

# Coventry and Warwickshire Partnership NHS Trust

## Mental health crisis services and health-based places of safety

### Quality Report

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### Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RYGCR	Wayside House	Coventry Crisis Resolution and Home Treatment Team	CV2 2TE
RYGCR	Wayside House	Arden Mental Health Assessment Team	CV2 2TE
RYGCR	Wayside House	South Warwickshire Crisis Resolution and Home Treatment Team	CV2 2TE
RYGCR	Wayside House	North Warwickshire Crisis Resolution and Home Treatment Team	CV11 5HX
RYGCR	Wayside House	Health-based Place of Safety	CV2 2TE

# Summary of findings

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

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

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

# Summary of findings

## Ratings

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

### Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

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

- Services were able to respond to people's needs promptly and effectively, helping to minimise distress and risk to individual patients. Teams contained sufficient staff of a suitable quality, skills mix and experience to enable this to happen. Staff shared knowledge and skills to the benefit of patient well-being and recovery. Teams worked well together with a good mix of professional disciplines, ensuring expert advice was readily available. Where specific professionals were not present in a team, teams could contact them for advice and support promptly as required.
- Teams had good links with other statutory or and voluntary agencies and organisations, helping to ensure patients moved from one service to another to meet their needs as effectively as possible.
- Staff were caring, dedicated and showed understanding of people in crisis. Feedback we had from patients and carers showed they valued the caring, compassionate and understanding approaches displayed by staff.

- Staff ensured patients and carers were informed and involved in their care and treatment.
- Staff knew how to report safeguarding concerns and incidents.
- Medicines were managed safely and effectively.
- Staff were well supported, well-motivated, experienced, confident and proud of their work in helping people in crisis. Sickness, absence and turnover rates were low.

However,

- The service did not always effectively show in records the work it was doing, particularly with regards informing and involving patients and carers in care and treatment.
- Not all non-medical staff were receiving appraisals.
- The planned imposition of car parking charges for staff, including essential car users, had an adverse impact on staff morale.
- Not all staff were effectively utilising lone working safety systems to enable them to work safely.

# Summary of findings

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

### Are services safe?

We rated safe as **good** because:

- Services had sufficient staff to ensure they saw patients promptly and did not leave them at undue risk. Services were able to contact appropriate clinicians whenever needed. Staff closely monitored patients so they could respond swiftly to any change in their well-being.
- Interview and waiting areas used by patients were clean, well-maintained and safe. The health-based place of safety unit had secure facilities and enabled safe monitoring at all times.
- Staff were experienced and suitably trained.
- Medication management was safe.
- Staff knew how to make safeguarding alerts and report incidents when necessary. Incidents and complaints were investigated and learnt from.
- There were good working practices in place to keep both staff and patients safe.

However:

- Not all crisis resolution staff were adhering to the lone worker policy by using the available electronic monitoring system.

Good



### Are services effective?

We rated effective as **good** because:

- Staff completed assessments in a timely manner and these guided and reflected good practice.
- Staff involved and informed patients about their care and treatment. Patients were able to discuss and question their treatment. Services kept families and carers fully informed where this did not conflict with patients' wishes for confidentiality.
- Medicines were managed effectively.
- Teams had access to relevant health professionals and ensured concerns about patients received prompt and effective treatment by the relevant professional or agency.
- The service used recognised outcome and monitoring measures to help assess the level of support and treatment required.
- The service monitored the performance of teams to ensure work was effective.
- Teams were staffed by skilled and experienced staff who benefitted from training, support and supervision.

Good



# Summary of findings

- Staff passed on information effectively. Handovers between crisis resolution teams showed knowledgeable staff conveying relevant information.
- Teams had good links with other organisations. Crisis teams linked well with partner agencies. The place of safety team met monthly with the police, ambulance and social services.

However:

- There was little evidence in care records of patients being involved in their care and treatment.
- Less than half of non- medical staff in south Warwickshire had received appraisals.

## Are services caring?

We rated caring as **good** because:

- Staff were supportive, kind, and caring throughout and showed a good knowledge of the individual needs of patients.
- We received positive feedback about staff from patients and carers.
- Patients and carers were involved in their care and treatment.

However:

- Evidence of patient and carer involvement was not always documented in records.

Good



## Are services responsive to people's needs?

We rated responsive as **good** because:

- Response times were good. Crisis resolution teams contacted patients within four hours of referral. The Arden mental health acute team began assessments within 90 minutes of receiving referrals. The service offered flexible appointments and engaged with people who were reluctant to engage with the service.
- The service was supportive of people in crisis and helped identify additional help, enabling them to move on as required to more suitable locations.
- Where patients attended trust premises, facilities were good and promoted recovery, dignity and confidentiality.
- The service received few formal complaints. It was able to resolve concerns locally and was able to learn from complaints.

Good



## Are services well-led?

We rated well led as **good** because:

Good



# Summary of findings

- Teams worked in accord with the values of the trust.
- Staff were positive, experienced, confident, well-motivated and worked together well. They frequently expressed satisfaction in doing a good job in helping people in crisis.
- Staff were well-supported and received suitable training. Sickness, absence and turnover rates were low. Staff frequently told us they had worked for the trust and the service for a number of years.

However:

- The planned imposition of car parking charges, particularly on those regarded as essential car users, had a negative impact on staff morale.

# Summary of findings

## Information about the service

The crisis resolution and home treatment teams provide services in the community for people with mental health problems who are in crisis.

The teams are based in three 'hubs'. These are at the Caludon centre, serving the Coventry area, St. Michael's hospital in Warwick, serving South Warwickshire, and the Manor hospital in Nuneaton, serving North Warwickshire. They are led by team leaders, and together operate a 24/7 service. At night the service operates from the Coventry hub, with all calls being rerouted to there.

The health-based place of safety unit is a service for the whole of Warwickshire. It is located at the Caludon centre in Coventry, and is managed by the acute mental health inpatient service.

The Arden mental health acute team (AMHAT) serves the whole of Coventry and Warwickshire. It is based in the Caludon centre in Coventry, with staff working in the accident and emergency services in acute hospitals in Coventry, Warwick and Nuneaton. It assesses those patients who are ready for discharge from acute hospitals so that those patients can move on to other settings. At the time of our visit, the service manager of the crisis resolution service was managing this service.

We had previously visited these services as part of the inspection of this trust in January 2014. There were no compliance actions set regarding them.

## Our inspection team

The team was led by:

**Chair:** Paul Jenkins Chief Executive of Tavistock and Portman NHS Foundation Trust.

**Team Leader:** Julie Meikle, Head of Hospital Inspection (mental health) CQC.

**Inspection Manager:** Margaret Henderson, Inspection Manager, mental health hospitals CQC.

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers and a variety of specialist advisors.

The team which inspected this service consisted of two CQC inspectors, two mental health nurses, a Mental Health Act reviewer and an expert by experience. An expert by experience is someone who has direct experience of using mental health services.

The team would like to thank all those who met and spoke with inspectors during the inspection and who were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

## 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?

# Summary of findings

- Is it well-led?

Before the inspection visit, we reviewed information we held about these services.

During the inspection visit, the inspection team:

- visited the three crisis resolution teams, the hub of the Arden mental health acute team and the health-based place of safety
- spoke with 11 patients and carers who were using the service
- spoke with the team leaders or acting team leaders for each of the teams
- spoke with 32 other staff members; including doctors, nurses and social workers
- observed nine visits to the homes of patients and carers by health workers
- attended three medical reviews of patients
- attended and observed three hand-over meetings and one multi-disciplinary review meeting.
- looked at 40 treatment records of patients
- reviewed medication management of each team
- 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

Patient survey reports showed broad satisfaction with the service. What people we spoke with told us about their experience of the service reflected this.

People who used the service were positive in their views of it. They, their carers and relatives were complimentary about staff, noting their understanding, politeness and supportive approach.

People in crisis told us they were able to get prompt responses from the service. We had no adverse comments from people about having to wait for appointments or having them cancelled.

## Good practice

We did not identify any specific good practice, beyond the good, cohesive individual and team work displayed by motivated, experienced and skilled staff.

## Areas for improvement

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

- The provider should ensure all crisis resolution staff are adhering to the lone worker policy.
- The provider should ensure staff record patient and carer involvement in care and treatment records.
- The provider should ensure all non- medical staff receive yearly appraisals.
- The provider should note the negative impact on staff morale of car parking charges, particularly those regarded as essential car users.

# Coventry and Warwickshire Partnership NHS Trust

## Mental health crisis services and health-based places of safety

### Detailed findings

#### Locations inspected

##### Name of service (e.g. ward/unit/team)

##### Name of CQC registered location

Coventry Crisis Resolution and Home Treatment Team  
 Arden MH Assessment Team  
 South Warwickshire Crisis Resolution and Home Treatment team  
 North Warwickshire Crisis Resolution and Home Treatment team  
 Health-based Place of Safety

Wayside House

#### 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.

Each team had access to approved mental health practitioners (AMHPs) who either worked directly with the team, or who were readily accessible to them. They were able to share best practice guidance and provide support in team meetings. They demonstrated a good understanding of the Mental Health Act. AMHPS had regular monthly forums that discussed new case law.

Staff had access to a Mental Health Act administrator to give advice as needed on any Mental health Act issues.

There were no patients on community treatment orders being seen by the crisis resolution teams at the time of inspection. People who were detained in the health-based place of safety had their rights under the Mental Health Act explained to them.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff showed a good understanding of mental capacity on a case-by-case basis. Staff we observed on visits showed a good awareness of ensuring patients and carers understood and consented to proposed treatments.

One health professional acknowledged that capacity was assumed by nurses unless there were indications to the contrary, but then recognised it always needed to be recorded. They said staff would fully record if there were any concerns about ability to consent.

Where there was concern that a patient did not have capacity to give consent a capacity assessment was completed by the service.

There was an up to date policy on the Mental Capacity Act available for staff to refer to. Staff obtained consent from patients and incorporated this into discharge letters. Letters to GPs recorded that patients had consented to treatment.

# 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

### Crisis resolution and home treatment teams

#### Safe and clean environment

- The service saw and assessed the majority of patients in the patients' own homes. Where patients came to units for assessment, rooms were clean, safe and well maintained, and ensured privacy and dignity. Assessments at units happened primarily at Warwick. Rooms here were light and airy. The site had welcoming reception areas. The rooms were sound proof, and had alarms to summon assistance if needed. They were primarily for interview purposes, as an alternative to the patient's own home. Any more detailed physical examinations that were required would be done at the patient's GP clinic.

#### Safe staffing

- Crisis teams were allocated staff according to need based on population and demographics. The crisis resolution service had the working time equivalent of 60 nurses, with ten vacancies. There were 22 nursing assistants, with two vacancies. The number of shifts filled by bank staff for the three months up to 30 November 2015 was 404. The service had requested agency staff to fill one shift in that period. Sickness levels were below 10% on all the teams. Staff turnover rate was also below 10%.
- Staffing numbers were sufficient to ensure the service was able to contact, assess, and treat all people referred to it promptly. There were no waiting lists. In daily handovers, all new patients were allocated a member of staff, who would ensure a visit was arranged.
- Each crisis team had a pool of experienced bank staff they were able to call on if required to cover sickness or leave.
- Each crisis team was able to access a psychiatrist when needed.
- Mandatory staff training exceeded 80% in all areas. More current data we saw during the inspection showed the service had addressed these shortfalls.

### Assessing and managing risk to patients and staff

- Initial assessments were undertaken by two staff who visited the patient. Staff checked records to see if the patient was known to the service and whether there were any pre-existing risks.
- The service was able to respond to deterioration in a patient's health by increasing support and monitoring. Daily team handovers were the forum for noting and sharing any information concerning changes. The team made adjustments to monitoring and treatments at this point, ensuring any patient risks were addressed.
- There was no waiting list. The service contacted patients within four hours of referrals and put arrangements in place to visit them.
- Staff knew how to make safeguarding alerts when appropriate. They had all received safeguarding training. We discussed examples of safeguarding alerts with staff. Staff raised and discussed any safeguarding issues in handover meetings. We observed the discussion of two issues involving the monitoring of a patient who was a parent. A potential risk to children had become apparent. This resulted in the team making a safeguarding referral immediately after the meeting.
- There were good safe working practices in place. The service had clear lone working policies in place, with a recognised electronic system for recording and logging visits. One health professional told us how effective and reassuring they found this system. They said the system was excellent and tracked staff whereabouts for safety purposes. Team leaders told us they encouraged and expected staff to use the system. One team leader acknowledged that not all staff consistently used the system. We came across one incident where it was clear that the staff member had not used the available system, which would have afforded them better protection.
- There was good medicines management. Our pharmacy inspector visited the Coventry team and found medication managed safely. Where medicines were stored on units, they were stored securely and recorded accurately. Medicines were safely disposed of. One team did not store any medication, but had prescriptions

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picked up from local pharmacies when needed for patients. Where teams used Patient Group Directives, there were documents showing the appropriate persons had signed and authorised them. Patient Group Directives permit the supply of prescription-only medicines to groups of patients, without individual prescriptions.

## Track record on safety

- There had been 12 serious incidents recorded by the service in the past 12 months. The service had reviewed and investigated all incidents. Lessons learnt were cascaded to staff.

## Reporting incidents and learning from when things go wrong

- Staff knew what to report. A frequent example was of patients self-harming. This would result in staff updating risk assessments and arranging more frequent visits arranged to support and monitor the patient concerned.
- The trust published monthly learning alerts. These gave anonymised details of incidents, what lessons had been learnt from them and what impact this was likely to have on services. The alerts also identified actions from complaints received. Staff and team leaders were forthcoming about the most recent incidents involving their teams and what, if any, improvements were made to the service to make it safer.
- A team leader raised an example of an adverse incident where a member of staff felt intimidated on a recent visit. It had been risk assessed as a one-person visit. This led to further discussion on identifying risk and clarifying strategies on leaving situations where staff felt at risk. All staff members were aware of the need to read information on patients and environments prior to a visit. Nevertheless, staff were aware that unpredictable scenarios could develop.
- A crisis team leader discussed a recent serious incident. They explained how the service reviewed and investigated this to see what lessons the service could learn. There had been a debriefing for staff. Additionally, the team was ensuring support for the relatives of the patient.
- We discussed on incident in the Coventry team where the service had delivered medication to the wrong address. This had resulted in the service ensuring more

thorough checks were done before delivering such medicines. The service would only deliver medication if the patient was aware and in agreement with it being delivered in their absence and if staff were sure it was safe to do so.

- Staff had debriefings after incidents. Teams had access to a counsellor if required.

## Health based place of safety

### Safe and clean environment

- The health- based place of safety was clean, well maintained and safe. There were no observable ligature risks. A ligature risk assessment was in place and audited regularly. The trust held the audit centrally. Observation facilities were in place. Mirrors ensured there were no blind spots in the unit. There was a suitable clinic area, with facilities for monitoring and safeguarding the patient, including resuscitation equipment.
- There were two assessment rooms, both with sofas and chairs. This furniture was in a good state of repair.
- There were alarms in place. A current problem with the building meant power outages could adversely affect these and other equipment. The manager told us the last unplanned outage had been over six months ago. They confirmed battery-operated back-up equipment was in place for emergency use.

### Safe staffing

- Staff on the acute wards were rostered to staff the health- based place of safety when required. There was always staff available as required by the unit. There were two designated staff on each shift. These were the ward co-ordinator and an assistant who were present on an adjacent ward and who could be called for duty whenever needed.
- Staff received the appropriate mandatory training in accordance with that provided by the inpatient service.

### Assessing and managing risk to patients and staff

- The process of admission to the health-based place of safety was explained by staff. There was a clear, safe

# Are services safe?

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process in place. The unit could call on support from other units if required. There was access to 24 hour medical cover, with the aim for patients to be seen within four hours.

- The police and /or ambulance staff remained in the vicinity until staff had completed a satisfactory physical health care check of the patient.
- Staff were trained in safeguarding and knew how to make a safeguarding alert and do this when appropriate.
- Accessible emergency medicines were stored safely. The manager informed us the service rarely used rapid tranquilisation. Trust data showed rapid tranquilisation had been used once in the previous twelve months in the place of safety.

## Track record on safety

- We were informed there had been no serious incidents within the place of safety in the last three months. The manager told us that while patients showed signs of aggression or disturbance, the police remained on site. They detailed a recent but rare incident, where a patient who had appeared calm had struck out at a nurse. This was reported as an incident. There had been nine incidents reported in the past year.

## Reporting incidents and learning from when things go wrong

- The manager told us informal de-briefings took place after any incidents and any learning was shared amongst the team. They said any learning points were discussed at monthly meeting with partner agencies.

## Arden mental health acute team

### Safe and clean environment

- Staff met patients in suitable rooms in acute hospitals wards. We did not view these premises as they were maintained by another trust. Staff we spoke with raised no concerns about the safety or suitability of these rooms.

## Safe staffing

- The team had 29 nurses, including the manager, four support workers, a medical secretary and two consultants. The service had recently appointed three nurses to bring the team up to agreed numbers. These numbers allowed the team to meet the commissioned availability times for the service. This was currently 9am – 7.15am for the Coventry hospital, 9am – 5pm for the Warwick hospital, and 9am-11pm for the hospital at Nuneaton. All operated a 9-5 service at weekends.
- Agency and bank staff were used rarely. Sickness and absence rates were below trust averages.
- Staff received and were up to date with appropriate mandatory training.

## Assessing and managing risk to patients and staff

- The team received referrals from the acute hospitals and undertook assessments to inform suitable discharge to an appropriate facility. Members of the crisis teams we spoke with spoke of the value of these assessments in helping them plan and monitor care and treatment for people seen by the acute team.
- Staff were clear on identifying abuse and were able to give examples of where this had been done. One example showed how they had effectively supported and enabled a patient in not returning to an abusive situation.
- Good personal safety protocols were part of the operational policy for the team. Staff told us they felt safe in their working environment.

## Reporting incidents and learning from when things go wrong

- Staff were clear on what and how to report. Over the last 12 months there had been 29 incidents reported for this service. Staff had regular feedback in team meetings. Staff discussed any concerns in team meetings or in individual supervision sessions. Staff told us they felt well supported by their manager and team and received regular supervision.

# 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

### Crisis resolution and home treatment teams

#### Assessment of needs and planning of care

- We looked at 40 care records across the three crisis teams. Assessments were completed and care plans care captured the information obtained from assessments and visits
- Records were stored securely via electronic records. Some staff felt that this was a disadvantage, as they had to return to an office to complete records. Some compared this unfavourably to when they could complete paper records at a patient's home or immediately afterwards. They felt having laptops would assist them in doing this.
- There was no evidence of patient involvement in the electronic records we reviewed. However, it was clear from patient and carer comments and from our observations during visits that staff gave patients opportunity to discuss their treatment. The service gave patients a folder entitled 'My Care Plan'. This contained details of useful contacts, general useful information about the service, and details of how to get help. Those we saw did not contain personalised details of care and treatment.
- Letters sent to GPs were also addressed to patients.

#### Best practice in treatment and care

- Staff demonstrated an awareness of National Institute for Health and Care Excellence (NICE) guidelines in their practice and in prescribing medicines. We looked at 13 prescription charts at the Warwickshire team and found them to be satisfactory. Our pharmacy inspector reviewed medicines management at the Coventry hub and found it satisfactory and following NICE guidelines.
- Teams had access to psychology input and could refer patients for short-term intervention or have input and advice from psychologists. Teams had nurses trained in cognitive behavioural therapy. Patients were also signposted to external agencies offering services. These included anger management and anxiety management courses. One psychologist explained the work they were doing with one patient and how this was having a

positive impact on the patient's well-being. A consultant gave an example of how input from a psychologist had helped rule out Asperger's as a trigger for particular behaviour of one patient.

- Staff offered advice on employment, benefits and housing where this was a crisis issue. For example, we noted a nurse exploring sickness and employment issues when visiting a patient. Staff received training in the use of food vouchers, liaison with charities, and awareness of refugee centres. Interventions also including support to patients, where appropriate, to attend and use substance misuse services.
- Crisis staff checked patients' physical well-being. They monitored, where appropriate, effects of medication on physical health. Clinical reviews that highlighted physical health concerns ensured patients were referred to GPs for further checks and monitoring. Staff discussed medication and possible side effects. They advised on possible adjustments to medication with patients and carers. Where relevant they also discussed diets.
- Outcome measures and severity ratings such as HoNOS (Health of the Nation Outcome Scales) and STORM (skills training on risk management) risk assessments were used by teams to help measure support needed and as a tool to assess ongoing need.
- There were audits on performance. One prime performance target involved contacting patients within four hours of referral. Staff were all involved in maintaining these, or raising specific reasons for them not being achieved. Some patients being occasionally out of area or in prison were two of the examples we were given. Clinicians were involved in specific reviews such as transition issues, issues arising from single points of access, one clinician told us of their involvement in reviews of serious untoward incidents following a period of service reconfiguration. Audits were escalated to the trust board for action plans to be implemented in response.

#### Skilled staff to deliver care

- Teams consisted primarily of nurses and support workers. There was also a full range of mental health specialists to support them. Each team had psychiatrists to lead on clinical issues. There were AMHPs (approved mental health professionals) social workers,

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psychologists and occupational therapists available. These varied from team to team. Some teams had psychologists or occupational therapists within their teams, others had access to them on a regular or on call basis from other teams.

- Staff were experienced practitioners. Many had worked for many years within crisis and home treatment teams. Support workers supported nurses in clearly defined ways. They predominantly did follow up and monitoring visits. Teams had low staff turnover and the majority of staff we spoke with had been there for over two years. Many had been there for much longer.
- All staff received the trust induction, alongside the induction specific to the service they were working in.
- In addition to clinical and professional training, staff we spoke with had awareness training in such areas as forced marriages, honour based violence, food banks, refugee centres, as well as vet services and housing for pets.
- In addition to clinical and professional training, staff we spoke with had awareness training in such areas as forced marriages, honour based violence, food banks, refugee centres, as well as vet services and housing for pets.
- Records showed regular staff supervision took place. Staff we spoke with said they were well- supported by their manager and colleagues. Clinicians had annual appraisals and maintained up to date training for their revalidation.
- Non-medical staff received appraisals regularly, except for South Warwickshire team, where less than half the staff had received an appraisal in the 12 months prior to November 2016.
- Staff received specialist training. In addition to clinical and professional training, staff we spoke with had awareness training in such areas as forced marriages, honour based violence, food banks, refugee centres, as well as vet services and housing for pets.
- Team leaders we spoke with said poor performance was not an issue, and that staff were highly motivated and worked well as a team and as individuals. However, one

team leader gave an example, which showed the service addressed poor performance promptly. This related to an isolated incident that the service had addressed and investigated.

## Multi-disciplinary and inter-agency team work

- Teams had regular, detailed handovers. These occurred at least twice daily. We observed three handovers and were impressed with the knowledge, thoroughness and effective manner in which the teams shared and passed on information. Contributions were relevant and concise, and team leaders ensured that while healthy debate took place, handovers stayed focussed on the current needs of the specific patient. One health professional told us how essential these handovers were as there could be five or six new referrals in a day.
- One issue raised in Warwickshire was that the Arden mental health acute team (AMHAT) did not provide 24 hour cover in Warwick. This was a liaison team whose role was to ensure the transfer of patients with mental health issues from acute hospital care to more appropriate settings. The team leader felt discharges overseen by this team were excellent with clear statements of risks, or contact details. Referrals that came directly from the hospital when this team was not available were not always of such clarity and detail.
- Some referrals came from GPs whose patients were under the care of another community team, but whose next appointment was up to three months away. If they went into crisis because of the wait, they were seen by the crisis team. Some staff felt this was not a good use of resources.
- There were good links with other agencies. At the south Warwickshire team, for example, there were monthly 'protected time' learning sessions. These frequently involved input from other agencies, so all could swap ideas, learn from each other, and improve their working together. All teams had close working relations with other mental health agencies. One partner agency regularly attended review or handover meetings to update teams on progress or concerns regarding patients who were still open to the crisis team. There were also regular information exchanges with drug and alcohol services. We also saw evidence of staff ensuring contact was made with other teams in other areas to

# 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.

ensure support for patients moving across the country. The Warwickshire team had established monthly protected learning sessions involving other agencies giving talks and exchanging ideas and views.

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

- Staff had access to a Mental Health Act administrator to give advice as needed on any Mental Health Act issues. Each team had access to approved mental health practitioners (AMHPs) who either worked directly with the team, or who were readily accessible to them. They were able to share best practice guidance and provide support in team meetings.
- AMHPS told us their training on the Mental Health Act was all up to date and they had regular monthly forums where they discussed new case law. They demonstrated a good understanding of the Mental Health Act.
- There were no patients currently on community treatment orders being seen by community crisis teams.

## Good practice in applying the Mental Capacity Act

- Staff had information leaflets to highlight key points around capacity. Capacity was discussed on a case-by-case basis, with capacity always being assumed by the service unless there indications to the contrary. There was no evidence of standardised recording of capacity or of monitoring of this.
- There was an up to date policy on the Mental Capacity Act available for staff to refer to.
- Data submitted by the trust showed low levels of completion of joint Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards awareness training by crisis teams, with figures for eligible staff of 52% for Coventry, 50% for North Warwickshire, and 69% for South Warwickshire. Training data we saw during the inspection showed these shortfalls were being addressed.
- Staff showed a good understanding of mental capacity on a case-by case basis. Staff we observed on visits showed a good awareness of ensuring that patients and carers understood and consented to proposed treatments.

## Health based place of safety

### Assessment of needs and planning of care

- Initial assessments were completed in a timely manner. A clear process for commencing mental health assessment and physical health checks was in place and used when people were brought to the place of safety under Section 136 of the Mental Health Act.

### Best practice in treatment and care

- Trust guidelines for rapid tranquilisation were followed. Rapid tranquilisation had been used once in the past year.

### Skilled staff to deliver care

- The place of safety was staffed by staff from identified wards adjacent to the place of safety. There was a unit coordinator who was responsible for ensuring the place of safety was staffed appropriately on a 24/7 basis. Staffing minimum was a qualified nurse and a support worker.

## Multi-disciplinary and inter-agency team work

- The service had regular monthly meetings with the police, ambulance and social services. The manager of the service told us these were very helpful in improving relations, understanding and communication. They said relations with the police were very good and those with ambulance service were developing.

## Adherence to the MHA and the MHA Code of Practice

- People who were detained in the health-based place of safety had their rights under the Mental Health Act explained.

## Arden mental health acute team

### Assessment of needs and planning of care

- The team saw more than 90% of patients for assessment within 90 minutes of receiving a referral. This was within the target of 90% set by the trust. A nurse we spoke with gave a good example of an assessment being delayed for valid reasons. Recent

# 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.

events had left a patient extremely disturbed and they were not suitable for assessment at that point. By the next morning they were ready for assessment and were able to be discharged to a suitable location.

- Documentation was completed, kept securely and available to be shared with relevant professionals as required.

## Best practice in treatment and care

- The team included nurse prescribers who received regular clinical supervision.
- Staff used specific Patient Health Questionnaires (PHQ9) and Generalised Anxiety and Depression scales (GAD7) to help gauge and monitor patient well-being. One nurse told us the team used these because they knew the GPs who would be receiving referrals from them were familiar with these tools.
- The manager gave us an example of staff all participating in a case note audit. This had helped ensure all recording was up to date.

## Skilled staff to deliver care

- The team consisted of a range of qualified and experienced nurses with access to other health professionals and clinicians when needed.
- Staff received regular supervision, appraisals and access to regular team meetings. Staff told us they received and gave feedback in team meetings. Records showed mandatory training was up to date with 100% completion levels in almost all areas.

- Staff received the necessary specialist training for their role.

## Multi-disciplinary and inter-agency team work

- The team was able to work effectively and co-operatively with colleagues in the acute wards. Staff said they had good feedback from colleagues in the acute ward. We had good feedback concerning the quality and timeliness of assessments and referrals from colleagues in the crisis resolution teams.

## Adherence to the MHA and the MHA Code of Practice

- Staff worked on acute wards so did not receive detained patients there, but arranged for mental health assessments when required.

## Good practice in applying the MCA

- Records showed all staff were up to date with Mental Capacity Act and Deprivation of Liberty Safeguards training.
- Staff obtained consent from patients and incorporated this into discharge letters. Capacity was assumed unless there were indications to the contrary. Where there was concern a patient did not have capacity to give consent a capacity assessment was done by the service.

# Are services caring?

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

## Our findings

### Crisis resolution and home treatment teams

#### Kindness, dignity, respect and support

- Staff were responsive, respectful, understanding and gave practical and emotional support. We observed nine visits and three patient reviews and saw a positive, supportive approach from all staff. Throughout, staff treated patients with kindness, dignity and respect.
- Patients and carers were positive about staff. This was evident in direct feedback from patients and carers and from surveys of patients and carers. One carer we spoke with, for example, praised the responsiveness of the service and told us “they are excellent in everything”. Patient questionnaires returned from January 2016 showed over 80% being clear they felt listened to and respected.
- Daily handovers showed staff sharing their knowledge of patients, so that those going out to see them would have a good knowledge of individual needs. This was particularly impressive in respect of new patients, where staff passed on rapidly gained understanding of individual needs and risks. This helped patients and carers in not having to repeat information about themselves to different staff.
- Staff were clear on confidentiality and were able to discuss examples of when it should be maintained and where it had to be breached because of the nature of the disclosures. They were also clear on issues of confidentiality between patients and other family members.

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

- Observations of handovers, reviews and visits showed that teams involved patients in planning their care and treatment, although this was not so evident in recording in care plans. We saw examples of how treatment plans were jointly agreed with the patient and their informal carers. Treatment typically involved the team visiting the patient at home to deliver treatment in the least restrictive environment, rather than requiring admission to a ward.

- It was not always clear from documentation that families and carers were involved in patients’ care and treatment. However, our observations of interactions with patients, combined with patient and care feedback, confirmed that patients and carers were fully involved.
- Patients could access advocacy. One patient we met was having advocacy support relating to a housing issue.
- The service gave patients questionnaires to fill in and return. These formed the basis of surveys. We saw copies of these. These were very positive, with the majority of responses showing a high level of satisfaction with services.
- One person we spoke with had a negative view of the service. Amongst the issues they were concerned about was the number of different staff they saw. This was in contrast to the many positive views we heard from other users and carers.

### Health-based place of safety

#### Kindness, dignity, respect and support

- Staff we spoke with described how they supported people who used the service in a considerate manner, and how they ensured that those people were treated in a way that upheld their privacy and dignity at all times. They recognised that having a caring and positive attitude towards people in a place of safety suite was a vital factor in providing care for people in crisis.

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

- Advocacy service and interpreters were available for patients to access from the place of safety. Staff noted that advocacy services would be exceptional as the aim was to have people moved to a more appropriate setting in less than six hours.

### Arden mental health acute team

#### Kindness, dignity, respect and support

- Staff demonstrated in discussion and by example that they understood the individual needs of patients.

# Are services caring?

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

- We discussed a case that showed the teams maintained patient confidentiality. They were aware of the issues that patient confidentiality could raise and worked to resolve these sensitively.
- Examples and discussions with the manager and staff showed how families and carers were involved in decisions regarding care and treatment.
- Support from advocacy services was available to patients.

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

- People using the service were involved in decisions regarding their care and treatment. These decisions were based on meetings with them and agreed moves to other services.

# 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

### Crisis resolution and home treatment teams

#### Access and discharge

- The target response time from referral to initial contact was four hours. 97% of patients were contacted within four hours of referral.
- The service was a 24 hour 7 day a week service. It was able to see urgent referrals within acceptable time limits. The service responded to night referrals by telephone in the first instance, but staff could make visits if the urgency demanded it.
- The operational policy of the service gave criteria for who was offered a service. It did not exclude specific groups, but made it clear that, after initial assessment, it was less likely to offer intensive support to those with conditions such as dementia or a primary diagnosis of alcohol or other substance misuse. The service would refer such patients to appropriate services. Staff made it clear they supported patients until the team had identified an appropriate service. Our observations of reviews and handovers confirmed this.
- The service sought to re-engage with patients who did not attend appointments. They followed a protocol, but used existing knowledge and risk to guide their approach. They would contact the GP and use existing information to inform any follow up. In order to minimise non-attendance, the service would contact patients prior to appointments, as a reminder.
- The service was flexible in times of appointments. We saw examples where staff were aware of patients' commitments and needs and worked appointments around them. This varied from patients' work commitments, to their wish for privacy and discretion in the timing and siting of appointments. We saw patients offered a choice of appointments and of patients opting for evening appointments.
- The teams rarely cancelled appointments. We saw no evidence of cancellations, nor any concerns expressed by patients or carers about the service cancelling appointments. Managers advised us that very occasionally, the team delayed non-urgent appointments to accommodate an urgent appointment or staff sickness.

- Where the service visited patients at home, they did not usually give precise times, as staff delays in traffic could cause anxiety to a patient who, for example, was expecting a visit at 10am. They were more likely to agree appointments for a more flexible time, such as, for example, between 10am and midday.
- The service supported patients in crisis. One health professional noted the teams sometimes struggled to refer patients on, either to inpatient beds, or to the community teams. On the one hand, beds were scarce, so sometimes they managed patients in the community, whilst trying to find a bed for them. At other times, they were taking and holding referrals from people who had been unable to access the community mental health team. Staff we spoke with felt this was manageable and an inevitable result of being a crisis team and having a gatekeeping role.

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

- The teams saw most patients at home. However, some were seen at GP surgeries, or in the case of the Warwickshire teams, at rooms within the main building. Rooms used at hospital sites were pleasant, in bright and airy surroundings that helped put patients at ease. Interview rooms had adequate soundproof, to assist privacy and dignity.
- Information leaflets were available. We saw information packs the teams gave to patients and carers. These contained information for carers and patients, such as contact numbers, other organisations, and details of who to contact if there were concerns or complaints.

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

- Most visits were home visits. There was disabled access for patients if required where patients came to hospital premises.
- Information leaflets were available. These were available in different languages in teams where there were a range of users for whom English was not their first language.
- Interpreters were accessible when required.

# 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

- The service had one formal complaint in the past year. It was not upheld by the trust upon investigation. A health professional was able to discuss this fully. It had been forwarded to the trust and then investigated and responded to locally.
- Patients received details on how to complain as part of the information pack they received. Patients were aware of the Patient Advice and Liaison Service (PALS). We saw patients were aware of how to make complaints. Where their current mental health affected patient ability to do this, we saw how carers were aware of how to make comments or raise concerns. Patients and carers we spoke with were aware of how to complain but felt they had no concerns about the service they wished to raise.
- We discussed examples of how patient concerns were resolved at an informal, local level. Patients felt more comfortable doing this as they felt local staff or management would better understand and be able to resolve any difficulties. The formal complaint mentioned above was an example of this.

## Health-based place of safety

### Access

- The service was always available, except for those occasions when it was 'full.' This could be caused either by the suite being in use by an under 18 patient, or because both suites were in use. Figures provided by the trust showed this had occurred 29 times in the past year. These closures had occurred owing to under 18 year olds being detained there. Figures provided by the trust showed 464 patients had been detained in the place of safety in the previous year. Of these, 29 were under 18. This showed the suite was only ever 'full' when a person under 18 was using it.
- Trust figures for the previous year showed 63% of patients remained in the place of safety for less than four hours. The manager had patient figures for the previous month, when 32 people had used the service. Of these, nine had remained there for over six hours. The longest had remained there for 16 hours. This was

because the service had been unable to locate a suitable place in less time than that. This had involved a particularly specialist requirement. The suite was not used for seclusion of inpatients.

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

- The health-based place of safety suite was discreet, safe and secure. The assessment process was assisted by the design and layout of the facilities. They allowed for dignity and privacy within the parameters of being safe and observable to protect patients using it from harm. Although part of the main hospital, there was a separate dedicated entrance away from the main entrance. There was a clock in the corridor, visible to the person in the suite. There were tea, coffee, and snack facilities.

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

- The suite was accessible and had a disabled toilet.
- The service could access interpreters and/or signers if required.

## Listening to and learning from concerns and complaints

- Staff were aware of how to handle complaints and would try to resolve any issues locally. We were not made aware of any complaints raised regarding the service.

## Arden mental health acute team

### Access

- The team had target times of commencing assessments within 90 minutes of receiving referrals from accident and emergency departments. For referrals from emergency bed areas this was within 12 hours of referrals, and for general wards this was within 36 hours of receiving referrals. Figures supplied by the trust showed these were met in the previous year for all but one target in one quarter. This was as a result of significant pressures on the partner agency.
- The operational policy had clear criteria for who would be offered a service.

# Are services responsive to people's needs?

Good 

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

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

- The service spoke with patients in suitable acute hospital ward areas, ensuring patients' needs for privacy and dignity were met.

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

- The service was able to access interpreters as required.

## **Listening to and learning from concerns and complaints**

- The service had received no formal complaints in the past year. The manager told us of one informal concern raised locally. This was an example of how the service respected a patient's wish for confidentiality, which then caused anxiety to the patient's family. They tried to resolve this, but ultimately had to respect the patient's wish for confidentiality, and help the family to understand and acknowledge this right.

# Are services well-led?

Good 

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

## Our findings

### Crisis resolution and home treatment teams

#### Vision and values

- Staff may not have been aware of the wording of the trust's values, but the work they did was in accord with these.
- Team leaders were aware of senior managers. Staff were aware of the service manager. They said the CEO had visited teams.

#### Good governance

- Staff were experienced, well-motivated and well led. Observations of handovers showed teams were cohesive, assertive, and well supported and informed.
- Staff were appraised and supervised. Clinical supervision for the previous year exceeded targets in Coventry and Warwick, but at Nuneaton fell short, at less than 50% of the target of 90. Staff received mandatory training.
- The service used key performance indicators to measure the responsiveness of the teams in areas such as making first contact following a referral.
- Staff were willing to learn and progress.
- Managers told us they had sufficient authority. The Warwickshire team singled out the excellence of their administrative support.

### Leadership, morale and staff engagement

- Staff or management did not raise sickness or absence as a concern.
- There was one example of alleged bullying and harassment. This was being addressed. It appeared to be an isolated incident as all observation and discussion indicated teams were well-supported and had very positive working relationships.
- Staff told us consistently they were aware of how to raise concerns and felt they could do this without fear of victimisation.

- A consistent message we got from staff in crisis teams was their pride in achieving results and acting to better patients' situations. As one health professional remarked "we deal with things, we don't bounce them around."
- Staff were able to progress within the service. One support worker told us they had recently achieved advanced practitioner status and were able to utilise skills in psychological education.
- We saw good examples of team working and mutual support. This was evident in handovers, where staff offered information and support to other members.
- The one area of staff discontent we noted concerned staff disquiet regarding mileage payments and plans to charge for car parking. They felt they were not consulted about these by the trust.

### Commitment to quality improvement and innovation

- One health professional, with the support of the trust, had worked with a voluntary agency and local sports clubs in a campaign to improve awareness of mental health.

### Health-based place of safety

#### Vision and values

- Staff were aware of the values of the trust and how these values related to their work.

#### Good governance

- Data was collected that supported the monitoring of the performance of the health based places of safety
- Power outages were a current issue with the potential to disrupt the place of safety, as with the rest of the hospital. This was on the trust risk register.
- The service worked with the police and other agencies to develop and maintain good relationships and protocols for the use of the place of safety.

### Leadership, morale and staff engagement

- The team manager reported no issues or concerns with the staff related to their work on the place of safety suite.

# 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.

## Arden mental health acute team

### Vision and values

- Team objectives reflected the trust's values and objectives.
- Staff we spoke with were positive about their work and about the trust as an organisation.

### Good governance

- Staff received mandatory training, and were appraised and supervised.
- Incidents were reported and responded to by the service.
- Staff told us how they were involved in an audit of document recording. This checked how up to date recording was. This had moved from 92% to 100% following the result of the audit and actions following it.

- Clear key performance indicators showed the service meeting response time targets for assessments and actions. Where there was one exception to this in a three-month period it was noted this was as a result of significant pressures on the partner agency.
- The team manager had sufficient authority and administrative support.

### Leadership, morale and staff engagement

- Staff we spoke with were positive about their work, role, the opportunities for development and the variety and interest offered by the job.
- Sickness, absence and agency staff use was low.
- There were no records of bullying and harassment cases in this team.
- Staff told us they knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation.
- Staff we spoke with had high morale and job satisfaction and a sense of empowerment. They enjoyed the variety and scope of the work and the opportunities for development.