Birmingham and Solihull Mental Health NHS Foundation Trust

Mental health crisis services and health-based places of safety

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Mental health crisis services and health-based places of safety

Inspected but not rated

The mental health crisis services and health-based places of safety provide assessment, care and treatment for adults in a mental health crisis in the community or within the psychiatric decisions unit or health-based place of safety.

We conducted an unannounced focused inspection of mental health crisis services and health-based places of safety because we received information giving us concerns about the safety and quality of the services.

At our last comprehensive inspection, we rated the trust overall as requires improvement. This service was rated as requires improvement.

We inspected only those parts of the service that gave us cause for concern.

We spoke with staff and patients. We visited six of the nine home treatment teams, the health based place of safety and the psychiatric decisions unit. We reviewed documentation including patients' care records.

The four patients we spoke with had mixed views on the service. Three patients were complimentary, but one patient had found their experience to be 'detrimental' on their health and stressful. Two patients said they could not always get through on the telephone when in a crisis, and some staff attitude when contacting the crisis line had been poor.

We found the following:

- The service provided safe care. Clinical premises where patients were seen were safe and clean and the physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.
- The number of patients on the caseload of the mental health crisis teams, was manageable and did not prevent staff from giving each patient the time they needed. Patients who required urgent care were seen promptly.
- The service was well- led, and the governance processes ensured that team procedures ran smoothly.

However:

- Staff assessed risk well, although not all identified risks were recorded in risk management plans or were detailed in patients' care plans.
- Not all staff were up to date with emergency life support training.

Is the service safe?

Inspected but not rated

We inspected only those parts of safe that gave us concern. We did not rate safe. Our rating of requires improvement from a previous inspection remains.

Our findings

We found:

- Staff in the mental health crisis teams did not keep detailed or comprehensive records of patients' care and treatment. We reviewed nine patient care records; four did not include a risk management plan and six did not have a comprehensive and detailed care plan. Only three were personalised and individualised for the patient; six were generic and interventions not specific.
- The home treatment teams had introduced a call log system to ensure staff dealt with concerns or queries from patients, carers or others. We reviewed the logs from five of the teams and saw that call outcomes were not always recorded in four out of the five teams.
- Staff were not up to date with emergency life support training. The average training rate across all teams was 38%. Staff should have continued to have the training despite the pressures of COVID-19.

However:

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.
- The services had enough staff, who received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams varied across the City but staff managed them well and ensured patients' received the time they needed. Staff provided a range of either face to face contact, telephone or video calls.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. Staff monitored patients on bed waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff gave examples of changes made within the service following incidents. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service well-led?

Inspected but not rated

We inspected only those parts of well-led that gave us concern. We did not rate well-led. Our rating of requires improvement from a previous inspection remains.

We found:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.

Our findings

- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service worked with partner agencies (including the police, ambulance service, and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with legal requirements. This action related to the crisis services.

- The trust must ensure risk management and care plans are fully completed in line with trust policy (Regulation 17 (2) (c).
- The trust must ensure that staff are compliant with emergency life support training requirements (Regulation 18 (2) (a).

Action the trust SHOULD take to improve:

- The trust should ensure that outcomes are recorded within the crisis services call logs (Regulation 17).

Our inspection team

The team that inspected the service comprised of two CQC inspection managers, and six CQC inspectors and three expert by experience who had used community mental health teams to interview staff, patients and carers and on site we had two CQC inspectors and a specialist advisor in crisis services.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing