access to toilet and washing facilities. There was a clock visible to patients if they were secluded.
- Staff were trained in de-escalation. The manager described to us situations where professionals known to a young person or person with a learning disability had visited whilst the person was at the place of safety in order to reduce agitation or distress.
- Searches of patients were undertaken whilst the police were still present. The HBPoS had a metal detector wand which either the police or nurses used. Staff searched in line with the trust policy.
- The manager explained that safeguarding alerts regarding a person's circumstances prior to admission were usually made following assessment by the AMHP who would take a lead with this. The manager reported they would refer regarding safeguarding issues such as a patient on patient assault however these were rare.

Track record on safety

- There had been three serious incidents in the previous year. The investigation of one incident had led to positive feedback concerning the home treatment team's standard of care. We reviewed information held by CQC regarding these incidents and noted that learning, for example in an improved standard of documentation, had been implemented.
- Following a serious incident concerning a discharged patient and a complaint by the psychiatric liaison service a new procedure was in place. New referrals from the liaison service now received a minimum of two follow up visits from the home treatment team rather than one visit offered previously.
- Following a serious case review in respect of a patient who was repeatedly detained in the HBPoS under section 136 of the Mental Health Act new procedures had been put in place. Minutes of the crisis care concordat meeting demonstrated multi-agency communication had been improved to manage frequent attenders following this serious case review and all involved agencies were now aware of frequent attenders.

Reporting incidents and learning from when things go wrong

Home treatment teams

- Staff knew what incidents to report and how to report them using the electronic reporting system. Each team manager reviewed the reported incidents and took the required action. Where appropriate discussion and feedback was carried out in the team meeting or in individual supervision. One example described by staff was the change to offering two follow up appointments to patients seen by the psychiatric liaison team but not taken onto the home treatment team caseload.
- Staff told us they were debriefed and supported after a serious incident. The team psychologist was able to offer individual sessions to staff if required.
- The team manager informed service users under duty of candour where the trust investigated any incidents involving a patient and their care. Any service user who had their care investigated was informed of the investigation taking place by the team manager. The trust shared the outcomes of investigations with patients and families.

HBPoS

- Staff recorded incidents on the trust's electronic incident reporting system. There had been 39 incidents between January and August 2017. There were seven self-harming incidents, four incidents of breaches in policy, three incidents of aggression to staff. Issues regarding service capacity or closure of the HBPoS were also reported. Action or learning from the incidents was

Good

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recorded on both the trust's electronic system. For example an incident that related to a decision by police not to return to the place of safety had been followed up by the police liaison officer.

- A thematic review of incidents in the place of safety had been carried out jointly by the trust's quality lead and a police officer employed by the trust and the police force. This concluded that there were no themes requiring further investigation but that a quarterly review of incidents would be carried out on an ongoing basis jointly by the police and trust. This review would feed into the quarterly multi agency section136/Criminal Justice and Health Liaison Group for Cornwall and the Isles of Scilly.

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

Home treatment teams

- We looked at 16 care records and all assessments and care plans were completed to a high standard.
- All service users had a comprehensive assessment carried out at their first face to face visit unless this had already taken place by the psychiatric liaison service. During the inspection in April 2015, we found limited evidence of physical health checks or physical health monitoring taking place. At this inspection, we found staff had completed physical health checks for service users on admission to the team caseload.
- Staff had ensured that all care plans were personalised and contained appropriate information intended to support the service user with their assessed needs. We saw that care plans specified clearly what treatment would be provided by the home treatment teams. All information needed to deliver care was stored securely and was available to staff when they needed it.
- The psychiatric liaison team was part of the trust which meant that staff within this team had access to service users' electronic care records and also were able to update service users' records, notes and risk assessments. The inclusion of the liaison team meant that this team could be aware of any previous history and current crisis plans and able to follow any care plans already in place. This meant that patients would receive consistent care and treatment if they presented at A&E out of hours.

HBPoS

- There were no operational expectations to initiate care plans for those admitted under section 135 or section 136 of the Mental Health Act to the health-based place of safety (HBPoS). Of the six records we reviewed we did not see care plans for the period of detention in the HBPoS. The locally agreed practice was for the ambulance service to undertake a physical check of patients before they were received by the place of safety. For patients who had been brought in police transport, an ambulance was requested to attend the place of safety to do this. A thorough physical health examination had been completed in five of the six records we reviewed; the one not completed had been declined by the patient.

Best practice in treatment and care

Home treatment teams

- Staff in the home treatment teams were able to offer a range of psychological interventions, appropriate to patients in crisis. The team psychologist had trained staff in formulation (formulation is the process of making sense of a person's difficulties in the context of their relationships, social circumstances, life events, and the sense that they have made of them). Records showed that this informed care planning and the interventions offered. Staff had received a one day training course in brief solution focussed therapy and two members of staff had been released to undertake the foundation course in this. The team manager planned to send a further two members of staff on this course. We saw evidence in care records of staff delivering interventions to help service users reduce their anxiety and manage symptoms.
- Care was delivered in line with National Institute for Clinical Excellence Guidelines (NICE). For example the service followed NICE guidance on the induction onto clozaril Staff delivered appropriate psychological therapies in line with NICE guidance.
- A small number of patients were undergoing clozapine titration in the community. Staff carried out the required physical checks to ensure this was taking place safely. Due to the large area both teams needed to cover a protocol had been developed to take physical observations at 3pm which meant one visit could cover morning and evening clozapine doses. Staff completed observation charts to evidence these checks took place.
- Staff identified patients' need for support with housing and benefits and were able to signpost them towards the appropriate help.
- Where physical health was a factor in the patient's presentation the home treatment teams had developed care plans to support service users to access the necessary support. Records demonstrated staff had

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assessed falls risk if needed and the east team had made effective use of their occupational therapist to assess the need for physical health and social care support.

- Staff regularly participated in care records audit which had resulted in all care records being completed consistently by all staff.

HBPoS

- The ward manager undertook a monthly report to consider use of the HBPoS according to age, gender and assessment outcomes. This fed into the multi-agency section136/Criminal Justice and Health Liaison Group for Cornwall and the Isles of Scilly. This report did not capture information on the total length of detention or ethnic background of patients using the HBPoS. We did see patients' ethnic background recorded in individual patient care records however.
- The manager advised us she reviewed a random selection of care records each month, although did not record this as a formal audit.

Skilled staff to deliver care

Home treatment teams

- At our inspection in April 2015 we found that the multi-disciplinary team (MDT) lacked a psychiatrist and psychologist. The MDT now contained a part time psychologist and part-time psychiatrist in both home treatment teams. Staff told us that this had a very positive effect on their work. The psychologist worked with the team to develop formulations (formulation is the process of making sense of a person's difficulties in the context of their relationships, social circumstances, life events, and the sense that they have made of them) of patient need. Staff used any formulation to develop care plans and to inform risk assessments. The psychologist was able to see patients if they needed a psychological assessment.
- The east home treatment had an occupational therapist in post but the occupational therapist post in the west team was vacant. The west team manager told us they had been unable to recruit to the post but intended to re-advertise.
- Staff were experienced and qualified. The majority of the staff were registered nurses and social workers. Both teams had social workers who were approved mental health act professionals. Other members of the teams included psychiatrists, doctors and an occupational therapist.
- Staff had regular supervision and told us they were able to access informal supervision as needed. Both team managers were able to show records which demonstrated this. Staff were also able to attend supervision with the team clinical psychologist if needed.
- The managers of both teams told us that all staff had received an appraisal within the last year. However, the trust electronic systems did not reflect this. We were unable to look at any records to confirm this due to problems with the trust's electronic systems. We had no reason to doubt the information given the compliance with supervision and the additional training available.
- Staff received the necessary training for their role. All staff completed the trusts mandatory e-learning. In addition, staff received training on a service specific basis. Staff had been trained in brief solution focussed therapy, with two members of staff undertaking the foundation year training. The team psychologist had delivered training to staff to help improve the effectiveness of their care planning and delivery of interventions.

HBPoS

- Staff working in the place of safety normally worked on the adult mental health ward. The manager advised us that staff received training on taking physical observations and would be able to identify physical health issues in older people.
- Staff did not receive specific training relating to section 136 of the Mental Health Act, the manager explained that more experienced nurses cascaded information on the place of safety protocol in the induction process for new staff.

Multi-disciplinary and inter-agency team work

Home treatment teams

- We attended two handovers, one at each of the teams we inspected. Handovers were attended by all members of the multi-disciplinary team on duty and included the psychiatrist and clinical psychologist. The handovers

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.

were well-structured and detailed. Each patient's risk was discussed and there was an opportunity for staff to discuss any care or risk-related issues. Discussions were professional and patient-focussed.

- The teams met monthly. Staff told us they were able to raise issues in these meetings. The team managers told us that staff were supported to attend the meetings and if they attended on non-working days were able to take the time back.
- There was effective handover between teams within the organisation. Electronic records showed that services were able to view up to date records on the trust electronic patient record system. We were able to track the patient's care pathway from records, for example assessment by the psychiatric liaison service to the referral to the home treatment team and plans for discharge. If a patient was involved with the community mental health team the name of their care coordinator was recorded.
- The psychiatric liaison service told us they could refer directly to the home treatment team and the patient would be offered a minimum of two appointments by the team. Staff in the home treatment team told us they liaised with community teams either to accept referrals or to discharge patients. Staff and managers at both the home treatment teams and psychiatric liaison team told us that the community mental health teams were overwhelmed with referrals and struggled to allocate patients following assessment. The trust had identified an impact on the team earlier in the year in a serious incident investigation. Records showed that there were patients on the home treatment team caseload ready to be discharged but awaiting allocation within the community team.
- The home treatment team's gate kept beds within the trust with a member of the team responsible for bed management. The bed manager was also responsible for locating an out of area bed if needed. The bed manager liaised with the acute inpatient wards daily to identify any patients who could have an early discharge with support from the appropriate home treatment team.
- Social workers were integrated within the home treatment team. All of the staff we spoke with were positive about the arrangement and felt it provided good outcomes for patients. Nursing staff were able to access mental health assessments quickly as the AMHPs were already available within the team.
- Staff recorded contact with the GP on the electronic patient records and liaised with GPs for the prescription of medication and any physical healthcare needs identified.

HBPoS

- Staff on the acute ward were made aware of patients in the place of safety in handover sessions and via the activity board on the ward. However, we did identify an incident where a member of staff reported this had not occurred and the ward staff had not known the staff member was in the HBPoS with a patient, and the staff member had been concerned this had potentially placed them at risk. This was an isolated incident and resulted in the staff team being reminded of the need to include all staff on the staff allocation board.
- The HBPoS was located near one of the crisis teams. This team employed AMHPs and we observed face-to-face updates between the AMHP and place of safety manager regarding the timing of an assessment.
- The manager reported a positive relationship with the local safeguarding team.
- There were 136 and health and criminal justice liaison meetings for Cornwall and the Isles of Scilly every three months. The place of safety manager attended together with representatives from the AMHP service, the police and emergency department. Issues and incidents were reviewed.

Adherence to the MHA and the MHA Code of Practice

Home treatment teams

- We were told that all staff had received training in the Mental Health Act (MHA); however the trust electronic training records could not evidence this. A number of the social workers were AMHPs and were able to provide specialist support regarding the MHA.

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- Staff assessed the capacity of patients to consent to treatment and, if they assessed the person as lacking in capacity, were able to organise an MHA assessment to determine if the patient needed admission to an inpatient unit.
- Staff had support from the trust central MHA office. Staff told us the team were knowledgeable and approachable.

HBPoS

- There was a locally agreed multi-agency policy agreement on the response to people detained under the Mental Health Act. This covered arrangements for people detained on section 135 and section 136 of the Mental Health Act.
- The multi-agency group had prepared a new policy to reflect the reduction in the maximum detention period for detention under section 136 of the Mental Health Act to 24 hours in 2017.
- Mental Health Act training was up to date for 71% (five out of seven) of the staff on the two acute wards who staffed the place of safety and were required to do so as part of their role.

Good practice in applying the MCA

Home treatment teams

- All staff had received training in the Mental Capacity Act but the trust electronic training records did not contain evidence of this.
- Records confirmed that staff assumed a patient had capacity to consent to treatment unless there was evidence otherwise. Consent and confidentiality was recorded by staff and a consent form signed by the patient was uploaded onto their records.
- Staff were able to consult the AMHPs within the team, or the psychiatrist, if they needed to discuss capacity issues. Where staff had concerns about a patient's capacity to consent to treatment they arranged a Mental Health Act assessment to determine if admission to hospital was necessary.

HBPoS

- Training on the Mental Capacity Act had been undertaken by 87% of staff on the acute wards who staffed the place of safety.
- Staff assumed patients had capacity and only undertook assessments of capacity if there was a specific issue and the presentation of the patient indicated this was needed. We did not see assessments of capacity on the six records we reviewed.

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

Home treatment teams

- We attended one home visit with staff and observed staff to be very friendly, warm and professional. The member of staff undertaking the visit had very good interpersonal skills and used these effectively.
- We attended two handovers and observed staff discussions of patients on the caseload. Staff were focussed on the well-being and recovery of patients. Staff took time to discuss any risks or concerns, seeking team input to ensure the best outcome for the patient. Staff spoke respectfully about patients. Staff understood the context of the patients' lives and were aware of how their life circumstances interacted with their mental health.
- Staff in the home treatment team did not have individual caseloads; patients were supported on a team basis. This meant that staff could not guarantee who would be carrying out home visits. However, one patient told us that they struggled with seeing too many different people. The team had developed a plan to minimise the number of different staff visiting and where possible always tried to allocate one of a small number of named staff to carry out the visit.
- Some patients were able to carry on working and staff arranged visits on a flexible basis to support this. Staff would arrange to visit people early in the morning or after work. We saw evidence that if a patient did not want to be seen at home staff would support it and arrange to meet the patient at a mutually agreeable location.
- We spoke with nine service users and one carer. Patients and the carer told us that staff were understanding, respectful and supportive. All of the people we spoke with were positive about the staff they had met.

HBPoS

- We did not have the opportunity to observe staff caring for patients on the health-based place of safety (HBPoS).
- Patients had been involved in the 136 services by taking part as representatives on a 136 strategic group.
- The manager told us of a case where the staff working with a person with a learning disability had come into the place of safety periodically during the night to reassure them and reduce their agitation. These had been staff from their supported accommodation. A community mental health nurse had also come into the HBPoS to assist with a distressed young person.

The involvement of people in the care they receive

Home treatment team

- Staff had developed care plans in collaboration with patients. Care plans were clear and personalised and contained information about patient preferences. Care plans were developed with the aim of supporting the patient to stay at home rather than be admitted to hospital. Patients' views were recorded in care plans and patients had also been involved in the development of their crisis plans.
- We spoke with one carer who had been involved in their relative's treatment and one patient told us their partner had been involved. The service was in the process of developing a carers' pack and had identified a carers' champion within the team.
- We saw numerous thank you cards, letters and emails from past patients thanking the teams for their care and support.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Home treatment teams

- Triage staff responded to the referrer within 20 minutes of receipt of the referral. Both home treatment teams had a target of 24 hours between referral and assessment due to the nature of their areas which were large and rural. Patients would be seen sooner than this if the referrer indicated the patient may need to be detained under the Mental Health Act or triage indicated this was necessary. All assessments were face to face. Staff would make contact by telephone within the 24 hours and if a referral was urgent they would prioritise this and see a patient as soon as possible. Staff organised visits during the night shift or in hand over the next morning.
- Skilled staff were available to assess patients. Staff were available overnight as well as during the day to carry out urgent Mental Health Act assessments. The psychiatric liaison service based at Treliske hospital were able to see any patients presenting at the accident and emergency department between 0800hrs and 2200hrs, seven days a week.
- Both home treatment teams responded promptly when patients called in. If staff were not available immediately they would call back as soon as they were able. However, there had been a complaint by a carer that on occasion the team had not rung back. This was still open to the complaints team. We were able to observe some calls to patients and observed that staff were professional and caring in their approach.
- The service had clear criteria for acceptance on the caseload. Patients had to be in current mental health crisis. The service would accept referrals from the psychiatric liaison service, the community mental health team, GPs or patients could ring up. Patients did not have to be in receipt of services to be accepted onto the team caseload.
- Both teams were flexible about how they engaged with patients. Some patients preferred phone contact, or to be seen away from home or at specific times or preferred male or female staff. The teams did their best to facilitate this and engage people. If patients did not answer the phone and could not be contacted the team were persistent and would do unannounced home visits, for example.
- Neither teams cancelled appointments. We were told that on very rare occasions it may be necessary to re-arrange an appointment but that the team would ensure that the appointment re-arranged was with a patient who was ready for discharge to the community mental health team.

HBPoS

- The health-based place of safety (HBPoS) was open 24 hours a day. There had been one occasion in the year prior to inspection when the HBPoS had closed as staff on duty thought this was necessary due to an infection control issue on the acute ward. Following this it had been clarified for staff that they should contact the HBPoS manager for advice as in this case it had not been necessary.
- There was one incident recorded where the place of safety had been unavailable for a second patient due to the patient in the HBPoS being too agitated to receive a second.
- The police mental health lead confirmed that four people detained under section 136 or section135 of the Mental Health Act were taken to the police cells in the 12 months prior to the inspection. Two of these had been to do with the level of aggression of the person which made this appropriate, one had been planned for an assessment under section 135 due to the aggression on a previous occasion.
- The trust was in the process of trying to gain more accurate information on the frequency of people being brought to the emergency department under section 136 of the Mental Health Act, and whether this had been for a medical reason or due to any other issue such as a lack of capacity at the HBPoS. The trust were liaising with their link for the emergency departments in the county about this both directly and through the multi-agency forum.

Are services responsive to people's needs?

Good

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

- If a young person had been assessed in the HBPoS and was waiting for a bed to be located in a child and adolescent mental health ward, there was the potential for them to be transferred to the children's ward at the local general hospital to be cared for during this period.
- The mental health lead for the police identified that someone detained in Cornwall near the South Devon and Cornwall border could be taken a long distance to Redruth, when the place of safety in Devon was nearer. This had an impact on police time and distance for the detained person to travel. This was due to current accepted arrangements that all people detained in Cornwall were taken to the one HBPoS in Cornwall at Redruth, and was under review by the police and key agencies.
- At our last inspection in April 2015 we said that the provider should monitor the assessment process within the HBPoS, including length of stay, delays and admissions onto an acute ward. At this inspection we found that the provider had introduced a summary spreadsheet for patient admissions to the place of safety each month. The provider also recorded information regarding the section 136 episode on the patient's electronic care record.
- We reviewed this spreadsheet which had data for the period from February to August 2017. Whilst in most cases a time of arrival and leaving the place of safety was recorded on the spreadsheet, it was difficult to confirm from the spreadsheet how long a patient's length of stay had been. This was as the time of leaving column did not always ask staff to indicate the date the patient left, or staff had not always recorded this. The time of leaving had also been missed in some cases. This information was captured in the individual records but had been pulled through clearly on the monitoring spreadsheet. Additionally, although there was clear recording that an assessment had taken place in individual records, the time the patient waited prior to and post assessment in the place of safety was not captured on the spreadsheet. The individual records that we reviewed and entries on the spreadsheet that did have all the information indicated that people were being seen and transferred from the place of safety promptly.
- We discussed this with the provider on inspection and they informed us they intended to make changes with the data they captured. The manager also explained that she had identified the problem with determining length of stay from the existing spreadsheet as she had carried out an audit shortly before this inspection. She had gone into individual patient records to get the accurate data regarding length of stay. The manager advised us that this audit indicated that no one had remained in the place of safety for more than 24 hours in the three months reviewed. The manager also had a good awareness of any cases where there had been any issues to raise with other agencies and these were regularly reviewed in the multi-agency forum or directly with key representatives for the AMHP service and police. There were examples of staff recording delays such as securing the attendance of a section 12 approved doctor as incidents.
- At our last inspection in April 2015 we identified that there were sometimes delays in transfer from the place of safety due to difficulty in finding an inpatient bed. Since the last inspection the hours of availability of the trust's bed coordinators had been extended and operated seven days a week. We received positive feedback from staff about improvements in bed coordination. There was one incident recorded which related to a delay in finding a bed.

Meeting the needs of all people who use the service

- Staff were able to obtain leaflets in other languages from the trust and an interpreter service was available.
- Staff could provide hot or cold food and drinks from the ward and patients could have a shower if they wished. Staff could provide spare clothes from lost property if necessary.
- Staff were encouraged to spend one to one time in activities a patient might chose to do. There was a radio in both of the rooms and books and magazines were provided. Patients were able to use the telephone to contact others if they wished.
- The HBPoS had full access for wheelchair users.
- The manager advised us that leaflets were available in other languages. We did not see any information on display regarding how to complain

Are services responsive to people's needs?

Good

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

Listening to and learning from concerns and complaints

- There had been two complaints in the last 12 months and one was still ongoing.
- Three out of four patients we asked knew how to complain.
- Staff knew how to handle complaints appropriately. In the first instance the team manager would try to resolve the complaint locally but if this was not possible the patient advice and liaison service (PALS) could be contacted.
- The service had implemented changes to the number of visits to patients referred by the psychiatric liaison service following a complaint. Previously a patient only had one visit by the home treatment team if they were not going to be taken on the caseload. The service now offered a second visit.

Are services well-led?

Good

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

Our findings

Vision and values

- The manager of the east team told us that vision and values 'Delivering high quality care' were decided by staff on the front line. Staff consistently described their commitment to achieving this. Our inspection of the home treatment teams and the health-based place of safety (HBPoS) found that the service was delivering this high quality in all areas.
- The manager of the west team informed us that the executive team visited the service regularly, and completed regular safety walk arounds.

Good governance

- At our inspection in April 2015 we found that there were limited governance arrangements, particularly in the west team. At this inspection we found that the trust had systems in place to monitor the quality of the service. Team managers had access to a dashboard which contained performance information. This included care plan and risk assessment updates and due dates for home visits. Both team managers had access to up to date assurance reports which enabled them to feedback information to their teams.
- At our inspection of April 2015 we found HTT west had no permanent team manager in post and both the team manager of the east team and the service manager had only recently taken up their posts. At this inspection we found that, whilst the team manager of the west team was seconded as part of their professional development they had support from the team manager of the east team and the service manager who were now established in their posts.
- All members of staff received regular supervision in both one to one and group sessions. Records showed formal supervision took place every four to six weeks and additional support for staff was also available from the team psychologist. The staff we spoke with felt supported by their team managers.
- Staff and team managers told us that training and appraisal were completed however the trust systems could not demonstrate this. We raised this with the team inspecting the well-led domain with the trust leadership.
- We saw evidence that staff in both teams recorded and reported incidents through the trust electronic reporting systems. The team managers closed down less serious incidents in the team meeting once all actions were complete. The trust investigated incidents classed as serious and teams received feedback on the investigation outcome and any learning.
- The east and west home treatment teams cross audited care records using a standard tool they had developed. Every week each team audited three records and records showed that any actions identified were implemented and checked. The effectiveness of this audit was evident as care records were of a high standard. Each team followed clear safeguarding procedures and staff were able to discuss safeguarding at team meetings and daily handover.
- There was evidence of learning and team development from incidents and complaints. The teams were given feedback by the manager or on an individual basis if needed.
- Both east and west teams adhered to the Mental Health Act and Mental Capacity Act. Both teams were integrated with the local authority to provide home treatment so had approved mental health professionals (AMHPs) working within the team which team managers told us was beneficial and worked well.
- Team managers used key performance indicators (KPIs) to monitor team performance and delivery. There was a system in place to identify visits and tasks each day; this included updates to risk assessments and care plans. The shift leader checked the relevant spreadsheet every day and allocated staff appropriately.
- The team managers for the east and west teams both felt they had sufficient authority and felt supported by their line managers. They told us that they could contact their line manager or the associate director with responsibility for home treatment at any time.
- Staff had the ability to submit items to the trust risk register; however, the team managers would usually do this.

Leadership, morale and staff engagement

- The east team had low levels of staff sickness and low staff turnover. The west team had recently had a high

Are services well-led?

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level of sickness with four staff on long term sick leave; however all four staff had now completed a phased return. Both team managers reported that short-term sickness was not a problem for either team.

- The staff that we spoke with felt able to raise concerns about patient care and treatment. The team managers felt supported able to raise concerns with superiors without fear of victimisation.
- Staff morale was good in both teams, staff felt empowered and teamwork was good. . Staff told us that they did not always agree with each other but were able to speak out and challenge colleagues.
- Staff were open and transparent about their practice. Where any incident involved a patient both patients and staff were informed and offered the opportunity to have input into the investigation and to ask questions.

Commitment to quality improvement and innovation

- The east team had developed an adult mental health outcome measure and had begun a pilot of it. Patients were scored on admission, part way through and on discharge. All patients in the east had this in place.

Well-led

HBPoS

- The governance systems at the place of safety were managed in conjunction with Perran acute mental health ward. The west home treatment team manager was on secondment until January 2018 but the post was covered by a manager familiar with the team. The ward manager for Perran ward managed the HBPoS.
- The place of safety manager reported to an operational manager and associate director with responsibility for the place of safety. Senior staff from the trust, police and local authority all gave extremely positive feedback on the collaborative relationship between the agencies. There was written feedback from the police mental health lead to support the place of safety staff team in a trust team award in which they were highly commended.
- There was an effective s136 Criminal Justice and Health Liaison Group for Cornwall and the Isles of Scilly which met quarterly. The place of safety manager produced a report for this meeting and incidents, issues and policy were reviewed. The minutes indicated that action was being taken for example to address delays in the availability of ambulance transport to convey people to the place of safety when they were first detained.
- The trust held a quarterly Mental Health Act Managers' committee, and the minutes indicated that 136 issues and policy were also reviewed at this forum. There appeared to be good oversight of the level of 136 activities, however the length of stay was not consistently captured at the time of the inspection.
- Staff described very collaborative working relationships. Key staff described having worked well with each other for several years.
- Staff described many joint working initiatives that took place outside of formal meetings, such as the manager for the place of safety and the police mental health lead meeting to review recent activity or being able to address operational issues promptly via phone contact between meetings

Commitment to quality improvement and innovation

HBPoS

- The trust contributed to the funding of a police officer to liaise with the trust's mental health wards and place of safety. The officer worked closely with the place of safety manager and trust staff to review incidents and follow up issues. The officer also acted as a point of advice for staff and patients on the wards regarding criminal activity.
- The place of safety manager had been supported by their operational manager to start writing a joint article with the police lead on their approach to partnership working.
- The trust planned to have a dedicated adult acute bed early in 2018 to reduce any potential delays in transfer from the place of safety.