

Good



5 Boroughs 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)
RTV06	Warrington	Health based place of safety – Warrington Trust wide health based place of safety arrangements	WA2 8WA

This report describes our judgement of the quality of care provided within this core service by 5 Boroughs Partnerships 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 5 Boroughs Partnerships NHS Foundation Trust and these are brought together to inform our overall judgement of 5 Boroughs Partnerships 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?

Not sufficient evidence to rate 

Are services responsive?

Good 

Are services well-led?

Good 

### Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

- Following the inspection in July 2015, we rated mental health crisis services and health-based places of safety as good overall. We rated the service as good for the key questions of safe, effective and responsive. We did not rate caring. We did not inspect these key questions during the most recent inspection in July 2016 and we have not changed these ratings.
- Following the inspection in July 2015, we rated well-led as requires improvement. As a result of the most recent inspection, we have revised this rating to good.

# Summary of findings

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

<b>Are services safe?</b>	<b>Good</b> 
<b>Are services effective?</b>	<b>Good</b> 
<b>Are services caring?</b>	<b>Not sufficient evidence to rate</b> 
<b>Are services responsive to people's needs?</b>	<b>Good</b> 
<b>Are services well-led?</b> We rated well-led as good because: <ul style="list-style-type: none"> <li>• There was a local crisis concordat group and the concordat action plan was reviewed regularly to improve mental health crisis and section 136 responses.</li> <li>• Summary information about episodes of section 136 was recorded electronically on a database to enable managers to monitor its use and consider trends.</li> <li>• The trust routinely audited the use of section 136 and themes were identified.</li> <li>• Multi-agency meetings showed that themes identified during the audits were raised and addressed within the trust and with partners.</li> <li>• There was low use of section 136 across the areas the trust worked within. The joint working arrangements with the police helped to divert people where it was not appropriate to use section 136.</li> <li>• The target to ensure people were seen and assessed within four hours in the health-based places of safety was being met on most occasions.</li> <li>• The reporting of the health-based places of safety was overseen by an assistant director within the trust.</li> <li>• The environment of the health-based places of safety was monitored to ensure it was kept clean and well maintained.</li> </ul> However, we also found: <ul style="list-style-type: none"> <li>• The multi-agency policies on the practical use of section 136 did not reflect the guiding principles of the current Mental Health Act Code of Practice.</li> <li>• The trust's form for recording the use of section 136 did not contain space to record the reasons if the assessing doctors were delayed, or if it was not possible to provide people with their rights.</li> </ul>	<b>Good</b> 

# Summary of findings

- Minor issues had been highlighted by the police or professionals about the health-based place of safety and had not been addressed in a timely manner.
- The health-based places of safety at Hollins Park did not have a stock of patients' rights leaflets or a copy of the Mental Health Act Code of Practice available.

# Summary of findings

## Information about the service

The trust's crisis teams are integrated within the community mental health teams as part of the assessment, home treatment and recovery pathways. The health-based place of safety is used for the assessment of people brought in by the police under section 136 of the Mental Health Act.

Section 136 of the Mental Health Act sets out the rules for the police to arrest a person in a public place when they appear to be suffering from mental disorder and are in immediate need of care or control in the interests of that person or to protect other people. The arrest enables the police to remove the person to a place of safety to receive an assessment by mental health professionals. This would usually be a health-based place of safety unless there are clear risks, for example, risks of violence which would require the person being taken to a police cell instead. The trust has three health-based place of safety at Warrington, Leigh and Knowsley.

People could be detained for a period of up to 72 hours so they can be examined by doctors and assessed by an approved mental health professional to consider whether compulsory admission to hospital is necessary. However, national best practice guidance from the Royal College of Psychiatrists states that the assessment should occur quickly and within three hours and ideally within two hours. The health-based places of safety are available at all times - 24 hours a day, seven days a week and 365 days per year. The community assessment teams provide the staff to support the assessment and monitoring of people whilst they are in the health-based places of safety.

There are partnerships in place between the trust and Merseyside police to provide a street triage service in the Knowsley and St Helens areas and between the trust and Cheshire police to provide a street triage service in Halton and Warrington. Mental health nurses work alongside

police officers, responding to incidents where mental health concerns are indicated. This service is available 10 hours per day seven days per week across varying shift patterns mostly out of hours.

We inspected the crisis assessment teams during the comprehensive inspection in July 2015 when we looked at the community mental health teams. We found that these teams provided a good service across all five key questions we ask when we inspect.

We also inspected the health-based places of safety during the comprehensive inspection of the trust in July 2015. We found that the health-based places of safety was a good service overall and across three of the five key questions we ask when we inspect health services (safe, effective and responsive). We did not rate caring as we had insufficient data. However we rated the health-based places of safety service as requires improvement for well led because the trust was not routinely auditing the use of section 136. On the inspection in July 2015, the trust was unable to provide data to give assurance that the health-based places of safety were being used in line with national guidance around waiting times for assessment and timely attendance of assessing professionals. The trust data was held in paper format and could not be easily obtained through electronic systems. Following the July 2015 inspection we issued a requirement notice, which related to the lack of auditing arrangements around the use of section 136.

The trust provided an action plan telling us how they would improve the arrangements including action to introduce recording summary information electronically. On this inspection, we looked at the well-led domain and the action the trust had taken in response to the requirement notice. We found there were improved oversight and governance systems on the use of section 136.

## Our inspection team

Our inspection team was led by:

Team leader: Sarah Dunnett, inspection manager, Care Quality Commission

The team that inspected the health based place of safety arrangements included a CQC inspector and a Mental Health Act reviewer.

# Summary of findings

## Why we carried out this inspection

We undertook this inspection to find out whether 5 Boroughs Partnership NHS Foundation Trust had made improvements to their crisis and health based places of safety since our last inspection of the trust in July 2015.

When we last inspected the trust in July 2015, we rated crisis and health based places of safety as good overall. We rated the service as good for safe, effective, and responsive key questions and requires improvement for well-led. We were not able to rate the caring key question as we could not speak to anyone who was subject to section 136.

Following the inspection in July 2015, we told the trust that it must take the following actions to improve crisis and health based places of safety.

- The trust must review its systems to ensure data is collected, analysed and disseminated to all organisations involved in the application of section 136. This review should include the ability of the trust to review assessment periods, length of section 136 and equalities data (para 16.64, 16.63 and 16.71 MHA Code of Practice).

We issued the trust with one requirement notice that affected the crisis and health based places of safety service.

This related to:

Regulation 17 good governance.

## How we carried out this inspection

The inspection was a focused unannounced inspection and we asked:

- Are mental health crisis services and health based places of safety well led?

Before the inspection visit, we reviewed information we held about the service including the action plan sent to us by the trust following our inspection in July 2015.

During the inspection visit the inspection team:

- visited the health-based place of safety at Hollins Park which was the health-based place of safety for the Halton and Warrington areas
- spoke with the director of nursing, assistant director and one assessment manager who oversaw the use of the health-based places of safety

- looked at summary information about recent episodes of section 136 and looked in depth at three episodes of the use of section 136 and corresponding care and treatment records of patients
- looked at the audits on the use of section 136
- looked at minutes of the multi-agency meetings that oversee the use of section 136
- looked at the local crisis concordat action plans
- 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

The health based place of safety we inspected was not in use during our visit so we were not able to speak with anyone who was being assessed.



# Summary of findings

## Areas for improvement

### Action the provider **SHOULD** take to improve

- The trust should ensure they work with partners to update the multi-agency policies on the practical use of section 136 so that they reflect the guiding principles of the current Mental Health Act Code of Practice.
- The trust should ensure that the form for recording the use of section 136 contains space for professionals to record any delays of either of the assessing doctors and any reasons where it was not possible to provide patients with their rights.
- The trust should ensure that there is an effective system for ensuring any identified issues highlighted by the police or professionals about the health based place of safety are addressed in a timely manner.
- The trust should ensure that patients' rights leaflets and a copy of the Mental Health Act Code of Practice are readily available in the health based places of safety.

## 5 Boroughs 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
Health-based place of safety – Warrington	Warrington
Trust wide health-based place of safety arrangements	

#### 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.

- Overall, we found that the trust had improved its arrangements to oversee the use of section 136.
- Summary information about episodes of section 136 was recorded electronically on a database to enable managers to monitor its use and consider trends and themes.
- The trust carried out an audit of the use of section 136 which was developed using the requirements contained in the Mental Health Act Code of Practice 2015.

- The joint working arrangements with the police helped to divert people where it was not appropriate to use section 136.
- The audits showed mostly appropriate recording of section 136 episodes and accurate auditing.

However:

- The multi-agency policies had not been updated to reflect the changes within the revised Mental Health Act Code of Practice. For example, they still reflected the previous Code's guiding principles.
- Recent episodes still showed a small number of shortfalls in recording whether people were given their rights while detained under a section 136 and rights leaflets were not readily available.

# 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

<Enter findings here>

### Safe staffing

<Enter findings here>

### Assessing and managing risk to patients and staff

<Enter findings here>

### Track record on safety

<Enter findings here>

### Reporting incidents and learning from when things go wrong

<Enter findings here>

# 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

<Enter findings here>

### Best practice in treatment and care

<Enter findings here>

### Skilled staff to deliver care

<Enter findings here>

### Multi-disciplinary and inter-agency team work

<Enter findings here>

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

<Enter findings here>

### Good practice in applying the Mental Capacity Act

<Enter findings here>

Not sufficient evidence to rate



# 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

<Enter findings here>

### The involvement of people in the care that they receive

<Enter findings here>

# 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

<Enter findings here>

### The facilities promote recovery, comfort, dignity and confidentiality

<Enter findings here>

### Meeting the needs of all people who use the service

<Enter findings here>

### Listening to and learning from concerns and complaints

<Enter findings here>

# 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

There were agreed joint agency policies in place for the implementation of section 136 of the Mental Health Act. These had been agreed with each local authority, police authorities in each of the boroughs the trust worked within and the relevant NHS ambulance service. The duties of all agencies were set out to ensure that people received effective and timely assessment. These policies had not been updated to reflect the changes within the revised Mental Health Act Code of Practice. For example there had been minor changes to the guiding principles of the Code; the current policies still reflected the previous Code's guiding principles.

The trust had an overall purpose which stated 'We will take a lead in improving the well-being of our communities in order to make a positive difference throughout peoples' lives'. There was a continued commitment to working together with other agencies in line with the trust's purpose to ensure people brought into the health-based places of safety received a co-ordinated assessment. This included mental health nurses working out of police stations to ensure people with mental health needs received appropriate support or diversion when they were being dealt with by the police.

There was a local crisis concordat group and a concordat action plan which was reviewed regularly to improve crisis and section 136 responses across the trust. The mental health crisis care concordat was a national agreement between services and agencies involved in the care and support of people in mental health crisis. It set out how organisations would work together better to make sure that people get the help they need when they were having a mental health crisis. The local concordat action plans reflected the trust's values such as improved user feedback and voluntary sector input in line with the values of ensuring everyone was treated with dignity and respect and improving the quality of the response when section 136 was used in line with the values on quality and striving for excellence.

### Good governance

When we last inspected the health-based places of safety in July 2015, we found that the trust could not assure us that

the health-based places of safety were being used in line with the Mental Health Act Code of Practice because the governance arrangements were not effective in overseeing the use of section 136.

The trust sent an action plan telling us how they would improve the arrangements to oversee the use of section 136 and would complete these improvements by 26 February 2016. This included recording summary information electronically, an initial audit of the use of section 136 from this information and ensuring that the procedure for reporting performance was shared with partner agencies.

On this inspection we checked whether the trust had taken this action. Overall, we found that the trust had improved its arrangements to oversee the use of section 136.

Staff within the assessment teams collated information for each section 136 episode onto a database. Summary information about episodes of section 136 was now recorded electronically on this database to enable managers to monitor its use and consider trends and themes. This was submitted each month to the Mental Health Act administrators within the trust. The borough reports were then collated into a report which went to the bi-monthly mental health law forum which was attended by representatives from the trust, the local authorities and police authorities. Information from the forums was then reported to the quarterly mental health law strategic steering group. This meant that the use of section 136 was overseen at varying levels within the trust.

The trust carried out an audit of documentation of 75 people who were brought in by the police on a section 136 from 1 June 2015 to 31 December 2015. The audit tool was developed using the requirements contained in the Mental Health Act Code of Practice. These included checking the circumstances and outcomes of the use of section 136, and also recording patient demographic information including the age, ethnicity and other protected characteristics of the patients. The audit identified overall good practice with many areas showing 100% compliance in terms of recording episodes of section 136.

The most recent audit identified that in 35% of cases it was not clear that people were informed of their rights. The audit recommended that staff should be reminded that that they must read patients their rights when detained under section 136 of the Mental Health Act, or record why

# 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.

this had not been done in their records. The start time of the Mental Health Act assessment was not recorded in just over 20% of the records. The trust had a target to see and assess people who had been brought in on section 136 four hours. People were seen and assessed within four hours in the health-based places of safety on most occasions with 86% of all episodes where it was clearly recorded.

Following on from this initial benchmarking audit, the trust had routinely audited the use of section 136 since February 2016 and identified themes. This showed improvement in the audit results from previous periods. For example, the routine audits showed that in April 2016 in all 20 episodes of section 136 the people were informed of their rights, and 18 out of 20 assessments were carried out within four hours with the other two episodes taking longer because of people being intoxicated and/or medically unfit to be assessed.

We checked a small number of recent section 136 papers which corroborated the audit results. They showed mostly good recording of section 136 episodes and accurate auditing with ongoing occasional shortfalls in some areas. For example recent episodes still showed a small number of shortfalls in recording whether people were given their rights or the time that both doctors attended where the Mental Health Act assessment was proceeding. The trust's form for recording the use of section 136 did not contain space for professionals to record the delays for both assessing doctors or the reasons where it was not possible to provide people with their rights.

Multi-agency meeting minutes showed that themes identified during the audits were raised and addressed within the trust and with partners. The manager in the assessment team had good oversight of the use of the section 136 suite and talked in depth about recent episodes, recent audit results and action arising from these. The manager confirmed that there continued to be good multi-agency working and shortfalls were being addressed. For example, emails had been sent to assessment team staff to remind them of the need to give patients their rights and make a record that this had occurred.

The environment of the health-based places of safety was monitored to ensure it was kept clean and well maintained. We saw most of the maintenance work highlighted in the communication book at the health-based place of safety in Warrington had been addressed. However, a small number

of identified minor issues highlighted by the police or professionals about the health-based place of safety were not addressed in a timely manner. For example, the closed circuit television in the communal areas of the health-based place of safety was recording the incorrect time. This had been highlighted for a number of months by police officers who had asked for it to be addressed if closed circuit television evidence was required. The time was corrected on the same day of our visit once we had pointed it out to senior managers. The manager of the assessment team accepted the need to ensure any issues identified within the communication book should be considered and actioned appropriately.

The health-based places of safety at Hollins Park did not have a stock of patients' rights leaflets or a copy of the Mental Health Act Code of Practice readily available. These could be accessed through the computers within the health-based places of safety, from nearby wards or the Mental Health Act office.

This meant that the trust had improved its arrangements to ensure that the use of section 136 was monitored effectively.

## **Leadership, morale and staff engagement**

The health-based places of safety did not have dedicated staff based there. The day to day staffing and management of the health-based place of safety was overseen by staff from the assessment teams which formed part of the trust's community mental health teams. We did not speak to any staff that directly supported and staffed the health-based place of safety because we were focusing on the auditing process. The manager of the assessment team confirmed that the dual role of the assessment team staff to both manage the crisis and home treatment and to staff the health-based place of safety was manageable because of the low use of section 136 and the work of the street triage team to divert people appropriately.

The reporting of the use of section 136 and the health-based places of safety was overseen by an assistant director within the trust. This meant that a senior manager in the trust oversaw the use of section 136, and ensured that audits were carried out and effective multi-agency meetings occurred.



# 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.

## **Commitment to quality improvement and innovation**

The information from the trust confirmed that there was low use of section 136 across the areas the trust worked within. Mental health nurses worked out of police stations to ensure people with mental health needs received appropriate support or diversion when they were being dealt with by the police. The joint working arrangements with the police helped to divert people where it was not appropriate to use section 136.

The environment of the health-based place of safety at Warrington exceeded the requirements detailed in the Royal College of Psychiatrists' guidance on the use of section 136. The trust were building new mental health services at Leigh for the people of Wigan and Leigh which would include a new purpose built health-based place of safety.

The multi-agency section 136 procedures had a time frame from admission in the health-based place of safety to the

time the Mental Health Act assessment was completed of within two hours. This was the standard for reporting in the financial year 2016/7. Incidents which exceeded the two hour time frame required an explanation of why any delays occurred. This meant there was a commitment to ensure that people waited for the shortest possible time in the health-based place of safety which was in line with the national best practice guidance from the Royal College of Psychiatrists which stated that the assessment should occur quickly and within three hours and ideally within two hours.

There had been an independent evaluation of the street triage service in Warrington and Halton carried out by an independent consultancy service in August 2015. This corroborated the good interagency working around section 136 and the significant reduction in the use of section 136 largely as a result of the street triage service.