Good

Hertfordshire Partnership University 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)
RWR34	Lister Adult Mental Health Unit	Lister Hospital 136 / place of safety	SG1 4AB
RWR96	Kingsley Green	Kingfisher Court 136 suite / place of safety	WD7 9HQ
RWR99	Kingsley Green	Kingsley Green children's 136 suite	WD7 9HQ
RWR99	Trust Head Office	NORTH Crisis team (N CATT)	SG1 4AB
RWR99	Trust Head Office	NORTH WEST Crisis team	HP2 5XY

Summary of findings

		(NW CATT)	
RWR99	Trust Head Office	SOUTH WEST Crisis team (SW CATT)	WD18 0JP

This report describes our judgement of the quality of care provided within this core service by Hertfordshire 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 Hertfordshire NHS Foundation Trust and these are brought together to inform our overall judgement of Hertfordshire 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?	Requires improvement
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 gave an overall rating for mental health crisis and health based place of safety of Good because:

- Staff within the crisis teams we inspected demonstrated a good knowledge and understanding of people using the service. In the shadow visits we undertook, it was clear that staff had an understanding of people's needs. We observed examples of very sensitive information being discussed with the visiting professionals and being handled in an empathic and supportive way with choices being offered on how to guide and direct people to support their own independence.
- The crisis teams were responsible for gatekeeping 100% of all inpatient beds. They did this effectively. The teams maintained close working links with the outpatient and inpatient services across their geographical areas which enabled this effective level of gatekeeping.
- Staff morale was high in all of the teams we visited. Staff told us they were proud of the job they did and felt well supported in their roles.

However:

- At the North West CATT four of the eight medication cards we checked contained errors in administration recording. There were gaps in administration of medications and medicines had been given when dates showed they had not been prescribed. This meant that people's medication was not always being administered in a safe way. This was reported at the time through the trust incident reporting system.
- At the North West CATT the medication cupboard temperature was not being recorded. This meant that medication was not being stored in a safe way. This was discussed with the manager at the time of the inspection and a system had been put in place by the time we left the service.
- All the crisis teams we inspected were aware of the risks associated with lone working but there was no consistency of approach across the crisis teams in how they were managing the risks. The trust had a lone worker policy however staff did not always appear to be following this.
- The section 136 suites at Lister Hospital and Kingsley Green children's 136 suite did not provide a safe and/or suitable environment for the assessment of patients detained under section 136 of the Mental Health Act 1983.
- In the crisis teams out of the 15 sets of support plans we looked at, only four sets had recorded that the person receiving the service had been given a copy of their care plans and there was no documented reason as to why this had not been done. We spoke to 8 people receiving care from the crisis teams and four of those people were not aware of or had not received a copy of their care plan.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- At the North West CATT, the interview rooms were cluttered with worn furniture. The interview room was in a poor state of repair with large cracks between the walls and ceiling in the room. There were no built in panic alarms but staff were allocated infrared panic alarms from the reception area. There was no system for ensuring these were being regularly checked as the test station had been taken down from the wall during redecoration and not been replaced.
- At the North West CATT the medication cupboard temperature was not being recorded. This meant that medication was not being stored in a safe way. This was discussed with the manager at the time of the inspection and a system had been put in place by the time we left the service.
- At the North West CATT four of the eight medication cards we checked contained errors in administration recording. There were gaps in administration of medications and medicines had been given when dates showed they had not been prescribed. This was reported at the time through the trust incident reporting system.

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- All teams were aware of the risks associated with lone working but there was no consistency of approach across the crisis teams in how they were managing the risks. The trust had a lone worker policy however staff did not appear to be following this.
- The section 136 suites at Lister Hospital and Kingsley Green children's 136 suite did not provide a safe and a suitable environment for the assessment of patients detained under section 136 of the Mental Health Act 1983. The Trust immediately stopped using the 136 suite on Oak ward and utilised the suite within Kingfisher Court for children.

However:

- All of the crisis teams were seen to have daily multi-disciplinary team (MDT) handovers where each person on the caseload was discussed in detail.
- All the crisis teams' staff members were able to respond quickly to a sudden deterioration in a person's health.

Summary of findings

Are services effective?

Good

We rated effective as **Good** because:

- All the teams had access to the range of mental health disciplines required to care for the people that were using the service. Each had suitable access to a psychiatrist.
- The crisis teams were responsible for gatekeeping 100% of all inpatient beds which they managed effectively. The teams maintained close working links with the outpatient and inpatient services across their geographical areas which enabled this effective level of gatekeeping.
- Staff access to electronic case notes was protected and any paper notes were kept locked away in secure areas out of office areas.

However:

- None of the team leaders we spoke displayed knowledge of local or trust wide audits or of the outcomes and how these affected their service

Are services caring?

Good

We rated caring as **good** because:

- We found the staff to be kind, caring and compassionate in their interactions with people receiving care. All the services had a comprehensive welcome pack which provided a variety of information on the available resources and how to access them.
- Staff we spoke to were aware of the need to maintain people's confidentiality.
- Information on independent advocacy and support groups was available and promoted across the teams to promote the involvement of patients and carers.

However:

- Out of the 15 sets of support plans we looked at, only four sets had recorded that the person receiving the service had been given a copy of their care plans and there was no documented reason as to why this had not been done. We spoke to 8 people receiving care from the crisis teams and four of those people were not aware of or had not received a copy of their care plan.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

Summary of findings

- The trust had a mental health helpline that was staffed by the North West CATT. This line that is available out of hours. This provided advice, supporting and reassuring clients in the locality and signposting to other services.
- People were given flexibility in when and where they could see staff for appointments. We saw information about how to complain and the trust's complaints management process was displayed in the waiting rooms across each site
- All the crisis teams were committed to the host families scheme which is the first of its kind across the UK.
- The teams met the key performance criteria expected by the trust. This meant that all referrals were contacted either via face to face or telephone contact within 1 hour, with a face to face assessment within 4 hours.

However:

- The visiting rooms in the North CATT and the North West CATT did not have adequate sound proofing and were in a general poor state of repair.

Are services well-led?

Good

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

• Staff morale was high in all of the teams we visited. Staff told us they were proud of the job they did and felt well supported in their roles.

• Staff told us they felt empowered to raise any issues and promote service development and initiatives through their own individual supervision and through the local team meetings and business meetings with senior managers.

However:

- We did not see clear evidence that clinical staff were engaged with local clinical audits.
- The band 7 team leaders did not have a clearly defined roles and responsibilities allocated to them. This meant that there were gaps in local leadership.

Summary of findings

Information about the service

The crisis teams in Hertfordshire were available at short notice to help people resolve a mental health crisis, or to support them whilst it was happening. The main aim of the CATT team was to provide people with the most suitable, helpful and least restrictive treatment possible, in order to prevent or shorten hospital stays. The CATT teams decided who was admitted to hospital or whether they could provide an alternative treatment plan. They could also offer home support to enable people to leave hospital more quickly. There were five Crisis Assessment and Treatment (CATT) Teams operating across Hertfordshire.

We inspected three CATT teams, the North West CATT team at St Pauls House, the South West CATT team at Colne House and the North CATT team at Lister Hospital.

The teams operated 24 hours a days, seven days a week and could be accessed via a number of routes including the Single Point of Access.

The CATT teams also supported people who are staying with a host family, visiting daily if required to support the person and the Host family. The three health based place of safety provisions inspected were based at Lister hospital and two at Kingsley Green, one of which was designated as a children's health based place of safety. When people were detained by the police under section 136 of the Mental Health Act they were taken to a safe place where a mental health assessment can be undertaken.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett Consultant psychiatrist

Team Leader: James Mullins, Head of Hospital Inspection (mental health) CQC

Inspection Manager: Peter Johnson mental health hospitals

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers, support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected the mental health crisis services and health based places of safety consisted of six people: an expert by experience, two CQC inspectors, a nurse manager, a psychologist and a mental health act reviewer.

The team would like to thank all those who met and spoke to inspectors during the inspection and 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 trust as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To get to 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?

Summary of findings

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from people using the service.

During the inspection visit, the inspection team:

- Inspected the three health based places of safety run by the trust located at the Lister Hospital and at Kingsley Green and spoke to staff and people receiving the service.
- Inspected three crisis teams, the South West crisis assessment treatment team (CATT) based at Colne House, the North CATT based at Lister Hospital and the North West CATT based at St. Paul's.
- Spoke with ten people who were using the service.
- Reviewed15 treatment records of patients.
- Examined 18 sets of medication recording cards.
- Spoke with six team leaders, two support workers, two psychiatrists, one social worker, and one modern matron.
- Visited seven people receiving the service in their home and observed how staff were caring for people. This was done with the consent of the person receiving the service.
- Attended a multi-disciplinary meeting (MDT) and two team handover meetings.
- Carried out a specific check of the medication management in the three crisis teams.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- People using the service were generally positive about the care and treatment provided by staff. They told us that staff were professional, re-assuring, professional and polite
- People told us that they were treated with respect.
- People who used the services told us that the staff were supportive.

However:

- Four out of 8 people receiving care from the crisis teams were not aware of or had not received a copy of their care plan.

Good practice

- The crisis teams manage the host families scheme which is the first of its kind across the UK. The host families scheme allows service users who are acutely unwell to stay with a local family for a few weeks, as an alternative to inpatient care. The CATT teams were all actively participating in the development and support of this with allocated champions within the teams who liaised with the inpatient and community teams to ensure families and people receiving services were intensively supported.
- The training and development links between the Lister Hospital 136 suite and the local police force were excellent with nurses offering teaching sessions to the local police force and new police officers having an opportunity to shadow staff on the inpatient facility to enhance their understanding of mental illness.

Areas for improvement

Action the provider MUST take to improve

- **The provider must review their process within the crisis teams for safe transport of medication, safe storage of medication and safe dispensing of medication within the crisis services**

Summary of findings

- **The provider must review the environment allocated to the 136 suite to ensure that the health based place of safety is safe and fit for purpose**
- The provider must ensure that patients privacy and dignity is maintained whilst they are using the health based place of safety

Action the provider SHOULD take to improve

- **The provider should review their process for ensuring and documenting that people receiving the crisis servics have copies of their care plans.**
- **The provider should review the physical environment for people accessing the crisis services interview rooms at the North CATT and the North West CATT**
- **The provider should review the process for ensuring that band 6 team leaders have clearly defined management responsibilities within the framework of the management structure.**

Hertfordshire Partnership University 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
NW CATT	Trust Head Office
SW CATT	Trust Head Office
N CATT	Trust Head Office
Kingfisher Court 136 / H.B.P.O.S.	Kingsley Green
Kingsley Green children's H.B.P.O.S	Kingsley Green
Lister Hospital 136 / H.B.P.O.S	Lister Adult Mental Health Unit

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.

Staff explained patients' rights to them when appropriate and this was recorded in the electronic records system used by the trust. Most staff had a good understanding of the provision of the mental health act and the code of practice.

Staff across all teams demonstrated and awareness of how to access the advocacy services.

We saw from training records that staff had received mandatory training in the Mental Health Act, Code of Practice and guiding principles.

Detailed findings

Teams had access to approved mental health professionals should they need support in carrying out a mental health assessment on a person.

Mental Capacity Act and Deprivation of Liberty Safeguards

We saw from training records that all staff completed mandatory training in the Mental Capacity Act (MCA). Staff we spoke to all demonstrated a good understanding of the guiding principles of the Act and how it affected their work with the people they supported however when we discussed with teams issues around the application of the MCA we found mixed responses in relation to the recording of capacity.

Staff told us how they ensure they tested capacity when appropriate, recognising the importance of the persons wishes, feelings, culture and personal history.

Staff told us if they had any concern around capacity issues they would discuss the matter with their manager in the first instance and then with the MCA lead within the mental health act administration team.

We could not find a section in the crisis team's initial assessment process on the trust's electronic recording system that recorded that mental capacity had been considered.

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

Mental health crisis services:

North CATT, North West CATT, South West CATT

Safe and clean environment

- Each team had clinic rooms available for assessing people. However these rooms varied in their safety for staff and people accessing the services. It was part of the trust's operational policy that most people were seen at their own homes.
- At the South West CATT the interview rooms were all clean and designed to a high standard and well equipped with the necessary equipment to carry out the interview. Reception staff were aware of who was being seen and whether there was a heightened level of risk. Staff had access to panic alarms and there was a plan of response from the staffed areas of the building.
- However at the North CATT the interview rooms were on the same corridor as the 136 suite. This meant that people being seen by the CAT team might have their privacy compromised by a person accessing the 136 suite due to the door to the 136 suite being kept open whilst in use. We found that you could overhear what was being discussed in the interview room. The interview room appeared to be a meeting room and was cluttered with furniture. We were told the team is due to move and they have stipulated when they move they have a more appropriate room for meeting with people receiving services. The rooms did not have built in panic alarms but we were told the staff carry personal attack alarms.
- At the North West CATT team the interview rooms were cluttered with worn furniture. The interview room we were shown was in a poor state of repair with large cracks between the walls and ceiling in the room. There were no built in panic alarms but staff were allocated infrared panic alarms from the reception area. There was no system for ensuring these were being regularly checked as we were told the test station had been taken down from the wall during redecoration and not been replaced.
- The visiting rooms in the North CATT and the North West CAT teams were not ligature free. The ligature audit we saw for the North west CAT team indicated that high risk areas such as toilets should be managed via staff awareness and appropriate levels of observation which may impact on people's dignity when using the facilities.

Safe staffing

- The numbers of nurses working within the teams matched the establishment for most of the shifts and the staff we spoke with did not report any issues relating to problems with staffing numbers.
- Staff at the South West CATT told us they had a high turnover of staff and that recruitment was a problem. We looked at the rotas which showed us that they had high use of regular agency staff. This was not reported as being a problem across the other sites.
- The reported cover arrangements in place for sickness, annual leave and the vacant posts maintained people's safety and none of the teams reported any concern around lack of ability to cover their caseload. The teams all had access to regular agency staff with most staff working extra bank shifts if they chose to.
- Where services had high levels of sickness within their team this was being managed effectively via the appropriate trust HR policy.

Assessing and managing risks to patients and staff

- All of the teams were seen to have daily multi-disciplinary team (MDT) handovers where each person on the caseload was discussed in detail. Planning arrangements were discussed for that day and for the following 7 day period. People's individual risks were also discussed and personal support plans reviewed.
- The handovers used different methods for reviewing the caseloads with the more traditional "whiteboard" handover being used effectively in the North CATT, with the administrator typing the notes up into the person's

individual treatment record. However at the South West CATT and the North West team where the system used a "live" excel spreadsheet to capture the information we were told that the notes were not routinely entered onto the person's individual treatment record. These were instead held on a shared drive. This may cause confusion if the most up to date information needed to be accessed quickly.

- We saw that staff were responsive to referrals and took people onto their allocated caseload quickly. There were no waiting lists in any of the teams.
- Staff were able to respond quickly to a sudden deterioration in a person's health. The teams reported the ability to increase the frequency of their visits to up to four times a day if the person required an enhanced level of support. We saw from the assessments that people urgently requiring the services had either a face to face or a telephone contact within 1 hour and face to face contact within 4 hrs.
- Staff told us that they were trained in safeguarding and knew how to make a safeguarding alert. Staff reported any alert was forwarded to the safeguarding manager. Safeguarding flow charts were in place at each of the services and all teams identified safeguarding leads. Staff received training in safeguarding as part of their mandatory training. We saw the team training records and saw this was happening
- All teams were aware of the risks associated with lone working but there was no consistency of approach across the crisis teams in how they were managing the risks. In the North CATT team there were robust procedural systems ensuring that people's whereabouts was known and recorded. However the recording time of signing in and signing out was not being completed consistently across all the teams we visited. This meant that there were people out on visits without an allocated person that knew when they should be retuning. We did not see that an electronic or paper version of the trust's lone working policy being considered and followed by staff.
- There was inconsistent usage of lone working devices. Lone working devices are electronic devices, provided by the trust, that track the wearer and call for immediate assistance in an emergency. Across the sites visited only 11 staff had access to these. Staff told us this was in the process of being reviewed by the trust and a new system being implemented but we were not shown an action or business plan for this.
- At the North West CATT we found four of the eight medication cards we checked contained errors in recording. There were gaps in administration of medications and medicines had been given when dates showed they had not been prescribed. This was brought to the attention of the team leader during the course of the inspection and an incident reporting form was completed immediately.
- Working practice across all teams was for all people taken on by the CATT teams to have a medication card written up for them following the initial assessment. The medication cards being used were designed for inpatient services and not for use in the community which led to confusion as to how to complete them accurately.
- The South West CAT team had access to a clinic room and a treatment room which was suitable for their needs. At the North CAT team and the North West CAT team stock and personal medication was being stored in a locked cupboard.
- At the North CAT team the room temperature was being recorded as over the maximum temperature for medication storage, a regular incident report was completed for this.
- However at the North West CAT team the medication cupboard temperature was not being recorded. This meant that medication was not consistently being stored in a safe way. This was brought to the attention of the team leader. By the time the inspection had finished a recording sheet had been brought in to document this.

Track record on safety

- Information about improvements in safety was available to all staff members we spoke to and staff reported to us how they received safety information from the trust and from within their teams and how to access it on the shared drive.
- We were told about two incidents of unexpected deaths that had occurred within two of the teams within the preceding three months, both of which had gone to root

Requires improvement

Are services safe?

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

cause analysis and the investigations were ongoing. The teams were able to clearly explain to us what was happening in the process and where learning had been identified.

Reporting incidents and learning from when things go wrong

- Staff were aware of the reporting system for incidents. This was through the electronic incident reporting system. Improvements in safety were discussed at the team leads meeting, practice governance meetings, handover meetings, team meetings and by staff in supervision sessions. There was evidence of knowledge on how to report incidents, the process for escalation, including out of hours.
- Staff gave examples of team debriefing sessions with their manager and also how the people receiving the service had been debriefed following incidents in the community.
- Staff received feedback from investigations of incidents both internal and external to their service. Feedback was provided from other incidents affecting other teams. Copies of the findings of relevant root cause analysis were made available to all staff with the key learning points highlighted.

Health-based places of safety

Lister Hospital 136 suite, Kingfisher Court 136 suite, Kingsley Green children's 136 suite

Safe and clean environment

- In the three places of safety we visited there was a clear difference in the quality of the physical environments between the place of safety in Kingfisher Court and the other services. Kingfisher Court is a new and purpose built facility, Lister hospital and Kingsley Green are adapted older facilities.
- The section 136 suites at Lister Hospital and Kingsley Green childrens 136 suite did not provide a safe and a suitable environment for the assessment of patients detained under section 136 of the Mental Health Act 1983.
- At Lister hospital the emergency equipment, including automated external defibrillator and oxygen were stored in the ward on the floor above and two locked doors had to be accessed before the equipment could be taken to the 136 suite. This meant they could not be accessed effectively in an emergency. We were told by the trust immediately after our visit that this had been addressed by safely storing a crash trolley in the adjacent corridor.
- The 136 suite at Lister hospital consisted of a separate entrance leading into a single room. This room had a sofa, which appeared stained. The area was small and barren looking. In order to access a toilet or a drink you had to leave the room walk down the corridor and use the toilet adjacent to the crisis team's office. We saw plans to move this facility into a more appropriately designed service and we were told this would happen by the beginning of September 2015.
- The childrens136 suite at Kingsley Green consisted of 1 large room with an ensuite toilet. The room had a mattress on the floor and a chair. The room had visible signs of damage with the window in the door leading to the garden boarded up. The door to the garden did not appear to shut securely. The rooms felt barren and intimidating. Due to these concerns the trust made the decision to stop using this facility immediately following our visit.
- The layout of the 136 suite at Kingfisher court enabled staff to observe all areas at all times. The suite was clean and well maintained all of the furniture was in good condition and well maintained. The service is a single person service with self-contained bathroom, bedroom, and toilet facilities.

Safe staffing

- None of the sites we inspected had a dedicated staff team, the services were staffed using a bleepholder process. There was clear allocation of who was responsible to attend the 136 suite in each of the services. We were unable to determine the frequency of the 136 suites not being used due to low staffing levels, as the trust were unable to provide up to date information.
- The childrens 136 suite at Kingsley Green was staffed by the CAMHS team which in an adjacent building however staff told us that CAMHS staff were not always available to staff the service. This meant that children were being supported by staff that may not have had the necessary skills and training to manage them. We were unable to

Requires improvement

Are services safe?

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check this against trust data as they were unable to provide the inspection team up to date information indicating whether CAMHS staff had attended the 136 suite.

Assessing and managing risks to patients and staff

- The designated nurse bleepholder would receive the detained patient and a process was in place for an adult mental health practitioner to be contacted regarding the assessment. At the section 136 suite, a joint risk assessment by staff from the adjacent wards and the police was completed for all people admitted. Throughout the detention period effective systems were in place to assess and monitor risks to individual patients to determine whether the police officer would be required to remain at the place of safety to provide support.
- The 136 suite at Lister was in use during our inspection and the patient told us that during the assessment he felt “reassured and safe”
- The checklist for section 136 assessments in all services inspected recorded handover information and included details of any risks.
- Staff had received training in safeguarding vulnerable adults. Staff we spoke with knew how to recognise a safeguarding concern. Staff were aware of the trust’s safeguarding policy. They knew how to raise safeguarding concerns.

Reporting incidents and learning from when things go wrong

- A regular bi-monthly police liason meeting was well established to oversee the operation of the section 136 suite and discuss learning from any incidents.
- Staff we spoke with knew how to recognise and report incidents on the trust’s electronic incident recording system. All incidents were reviewed by the ward manager and forwarded to the clinical governance team for the trust who maintained oversight. The system ensured senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these.

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.

Summary of findings

Our findings

Mental health crisis services

North CAT team, North West CAT team, South West CAT team

Assessment of needs and planning of care

- Across all teams we found that assessments were being completed quickly with any urgent referrals being prioritised and assessed within one hour.
- The teams had three detailed handovers a day. It was clear during these hand overs that the staff teams were aware of the specific needs of the people they were supporting and discussed plans to address their care needs. We saw evidence of a culture of sharing ideas for the benefit of the people receiving the service.
- We looked at samples of care plans across the services. Most treatment records were regularly reviewed, personalised and orientated towards recovery. We saw how an initial care plan would be agreed with the person receiving the service in a leaflet style and then the staff would return and record a more detailed version of the care plan before returning with this new document to the person to discuss and develop the plan collaboratively. The care plans we reviewed did not have specific prompts for physical healthcare in their format but we could see examples of how people's physical healthcare requirements were being met on a personalised basis.

Best practice in treatment and care

- The staff teams had a level of trained staff within their teams which enabled them to consider a range of psychosocial interventions such as cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT). Staff referred long term psychological treatments to the community mental health team to pick up.
- The assessment documentation we looked at told us that physical healthcare needs were not addressed consistently. Out of the 15 care records we found 2 people had a suitable physical health check document completed upon accessing the team, 8 had no completed physical examination upon accessing the team and 5 had poorly completed physical health care assessments.
- The North West CAT team used Health of the Nation Outcome Scales to rate severity and outcomes. In the other teams they were unable to provide examples of how they were measuring service outcomes and client clinical outcomes in a measeured and evidence based way.
- We saw examples of how the teams were using the "having your say" questionnaires to discover people's views of the care they were receiving.
- There was a variation across the teams with regard to the number and focus of audits in the services. In the NW CATT team it was clear that the HR related auditing systems were happening, to monitor and maintain sickness absence effectively. No team leaders were able to provide information about what level of clinical audit their teams were carrying out. The trust monitors key performance data extracted from the electronic notes system but team leaders were not actively ensuring that local clinical audits were happening regularly.
- On the day of inspection we requested information and evidence of local clinical audits. Staff told us that access to trust wide clinical audits were not available due to an IT issue. The IT issues were resolved by 09.30 that same morning.

Skilled staff to deliver care

- All the teams had access to a range of mental health disciplines required to care for the people that were using the service. This included psychiatrists, nurses and social workers.
- When we looked at training records and spoke to staff we found that staff were suitably skilled and qualified to carry out their work.
- Staff were inducted when they started working within the teams. Supervision and appraisals were happening within the trust recognised timeframe. We saw that those staff that had not yet had their appraisal had been

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.

booked in. Staff were receiving suitable levels of supervision and that their team leaders offered an open door policy ensuring they were available for ad-hoc supervision when required.

- The teams we inspected had regular monthly team meetings and staff we spoke with felt well supported in their teams.
- Staff performance was monitored and measured using the trust wide key performance indicators (KPI) and the "workforce dashboard". This meant that poor staff performance was addressed promptly and effectively. The managers were aware of the procedures to follow when poor staff performance was identified.

Multi-disciplinary and inter-agency team work

- We attended two multi-disciplinary team (MDT) handover meetings where people receiving the service were discussed in a full and professional manner.
- The crisis teams were responsible for gatekeeping 100% of all inpatient beds which they managed effectively across all teams. This is consistently higher than the England average in all three quarters so far in 2014/15. The teams maintained close working links with the community services and inpatient services which enabled this high level of gatekeeping.
- Team leaders from across the services had a formal forum for meeting and discussing issues which meant that there was an opportunity for learning and sharing of information across the middle management structure.
- Across all services we saw excellent links with the community voluntary sector, with the staff at the South West CATT giving lots of examples of close working with local debt help agencies, sexual assault support services and homeless trusts and hostels.

Adherence to the MHA and MHA Code of Practice

- When we looked at training records we saw staff had received mandatory training in the Mental Health Act, Code of Practice and guiding principles.
- When people left inpatient services under section 17 leave the teams could support people whilst they were in the community. We saw that people that were on section 17 leave were identified in the weekly planning spreadsheet or on the white board. In South West CAT team we were unable to locate the copy of the section leave form for a person and the consent to treatment from was not attached to the team's copy of the medication card. This meant that they were not able to ensure that any medication dispensed was in the medical treatment plan.
- Staff across all teams demonstrated and awareness of how to access the advocacy services.
- Teams had access to approved mental health professionals should they need support in carrying out a Mental Health Act assessment on a person.

Good practice in applying the MCA

- All staff completed mandatory training in the Mental Capacity Act (MCA). Staff we spoke to all demonstrated a good understanding of the guiding principles of the act and how it affected their work with the people they supported.
- Staff told us how they ensure they tested capacity when appropriate, recognising the importance of the persons wishes, feelings, culture and personal history.
- Staff told us if they had any concern around capacity issues they would discuss the matter with their manager in the first instance and then with the MCA lead within the mental health act administration team.

Health-based places of safety

Lister Hospital 136 suite, Kingfisher Court 136 suite, Kingsley Green children's 136 suite

Assessment of needs and planning of care

- A clear assessment and physical health check was undertaken on arrival to section 136 suites and any ongoing physical health problems were followed up appropriately..

Best practice in treatment and care

- People who were being assessed in the section 136 suite were provided with an information pack explaining the powers and responsibilities under section 136. This ensures that people understand where they are, what is happening to them and what the process is and an explanation of their rights.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- The training and development links between the Lister Hospital 136 suite were excellent with nurses offering teaching to the local police force and new police officers having an opportunity to shadow on the inpatient facility to enhance their understanding of mental illness.

Skilled staff to deliver care

- Qualified staff undertook the co-ordination of admissions to the section 136 suites when they were holding the bleep, operating as the section 136 co-ordinator. There was guidance available to staff that included a screening tool and a checklist of action to be completed. There were also clear communication systems to ensure that the 136 co-ordinator was supported by a ward manager.

Multi-disciplinary and inter agency team work

- Links with the police in the operation of section 136 was good. Good joint working relationships were in place at both a strategic and operational level and attendance at the bi monthly monitoring meetings was good with representatives from a variety of agencies present.
- All staff we interviewed described good working relationships between partner agencies with particular regard to excellent links with the local police force with staff regularly supporting the police with guidance in managing people suffering from a mental health concern

Adherence to the MHA and the MHA Code of Practice

- We found that the relevant legal documentation was completed appropriately in those records reviewed. Staff were clear about the procedure and processes involved if a person required assessment under the Act.
- Staff appeared to be knowledgeable about the Mental Health Act and the code of practice. They were aware of their responsibilities around the practical application of the Act.

Good practice in applying the MCA

- Staff said they were aware of the Mental Capacity Act 2005 and the implications this had for their clinical and professional practice. Most staff had received refresher training on this Act.
- There was evidence in those records seen that capacity assessments were being completed appropriately and were being reviewed as required.

Are services caring?

Good

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

Summary of findings

Our findings

Mental health crisis services

North CAT team, North West CAT team, South West CAT team

Kindness, dignity, respect and support

- In all the teams we visited we observed staff to be kind, caring and compassionate in their interactions with people receiving care. People who used the services told us that the staff were supportive, re-assuring, professional and polite.
- All the services had a comprehensive welcome pack which provided a variety of information on the available resources and how to access them. Information on how to make a complaint, what to do if they needed more support or were not happy with their level of care and advocacy support groups was also readily available.
- Staff demonstrated a good knowledge and understanding of people using the service. In the shadow visits we undertook, it was clear that staff had an understanding of people's needs. We observed examples of very sensitive information being discussed with the visiting professionals and being handled in an empathic and supportive way with choices being offered on how to guide and direct people to support their own independence.
- We observed that people's confidentiality was maintained by all the staff teams we visited. When we accompanied staff on shadowed visits the staff members ensured they sought consent prior to the visit.
- All the staff we spoke to were aware of the need to ensure people's confidential information was kept securely. Staff access to electronic case notes was protected and any paper notes were kept locked away in secure areas out of office hours.

The involvement of people in the care they receive

- Most people we spoke to during our shadowed visits told us that they were actively involved in their care planning and that their support was orientated toward keeping them well and out of hospital. However the electronic notes system indicated that only four out of the fifteen sets of support plans we looked at recorded that the person receiving the service had been given a copy of their care plan. There was no documented reason as to why this had not been done consistently.
- We observed that the services were involved in providing carers assessments when required. During the shadowed visits we were able to see an example of this occurring and it was carried out in a comprehensive and effective way.
- The teams were able to get monthly feedback from the trust on the return rate of the "having your say" forms which is the way the trust collects data about people's experience of the services. They were reported to be for the most part positive. However it was recognised that there was a low rate of response from people receiving the services.
- Information on advocacy and support groups was available and promoted across the teams and we saw information in waiting rooms was provided in languages and formats that were accessible to the local population.

Health-based places of safety

Lister Hospital 136 suite, Kingfisher Court 136 suite, Kingsley Green children's 136 suite

Kindness, dignity, respect and compassion

- The staff explained to us how they attempted to build a rapport with the individual as soon as they could engage. This meant that the police could be released which meant that the individual would normally become less anxious and agitated.

The involvement of people in the care they receive

- The two staff we spoke with were able to describe specific interventions they used to help people with managing their distress such as anxiety management, alcohol withdrawal, psychological interventions and relapse prevention work.
- We noted all the 136 units visited had patient information readily available for those people placed in the suites and everyone was given a leaflet about the powers and responsibilities of Section 136 of the Act. The patient we were able to speak with told us that they

Good

Are services caring?

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

had been involved in the decision making process of their detention throughout and had the opportunity to discuss any additional social circumstance issues following their departure from hospital.

- There is currently no formal mechanism to obtain feedback from people detained under Section 136.

Good

Are services responsive to people's needs?

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

Summary of findings

Our findings

Mental health crisis services:

North CAT team, North West CAT team, South West CAT team

Access, discharge and bed management

- The teams met the key performance criteria expected by the trust. This meant that all referrals were contacted either via face to face or telephone contact within 1 hour, with a face to face assessment within 4 hours.
- Skilled staff were available to assess people immediately and all services had cover across a 24 hour period 7 days a week. The trust had organised central locations for night staff to be based and an allocated rota across the trust was available and functioning effectively.
- The trust had a mental health helpline available out of hours staffed by the team based at the NW CATT. This provided advice, supporting and reassuring people in the locality and signposting to other services. The services were very proud of this supportive measure and how it was resourced from within their team.
- The crisis teams were responsible for gatekeeping 100% of all inpatient beds which they managed effectively across all teams. This is consistently higher than the England average in all three quarters so far in 2014/15. The teams maintained close working links with the outpatient and inpatient services across their geographical areas which enabled this high level of gatekeeping.
- Each team had a positive response to managing people who did not attend appointments. We saw evidence that where there had been a failed visit repeat visits would be carried out. Risks were then considered prior to requesting a welfare check from the police.
- In each of the teams we visited we saw that people were given flexibility in when they could see staff and where.
- Staff were responsive to people's individual requests and needs and tried to work around these. Appointments were rarely cancelled and mostly ran on time. Staff told us that people were kept informed when they did not.
- The experience reported to us by the people receiving the service indicated this to be the case but two of the people told us that when care initially started they were not given specific times they would be seen but just told either in the morning or afternoon. This was reported to improve as their care and contact with the service progressed.

The facility promotes recovery, comfort and dignity and confidentiality

- We did not find a consistent standard of physical environment across the crisis teams we visited. The South West CAT team had a bright open and accessible premises for clients to access however in the other two sites places we observed a general poor state of repair with large cracks across the ceilings and well worn furniture.
- The visiting rooms in the North CATT and the North West CAT teams did not have adequate sound proofing.
- We were told that the North CAT team were due to be moving to new premises but they were not sure when this was due to happen.

Meeting the needs of all people who use the service

- Information was available for people across all the services we visited. This was predominately in English across all the teams although there was access to addition languages on request and this was based on the cultural and ethnic mix with in the local area.
- Staff confirmed that they had access to translation services and interpreters where required. We saw that most staff had received their mandatory equality diversity and human rights (EDHR) training.
- Staff were aware of the need to support people in a manner that respected their preferences. For example, if someone requested a visit from a female member of staff the teams facilitated this.
- We saw that in the Watford area the South West CAT team had established strong links with a broad mix of ethnic and cultural groups based around that area.

Good

Are services responsive to people's needs?

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

Listening to and learning from concerns and complaints

- All the welcome packs we looked at contained a guide that informed people who were using the service on how to complain. Staff assisted people to do so using the patient advice and liaison service (PALS). The guide contained all the contact details and had a self-contained free post envelope return to make the process straightforward.
- We saw information about how to complain displayed in the waiting rooms across the sites we visited.
- Complaints were managed via the trust central location and not usually made direct to the services. Team leaders we spoke to at all sites told us that complaints were discussed at the monthly team lead meetings so experience could be shared and learning identified with their local teams via the monthly staff meetings.

Health-based places of safety

Lister Hospital 136 suite, Kingfisher Court 136 suite, Kingsley Green children's 136 suite

Access, discharge and transfer

- Each of the 136 suites can only accept one person for assessment at a time.
- Should the person concerned not be admitted following initial assessment they may be many miles from their home or where they had first been placed on a Section 136 by the police. All units confirmed that in such circumstances, the trust would pay for a taxi to return the person home if no suitable trust transport was available.

The facilities promote recovery, dignity and confidentiality

- The environment at Kingfisher court has been purpose built to optimise comfort and dignity during the assessment process.
- We found the environents at Kingsley Green and Lister hospital to be small and barren looking with no access to a clock. The childrens 136 suite at Kingsley green was not considered to be an appropriate place to bring a child and the trust took immediate action to stop using this area for children and to use the more appropriate environment at Kingfisher court immediately following the inspection. Lister hospital136 suite had a development plan and the building work was due to finish September 2015.

Meeting the needs of all people who use the service

- Staff confirmed that they had access to translation services and interpreters where required. We saw that most staff had received their mandatory equality diversity and human rights (EDHR) training.
- Staff working in the section 136 suites had all completed their required and mandatory training. There was no additional training provided formally but the staff supported each other to ensure that they have sufficient knowledge to work in the 136 suite.

Listening to and learning from concerns and complaints

- The trust does not have a method of gathering feedback from people detained under Section 136.

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.

Summary of findings

Our findings

Mental health crisis services

North CAT team, North West CAT team, South West CAT team

Vision and values

- Staff felt connected to the trust and knew of its visions and values. Staff had been accessing workshops to discuss the trust values and felt the values genuinely underpinned what they were trying to achieve.
- Staff knew their immediate line management structure up to the acute services manager and felt well supported within that structure with regular monthly business meetings. We were also told that senior managers had visited the North CATT and South West CATT sites.

Good Governance

- The trust were using KPI systems (key performance indicators) based on extracting data from the trust's electronic treatment records system and via the electronic rota system. These indicators helped to gauge the performance of the teams. However, team leaders did not fully understood how to access these systems.
- We looked at training records and staff rotas and saw that staff received mandatory training and were appraised and supervised, incidents were reported and investigated and safeguarding and Mental Health Act procedures were followed.
- Team leaders were able to book additional staff cover when required to ensure their services continued to run when there were vacancies or occasions of staff sickness.

Leadership, morale and staff engagement

- Staff morale was high in all of the teams we visited. Staff told us they were proud of the job they did and felt well supported in their roles.
- Staff members told us that recruitment and retention was a problem in the South West CATT area because of its proximity to London but they were aware the trust was attempting to address this issue.
- Staff felt well supported by their medical colleagues.
- There was no culture of bullying within their teams and they felt empowered to raise concerns in the workplace if and when bullying occurred without fear of victimisation.
- The teams we visited did not appear to have a clearly delineated set of roles and responsibilities allocated between the middle management structure of the team leaders. This lack of clearly defined roles meant that there were gaps in local leadership
- Staff told us they felt empowered to raise any issues and promote service development and initiatives through their own individual supervision and through the local team meetings and business meetings with senior managers.

Commitment to quality improvement and innovation

- We saw that each team had a recent quality improvement action plan which the team leaders went through at the business meetings, this indicated that the services were committed to quality improvement.
- The crisis teams were committed to the host families scheme which is the first of its kind across the UK. The host families scheme allows service users who are acutely unwell to stay with a local family for a few weeks, as an alternative to inpatient care. The CATT teams were all actively participating in the development and support of this intervention with allocated champions within the teams who liaised with the inpatient and community teams to ensure families and people receiving services were intensively supported.

Health-based places of safety

Lister Hospital 136 suite, Kingfisher Court 136 suite, Kingsley Green children's 136 suite

Vision and values

- Staff we met with at Kingfisher court told us that senior trust managers had recently visited the section 136 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.

- Staff that we spoke with during the inspection were aware of the trust vision and strategy and the joint agency policy for the implementation of section 136 policy.

Good governance

- There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act. This policy and procedure has been jointly agreed by the local police force and ambulance service
- Clear clinical governance arrangements were in place. Data was collected by means of a checklist tool that measured the process of the detention including the number of times that people were brought into the section 136 suite and outcomes for people following assessment. This data was then reviewed by the mental health act administration team. The Trust collects and audits this data, and provided an audit report on the Section 136 MHA to health based places of safety from July 2014 which contained data on the length of time the police stayed, length of detention in the 136 suite, AMHP waiting times and outcomes, The Trust acknowledged that the audit was based on data from April 2014, the next planned audit is due to be completed by the end of June 2015. The trust were unable to provide the inspection team with real-time data as the documents are scanned into PARIS (the Trusts electronic patient record) and audits were not due to be completed until June 2015.

Leadership moral and staff engagement

- The inspection team were impressed by the commitment of staff and the police we met in providing a safe, responsive, and caring environment to people who were being assessed at these units. Staff spoken to were aware of the local vision and strategy of this service.

Commitment to quality improvement and innovation

- There was a quarterly joint liaison group which was chaired by the service director and all key stake holders were invited to attend including the local Police safeguarding unit, the local ambulance trust, the local acute trust and the local authority lead.
- There was also a bi monthly meeting with trust staff (both ward staff and a senior manager) and the police. This meeting aims to deal with any important issues that may have arisen with delivery against the joint agency policy for the implementation of section 136.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: The section 136 suites at Lister and Kingsley Green did not provide suitable facilities and premises for the services being delivered. Regulation 15 (1) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: At the North West CATT four of the eight medication cards we checked contained errors in administration recording. There were gaps in administration of medications and medicines had been given when dates showed they had not been prescribed. This meant people's medication was not being administered in a safe way. Regulation 12 (2) (g)