

Worcestershire Health and Care NHS Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
Isaac Maddox House Shrub Hill Worcestershire WR4 9RW	R1AZ3	Health based place of safety	WR5 1JG
Isaac Maddox House Shrub Hill Worcestershire WR4 9RW	R1AZ3	Psychiatric assessment team	WR5 2LG
Isaac Maddox House Shrub Hill Worcestershire WR4 9RW	R1AZ3	Mental health liaison Team	B987WG

Summary of findings

Isaac Maddox House Shrub Hill Worcestershire WR4 9RW	R1AZ3	Redditch & Bromsgrove Home Treatment Team	B98 7WG
Isaac Maddox House Shrub Hill Worcestershire WR4 9RW	R1AZ3	Wychavon home treatment team Worcester & Malvern Home Treatment team	WR5 1JG
Isaac Maddox House Shrub Hill Worcestershire WR4 9RW	R1AZ3	Wyre forest Home Treatment Team	DY11 6RY

This report describes our judgement of the quality of care provided within this core service by Worcestershire Health and Care 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 Worcestershire Health and Care NHS Trust and these are brought together to inform our overall judgement of Worcestershire Health and Care 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 mental health crisis services and health-based places of safety

Good 

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

Good 

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

Good 

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

Good 

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

Good 

Are mental health crisis services and health-based places of safety 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

People were assessed in a timely manner and risks were reviewed regularly and updated. Information was shared between agencies such as the police, acute trust and local authority. Crisis and care plans were in place and personalised for all patients.

Incidents, complaints and safeguarding were low; However staff were trained and could describe what they would do when these instances arose. Learning from these was discussed in team and business meetings and supervision.

The Health Based Place of Safety (HBPoS) had been effective in reducing the need for police cells to be used. All teams met their targets for managing referrals and assessments.

Care was being delivered by highly skilled staff. Care and treatment was reported by patients and carers unanimously positive. Patients had been involved in some staff interviews and patient groups were being involved in the development of the local crisis concordat.

The local crisis concordat plan was in the early stages of development and information had not been cascaded to the operational teams.

Staff understood their roles and responsibilities and how this linked to the team and trust vision. They said it was a good place to work in, where they were valued and listened to.

Summary of findings

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

Are services safe?

This was rated as good because;-

People were assessed in safe environments that afforded privacy.

Information protocols enabled assessments to be shared between agencies.

Risk assessments were discussed and updated regularly.

Staffing levels enabled staff to manage the number of referrals.

Staff had been trained in incident reporting and safeguarding for children and adults. Whilst the number of incidents, safeguarding's were low, learning was shared and the trust published a bulletin with this information in.

Crisis plans had been introduced and contained information about what to do in an emergency.

- The resuscitation trolley in the HBPoS had not been checked since October 2014.

Good



Are services effective?

We rated this good because ;-

The HBPoS had positively impacted by reducing the use of police cells as a place of safety.

The clinical team ensured that people were risked assessed and regularly reviewed.

Care plans were personalised and in place for people using the service.

A range of psychological therapies were provided by skilled practitioners.

HoNOS was used to monitor people's progress in treatment.

On-going improvement quality was demonstrated through the accreditation system managed by the Royal College of Psychiatrists.

Staff received mandatory training, specific role training and clinical supervision.

- The resuscitation trolley in the HBPoS had not been checked since October 2014.

Good



Are services caring?

We rated this as good because ;-

Good



Summary of findings

Patients were overwhelmingly positive about the service they received.

We observed people being cared for with dignity and respect.

Staff understood the individual needs of patients and visited accordingly.

Joint visits were carried out with other teams to provide continuity of care.

There were good links with other agencies to provide support and advice.

Family members were involved and carer's assessments offered.

Information was provided to support patients.

Patients were involved in staff employment interview panels and had been involved in preparing for the Home Treatment Team accreditation.

Advocacy was promoted by approved mental health practitioners (AMHP) mainly.

- Advanced directives were not seen and were not promoted so that people could state how they wished to be treated in the future.

Are services responsive to people's needs?

We rated this service as good because;-

The psychiatric liaison team was used to provide a 24 hour service as a pilot with successful results.

It provided services from 8am to midnight. This meant that people in A/E at night were looked after by general nurses, although telephone advice was available by the psychiatric assessment team and on call psychiatrist.

Whilst there was no crisis house, staff could book emergency accommodation in a hotel.

Good



Are services well-led?

We rated this service as good because;-

The teams had clear vision and values that linked to the trusts vision.

There was effective working within and between teams.

Regular meetings occurred to look at performance.

Good



Summary of findings

The local crisis concordat plan was in the early stages of development and teams were not aware of developments.

Staff felt valued and able to discuss concerns .Staff described it as a good environment to work in.

Multi-agency working was occurring through individual joint agreements; however there was no overarching multi-agency agreement in place for crisis care.

Summary of findings

Background to the service

The CQC crisis data base results can be accessed on the CQC website <http://www.cqc.org.uk/content/thematic-review-mental-health-crisis-care-initial-data-review>.

The CQC crisis data base compared the Worcestershire area with other local authority areas and found the emergency department pathway, specialist crisis team pathway and health based pathway placed them in the middle of the range in comparison.

People in the Worcestershire area, who have a mental health crisis, follow a number of routes to be seen by the crisis services.

People in a public place experiencing a crisis may be taken under section 136 of the Mental Health Act to a health based place of safety (HBPoS) by the police so that their mental health can be assessed and referred to the most appropriate service or discharged.

People who have a mental health crisis may attend the emergency department at the Royal Worcester Acute hospital and be seen by the psychiatric liaison team (PLT) who are employed by the Worcestershire Health and Care Trust. From here people may be referred back to their GP, or admitted to the acute inpatient ward, or admitted to a psychiatric ward. Alternatively they may be taken on by the home treatment team (HTT) and care provided to them at home.

The psychiatric assessment team are the gatekeepers to admission to hospital. They look at all referrals and signpost people to the appropriate services.

Services

- A Health Based Place of Safety based at Newtown Hospital site and is available 24 hours a day.
- A psychiatric liaison team was based in an accident and emergency at the Royal Worcester NHS Trust and operated from 8am to 10pm daily.
- A psychiatric assessment team which take same day referrals from GPs, community mental health teams, social workers, wards and provided overnight cover for the psychiatric liaison team from midnight to 8am.
- Four home assessment and treatment teams which provide services to people 16 years and over, in their own homes as an alternative to hospital admission to a psychiatric ward. The service is accessed via the psychiatric assessment team or through the wards requesting and early discharge assessment. The teams cover the following geographical areas; - Redditch and Bromsgrove, Malvern and Worcester, Wyre Forest, Wychavon, and are located near the wards. The teams provided a seven day service from 8am to 10pm and were located near adult acute wards.

The crisis services have not been inspected since registration by the Care Quality Commission.

A Mental Health Act monitoring visits in 2013 had focused upon the health based place of safety, psychiatric liaison, and multi-agency partnership working in operating the Mental Health Act in the area.

Our inspection team

Our Inspection team was led by:

Chair: Dr Ros Tolcher, Chief Executive Harrogate and District NHS Foundation Trust.

Team Leader: Pauline Carpenter, Head of Hospital Inspection, Care Quality Commission.

The team included 2 CQC inspectors, a specialist registrar, a consultant psychologist, and a mental health act reviewer.

Why we carried out this inspection

We inspected this core service as part of our on going comprehensive mental health inspection programme

Summary of findings

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about Worcestershire Health and Care NHS Trust, this included data published on the CQC website about the Worcestershire area crisis services as part of our thematic review of crisis services.

<http://www.cqc.org.uk/content/thematic-review-mental-health-crisis-care-initial-data-review>

We carried out an announced visit on the 20, 21, 22 January 2015. During the visit we ;-

- Spoke with 28 staff, such as nurses, doctors, therapists, social workers.
- Talked with 6 people who use services by telephone and observed 5 home visits, and a rapid review assessment on a ward.
- Observed 5 staff meetings such as handovers, business meetings, clinical meetings, rapid review meeting.
- Talked with one carer by phone.
- Reviewed 30 patient records, and 5 patient medication charts. Reviewed 4 places of safety patient records.

What people who use the provider's services say

- Friends and family test were carried out and reported very positive results
- Patients were overwhelmingly positive about the care they received from the home treatment teams, we received no negative comments. Patients reported that the teams were responsive to their needs.
- Emergency contact information was provided to patients should a mental health crisis occur again.
- Patients received information about their medication and side effects.
- Families were involved in the crisis care planning, and carers' assessments were undertaken.
- Patients were involved in the preparation of the Home Treatment Team Accreditation scheme with the Royal College of Psychiatrists. Patients were also involved in staff interviews for employment.
- There was lack of information provided about advocacy and advanced directives were not promoted or used

Good practice

Worcestershire Health and Care 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
Heath based place of safety	Isaac Maddox House Shrub Hill Worcestershire WR4 9RW
Psychiatric liaison team	Isaac Maddox House Shrub Hill Worcestershire WR4 9RW
Psychiatric assessment team	Isaac Maddox House Shrub Hill Worcestershire WR4 9RW
Redditch & Bromsgrove home treatment team Wychavon home treatment team Worcester & Malvern home treatment team Wyre Forest home treatment team	Isaac Maddox House Shrub Hill Worcestershire WR4 9RW

Detailed findings

Mental Health Act responsibilities

- There was generally good availability of section 12 MHA doctors to undertake Mental Health Act assessment in a timely manner, where this did not occur an incident form would be completed. Many of the trust's doctors acted as section 12 approved doctors.
- The trust had approved mental health professionals (AMHP) that were directly employed or seconded from the local authority who went on the AMPH rota to undertake MHA assessments.
- Staff had undertaken MHA training as part of their induction and mandatory training; we observed teams had access to the MHA and Code of Practice.
- There was an AMPH who was the lead for the health based place of safety (HBPoS).

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had undertaken MCA and Dols training as part of their induction and mandatory training, Staff had not received updates following the Cheshire West Judgement to consider the impact upon their patients, and there was reliance upon AMPHs in taking the lead in this area.
- The MCA and Dols was considered when undertaking MHA assessments and looking at the least restrictive options.

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

- People were assessed in safe environments that afforded privacy.
- Information protocols enabled assessments to be shared between agencies.
- Risk assessments were discussed and updated regularly. Staffing levels enabled staff to manage the number of referrals.
- Staff had been trained in incident reporting and safeguarding for children and adults. Whilst the number of incidents, safeguarding's were low, learning was shared and the trust published a bulletin with this information in.
- Crisis plans had been introduced and contained information about what to do in an emergency.

The resuscitation trolley in the HBPoS had not been checked since October 2014.

were available. We were told that hot meals were provided by neighbouring wards as required. There were notice boards on the unit which contained information for patients and carers.

- There was one wet room and toilet available in the HBPoS, which was pleasant and clean and appeared to be designed to minimise ligatures. We were told that doors were two way opening for health and safety purposes. There was also a staff toilet available.
- We observed the resuscitation trolley in the HBPoS had not been checked since October 2014 and brought it to the attention of the trust who took action.
- Alarms were present in the HBPoS to summon help and support workers carried alarms. Managers said staff from PICU would come and assist in emergency and staff would also use 999 in emergency. There was a protocol on the trust intranet for this.
- The psychiatric liaison team had dedicated assessment rooms based in the A/E which were clean and had panic alarm buttons in place. Staff stated that they felt safe in the rooms. When people on the wards required assessment the team brought them down to the mental health assessment room in A/E unless they were bedbound, so that they were seen in a private space.
- The psychiatric liaison team undertook joint assessments with other teams such as learning disabilities, child and adolescents so that specialist input was used. Patient notes flagged up when a patient needed to be seen by two people due to risks presented.

Safe staffing

- The HBPOS was staffed when required through an on call rota for an approved mental health professional (AMHP) who would be required to attend and remain if any patient was admitted to the unit. There was also on call rota of band 3 health care support workers (HCSW) who are provided by the bank service. This meant that wards were not depleted of staff when someone was admitted.
- The minimum staffing for the HBPOS was one AMHP and one HCSW; more staff would be made available based on patient need and patient numbers. There was a lead AMPH who was a designated lead for the unit. We were informed by staff that there were concerns over the

Our findings

Safe environment

- The health based place of safety (HBPOS) also known as the section 136 assessment unit was located at the Newtown Hospital, next to the psychiatric intensive care unit (PICU) and an acute admission ward. It had a coded lock to enter which the police are able to use.
- The HBPOS unit was clean and well maintained. It contained three separate lounges with one having access to a secure outside area where patients were allowed to smoke or to get fresh air. This lounge had a couch, chairs and a television which was not boxed in. The other lounges were smaller and had adequate seating but there was no couch or television available in either. All three lounge areas had a clock on the wall. The furniture appeared pleasant, comfortable and robust.
- The HBPOS unit had one office for staff. There was a small, well equipped kitchen where drinks and snacks

Are services safe?

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allocation of support workers when required via the on call rota facilitated by NHS Professionals. This has led to the police remaining on the unit for longer periods than would normally be required. When this occurred it was raised as an incident and it had been placed on the trust risk register as an area of concern. The trust was pursuing a number of options to improve this situation.

- The psychiatric liaison team operated over two sites in the A/E departments and wards. Medical staff were part of the team. They had sufficient staffing and did not use bank or agency staff, there was one vacancy being carried.
- Safe staffing generally was in place enabling staff to manage the number of referrals and meet target times set for referrals to be seen in each team, which are monitored and met.
- The home treatment teams consisted of social workers, nurses some of whom were nurse prescribers, occupational therapists, unqualified staff and medical staff. We saw highly experience and qualified staff who showed high level interpersonal skills in engaging patients and were very knowledgeable in applying robust processes in managing care for example one staff member we spoke with was a qualified nurse, AMPH, nurse prescriber who was also trained in psychotherapeutic interventions.
- Some mental health practitioners in the HTT were also AMHPs who also went on the AMPH rota in order to undertake Mental Health Act Assessments. They were employed by the local authority and seconded to the trust. A Single appraisal system was in place. AMPH supervision was provided by the local authority by an AMPH supervisor and line management by the trust manger monthly. Staff reported they felt integrated in the trust.
- All home treatment teams (HTT) except one told us they had enough staff to manage their workload. Staff in that team reported that there had been vacancies and sickness which although covered through bank and agencies had led to pressures and effected morale.
- One HTT had psychologist input one day per month to see patients and another HTT had half a day input. Staff stated this had made a positive impact. There was no psychology input into all the HTT; staff reported that accesses to psychology would strengthen the service they were delivering.
- There was rapid access to a psychiatrist when required by the psychiatric liaison team and the HTT.

- Agency staff were not used. Bank staff were used and continuity was maintained by using the same bank staff.

Assessing and managing risk to patients and staff

- Some assessment records reviewed in the HBPOS showed that the sections rating risks as high, medium or low was not completed.
- The psychiatric liaison team completed risk assessments within target times. We saw the psychiatric assessment teams guidelines and protocols. There were information sharing protocols in place with the acute trust, also with other teams such as child and adolescent teams so that assessments could be shared.
- We observed risk assessments being carried out sensitively and professionally during home visits. Records reviewed showed that clear risk assessments and plans in place in the HTTs. Risk assessments were carried out using a range of tools ; called MR1 a general assessment tool used by the trust, the Worthing assessment tool, the STORM suicide risk assessment tool and the Galatian risk screening tool (GRIST).
- We observed risk factors being discussed in handover meetings between shift changes in the HTT and saw risks being updated regularly.
- The HTTs maintained check lists to monitor that risk assessments and plans were in place.
- Joint risk assessments with the police and ambulance triage were carried out prior to admitting to the HBPOS to ensure that the person was not physically unwell. Staff reported good information sharing on risk with the police.
- Patient records carried flags that indicated violence and aggression risks necessitating two people to assess in the A/E department or when it was not appropriate for female staff to undertake the assessment.
- Crisis plans had recently been introduced and were observed to be in place during home visits. The crisis plans were written in the patient's own words and gave information of what to do in a crisis and who to contact.
- All records reviewed did not show advance decisions being promoted or in place.
- We observed the HTT visit a patient on a ward. We observed a decision to write a personal crisis plan which would assist all professionals in providing care.

Are services safe?

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- The trust had a protocol of what to do if an IT failure occurred. Occasionally the computers did go “down”, however not all staff we spoke with were aware there was a protocol. This meant that there could be delays in accessing clinical information.
- Safeguarding for children and adults training had been undertaken by all teams.
- There were adult and children safeguarding policies in place. Staff had access to two safeguarding leads for advice. The number of safeguarding reported in each of the crisis teams was low. Staff we spoke to did understand the process of reporting safeguarding concerns and did so electronically, with a follow up call to ensure the safeguarding alert had been received.
- Safeguarding concerns were discussed initially with the manager of the team, in the handover meetings, supervision and clinical meetings. Staff attended strategy meetings called by the local safeguarding team.
- The trust had a lone working policy in draft in place. Staff informed the office of visits, some teams had a code word that they could use in case of emergency during a home visit, and others did not.
- Home assessment teams had nurse prescribers in place that took the lead in medicines management in each team. They attended monthly medicine management meetings. Staff showed us the NICE guidance relating to medicines and mental health conditions that they referred to in delivering care.
- There was a medicine management policy and standard operating procedures to minimise errors in secondary administration. There was a set of patient group directives which had not been implemented by the current nurses; work was on-going to develop the nurse prescriber’s competencies in order to implement the directives. All new prescriptions were written by an on call doctor, verbal prescriptions were not accepted. There had not been any medication errors in the last two years
- Access to medicines cupboards was via a key locked in a coded box. Medicine cupboards had a limited supply of stock for emergencies. The teams ordered take home drugs from the local pharmacy. A new procedure was being introduced to move away from individual drug bottles leading to secondary dispensing. There were new boxes of doses covering 24 hours from a list of psychiatric medication.
- We observed monthly checklist being completed. Protocols for ordering medication were in place. A

standard operating provider dated 27/8/14 was in place for the supply of pre packed and over the counter medication. Nurses signed out the drugs and team members delivered the drugs to people in their home. All nurses had undertaken online training with a test relating to medicine administration. Staff took medicines in a bag and stored them securely in the boot of their cars. Some depot injections were given, these were normally started on the ward or by the CMHT, and staff stated that because the risk of anaphylaxis was low they did not carry crash bag or anaphylaxis medication. Monthly checks of drugs were undertaken

- The lead pharmacist visited the team weekly and spoke to the team regularly
- The psychiatric liaison team did not undertake rapid tranquilisation. This was undertaken by the acute trust using through their policies. The psychiatric liaison team did provide training and advice.

Track record on safety

- The number of incidents, serious untoward incidents and safeguarding were very low. Monitoring reports for September 2014 to November 2014 showed between 20 to 38 incidents per month across the eight crisis teams. The 15 incidents in the 3 months being related to staffing, and 6 related to safeguarding, the adult mental health governance group received detailed analysis of all incidents, and response.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents to report and how to report them examples given related to delays in transfers due to Waterside CMHT staffing issues, delays in section 12 doctors attending MHA assessment, self-harm, medication and safe discharge. We looked at five incidents which confirmed that incidents had been reported and managed.
- There were joint procedures in place between the psychiatric liaison team and the acute trust for joint investigations into incidents and complaints.
- The numbers of serious untoward incidents were rare. We looked at a serious untoward incident, a root cause analysis had been undertaken and there was an action plan supporting the recommendations.

Are services safe?

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- Lessons learnt discussed were discussed in business meetings and team meetings. Staff in the Worcester team gave an example of change as result of learning, which was to document the reasons why changes to visit patterns and care plans were made.
- Learning bulletins were sent out by the trust which gave the top three governance issues for the trust. The psychiatric assessment team gave the example of a new referral tool being piloted following an incident.

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

- The impact of the HBPoS had been to cause a decline in the use of police cells as a place of safety.
- Needs were assessed and reviewed regularly by the clinical team.
- Care plans were in place and personalised.
- Skilled health practitioners provided DBT therapy, anxiety management interventions.
- Outcomes were measured by HoNOS.
- Home treatment team accreditation had been achieved through the peer review system managed by the Royal College of Psychiatrists, demonstrating a commitment to on going improvement.
- Staff received mandatory and clinical supervision, mandatory and specialist role training.

Our findings

Assessment of needs and planning of care

- Patient records reviewed contained through assessment and care plans which were regularly updated and reviewed. They demonstrated ongoing risk assessment and provided a clear understanding of patient need. We reviewed patient records and found that they reflected the general circumstances when people first presented to the services in crisis. The notes indicated if the person had tried to access other services before contacting the specialist mental health services either through A/E, GP or HBPoS. Records showed a prompt response from referral to assessment and treatment. There was evidence of clinical team involvement; Records gave details of peoples residential and family connections. Records showed that referrals were made to other services and there was good effective coordination.
- The HTT's, Assessment team and mental health liaison team had their own electronic system to store assessments and care plans in a database which the psychiatric assessment team could access, but not all the wards and CMHTs. Wards had a database of basic information that HTT's could access. This meant that all the information about a patient was not available in a comprehensive format to all teams.

Best practice in treatment and care

- Records showed that staff had been trained in dialectical behaviour therapy (DBT) awareness, and DBT was being offered to patients so that they could learn skills and change behaviours to cope with difficult situations.
- Records showed that physical healthcare needs were assessed and supported. There were monitoring arrangements in place for prescribed antipsychotic medication.
- The use of the HBPoS had led to a significant reduction in the use of the police station as a place of safety within the last 12 months, only 8% of Section 136 detentions were taken to the police station. Work was ongoing with the police to reduce this from happening at all, resulting in no use of police stations for the last three months prior to our visit.
- The HTT's used "recovery star" with appropriate people so that they could map their progress and recovery. The HTT's were well connected with employment officers, voluntary organisations links, housing trust in order to support patients.
- We saw that the HTT's used health of the nation outcome scores (HoNOS-S), an outcome measure which decides the progress made following therapeutic interventions.
- All staff were unclear about what national institute of health and care (NICE) guidance was being audited. Team managers undertook documentation audits. One HTT had undertaken a physical health audit and was the process of implementing a medication audit.
- None of the operational staff we spoke with had heard or seen the CQC crisis review data for their area.
- The HTT's had been accredited through the home treatment team accreditation scheme, a peer review scheme run by the Royal College of Psychiatrists; one other team were rated as achieving excellence in meeting their standards.

Skilled staff to deliver care

- The HTT's consisted of mental health practitioners from a variety of backgrounds such as occupational therapists, medical consultants, social workers. Staff in the teams had a good range of skills such as children and adolescents mental health, learning disabilities and drugs and alcohol.
- The uptake of mandatory training was good. Staff reported and records confirmed that they had received mandatory training.

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.

- Staff reported and records showed that staff received management supervision every six to eight weeks. Clinical supervision was provided by psychologists who could be either in a group or individual. We were informed clinical supervision is going through a transition and was being changed. The majority of staff reported being well supported by the service.
- We spoke with a new starter who spoke positively about the trust induction programme and the team preceptorship programme. Staff were given team inductions and opportunities to shadow other staff.
- Staff had received specialist training for their roles. For example all staff had completed cognitive behaviour therapy and solution focused therapy awareness training. Suicide prevention training had been undertaken by staff. Staff had attended personality disorder awareness training which had been facilitated by service users. Dementia awareness training had been undertaken by electronic learning and early intervention dementia training had been undertaken. Staff reported that they also had speakers from different parts of the trust to assist for example in relation to eating disorders; the police had also provided training. Nurse prescribers who had not practiced as nurse prescribers were receiving further development so that they could undertake the role fully. Staff provided mindfulness and anxiety management activities with patients.
- The consultant staff spoken with had job plans and had been revalidated to continue to practice. They attended monthly training sessions for all trust consultants.
- We saw sickness and absence performance monitoring reports which showed sickness and absence levels were falling and were low.
- We observed a shift handover meeting in which all patients were discussed physical health assessments and plans were considered. Follow up visits were planned. Visits that required two people because of risks identified were planned. The shift handover was structured in accordance with local protocol; the process was led by a senior clinical with all staff contributing.
- Staff described how well they worked closely as a team and with inpatient services and other agencies undertaking joint visits where appropriate as part of the handover. We observed a rapid response assessment taking place on the wards being undertaken by the HTT and the discussion with the ward staff.
- Home treatment teams had average daily caseloads of 10 to 12. Staff described having manageable caseloads in that three to four visits per day were undertaken daily and we observed personalised responsive care being delivered.
- The psychiatric liaison team could access the electronic records in the acute trust, and the HTT databases. The team were able to write in the patient records in the acute trust. The team however did have difficulty in accessing the child and adolescent records out of hours as they were paper based.
- Handovers were carried out in the morning, afternoon and evening. Their handover protocol was followed which discussed patients progress, issues, risks and ongoing care input, staff contributed and had clear instruction on the tasks required for the next shift. New referrals and discharges were considered. Detailed presentation was given of a newly referred patient.
- Staff described that a lot of time was spent writing up notes following visits which was necessary so that anyone in the team could view the notes in response to patient queries.

Multi-disciplinary and inter-agency team work

- We observed a rapid response team meeting in which individual patient progress was discussed. Team members were knowledgeable about their patients and discussions centred on patient safety, their care, the effectiveness and responsiveness of care. Patients who required a 72 hour review were discussed. Patients were discussed holistically with input from all disciplines. The team also discussed family input in to the patients care. The meeting identified that the team had links with care homes, rehabilitation placements and voluntary sectors specialising in personalised care, the team discussed the best options that were available to people in their care.

Adherence to the MHA and the MHA Code of Practice

- Staff received training in the MHA and MHA Code of Practice. There was access to the Code of Practice in the team offices. AMHPs were very knowledgeable about the MHA and Code of Practice. Staff had access to legal advice if required.

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.

- There was generally good availability of section 12 doctors to undertake Mental Health Act assessment in a timely manner, where this did not occur an incident form would be completed. Many of the trusts doctors acted as section 12 doctors.
- There was an AMPH who was the lead for the health based place of safety (HBPoS). The trust had approved mental health professionals (AMHP) that were directly employed or seconded from the local authority who went on the AMPH rota to undertake MHA assessments. AMPHs were responsive in coming to the HBPoS to undertake MHA assessments.
- Staff had undertaken MHA training as part of their induction and mandatory training; we observed teams had access to the MHA and Code of Practice.
- There was good partnership working with the police in relation to section 136 of the MHA HBPoS.
- Staff informed us that on the rare occasion when a person was admitted under a section 136 of the MHA from home by the police, staff would report it through the trust incident reporting system and informed the individual of their right to leave because they had not been admitted from a public place.
- We found that people admitted under section 136 to the HBPoS did not have leaflets explaining their rights in other languages or in a format suitable for people with learning disabilities.
- Children and adolescents and people with learning disabilities admitted under section 136 to the HBPoS had access to specialist doctors in child and adolescent mental health or learning disabilities for MHA assessments.
- We reviewed AMPH reports in the HBPoS and found that there were two different versions being used. One had more information recorded.
- Legal advice was available to AMPHS and mental health practitioners.
- AMPS we spoke with did consider and make referrals to advocacy. However other staff did not.

Good practice in applying the MCA

- There was a MCA policy. Staff had undertaken MCA and Dols training as part of their induction and mandatory training, Staff had not received updates following the Cheshire West Judgement to consider the impact upon their patients, and there was reliance upon AMPHs in taking the lead in this area.

The MCA and Dols was considered when undertaking MHA assessments and looking at the least restrictive options.

Are services caring?

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

Summary of findings

Patients were overwhelmingly positive about the service they received.

- We observed people being cared for with dignity and respect.
- Staff understood the individual needs of patients and visited accordingly.
- Joint visits were carried out with other teams to provide continuity of care.
- There were good links with other agencies to provide support and advice.
- Family members were involved, and carers assessments offered.
- Information was provided to support patients.
- Patients were involved in staff employment interview panels and had been involved in preparing for the HTT accreditation.

Advocacy was promoted by AMHP mainly. Advance directives were not seen and were not promoted.

Our findings

Kindness, dignity, respect and compassion

- Five home visits were observed in the HTTs. Staff were professional and respectful. They reviewed patient's activities of daily living, and discussed what was happening in their lives, and evaluated risks and improvements. We found staff to have a good depth of knowledge about the patients. The discussions they had with patients correlated with the description of issues in the patients notes we reviewed
- We observed patient choices being respected. Visits were in agreement with patients' needs including weekend visits.
- We observed a visit that was carried out by two professionals because of the perceived risks.
- All patients were unanimous in their praise for staff in supporting them during their crisis frequently describing them as "fantastic". No negative comments were made.

- Staff demonstrated understanding of individual patient needs, we observed a patient commenting that she was grateful for the team telephoning her to check she was up in the morning. In another visit we saw the staff check that the patient had sufficient food in the house.
- A ward review by HTT of patient returning from the community on Section 17 leave was observed, all the members of the clinical team contributed to the discussion about risks, support programs required and options about discharge planning including options of independent living following residential care. The patient wanted visit between 5-7 pm which was accommodated. Another patient gave a positive account of the support received from the HTT, staff offered support to answer benefit queries. Good team work and discussion seen.
- A visit was observed with a consultant psychiatrist carrying out a home visit to assess the impact of medication. Information was given to about the side effects. The consultation was carried out respectfully involving and the patient and spouse. A medication regime was agreed with the patient ascertaining the best times to be taken. The student nurse was involved in the process.
- Records reviewed did not show any advice directives or advanced decisions being promoted. Records showed inconsistent recording of people's ethnicity and religion.
- Involvement of family members was in accordance with the patients consent. We observed relatives in one visit discuss the management of symptoms.

The involvement of people in the care they receive

- We observed on home visits that patients were provided with an initial care plan. A "little book of mental health" booklet was provided together with guidance to the metal health website. Consent form sharing information with other agencies on a need to know basis was explained to patients before completion.
- Crisis care telephone numbers were provided for office and out of hours.
- Care plans were clear relevant and gave direction for consistent care delivery and were written in the first person in agreement with the patient. Documentation of each intervention was clearly recorded with and recording of all contacts.

Are services caring?

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

- We observed a home visit in relation to a new referral, the purpose of the visit was to identify the patient's needs and the support the relative needed in order for the patient to remain home.
- The CPN prior to visiting a patient had checked the history of the patient and confirmed details with the medical officer that had provided the previous assessment. The CPN was observed checking that they patient were happy for the spouse to be present during the visit. CPN checked physical health concerns during the visit. CPN arranged for an evening visit in response to the patient's condition and provided information on how to contact the services.
- We observed Support worker providing sleep charts, finance, facilitating contact with CMHT, taking patient for a physical health hospital appointment and revisiting to undertake exposure work.
- Families are involved in risk assessments and care plans with the patients consent.
- We spoke to a carer who felt involved in the care and describe the HTT as "fantastic".
- Each HTT had a carer's champion who could refer to the trust carers unit to undertake carers' assessments.
- Care plans have a section in which noted the carers involvement and assessment. There was a mixed picture of advocacy information being provided to patients. AMPHS did consider this.
- Some teams had used service users in the interview panels to recruit staff.
- Patients were able to give feedback on the care received following treatment and the results were positive. For example we looked at the Redditch and Bromsgrove patient experience survey 2014, which shows that 59 out of 60 patients said the service was easy to access , compassion was showed all of the time , the majority of people felt they had enough time with staff. 74% of patients felt that staff were responsive all of the time and 23% most of the time. A high majority of patients extremely satisfied with the service received and felt well communicated with. Other team results were similar.

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

- Each team saw patients within the target timescales.
- Visiting appointments were given to suit patient's needs.
- Patients could receive up to three visits per day.
- Joint visits were undertaken with other teams as part of continuity of care.
- There was access to interpreters and information leaflets were available.
- Patients were given emergency contact numbers and told what to do if their health deteriorated.
- Whilst there is no crisis house, staff could book emergency accommodation in a hotel.

The psychiatric liaison team used to provide a 24 hour service as a pilot with successful results. It provided services from 8am to 12pm. This meant that people in A/E at night were looked after by general nurses, although telephone advice was available by the psychiatric assessment team and on call psychiatrist.

Our findings

Access, discharge and transfer

- There were mixed views about accessing crisis services. Healthwatch told us they had been talking to local people about their experiences and feedback that people had concerns about accessing crisis services out of hours, not knowing who to contact in an emergency. We found that once in crisis services patients experiences were good. Patients we spoke to by telephone and during visits reported easy access.
- Performance reports relating to the HBPOS for 2014 persistently showed that the majority of detained patients did not receive ambulance triage at the point of arrest.
- The psychiatric liaison team were meeting their targets in seeing patients within an hour in the A/E, and four hours in the emergency decision unit, and within 24 hours on the wards.
- The psychiatric liaison team and the psychiatric assessment team acted as the gatekeepers to admissions and referred people to the HTTs. The psychiatric assessment team were able to see same day referrals.
- The psychiatric assessment team provided out of hours support and advice and went to the A&E when a MHA assessment was required.
- The psychiatric liaison team looked at the 100 most frequent attenders and put in plans to manage them.
- HTTs took referrals from community mental health teams and GPs. However did not take self referrals or referrals from mental health voluntary organisations.
- There were no crisis house facilities, however in an emergency staff could book hotel accommodation for patients. Young people could be referred to a carers unit in an emergency.
- HTTs operated from 8am to 10pm and visited at weekends. The team were able to provide up to three visits per day if a patient required it. The average length of care provided was for approximately 8 weeks.
- The HBPOS unit had an average of 30-40 admissions per month and that most of these admissions were later discharged home. The unit rarely had three patients admitted at one time.
- The AMPH arrived within 90 minutes to the HBPOS from referral. Support workers arrival time in the HBPOS was variable and in some instances it was difficult to obtain support workers to cover the shifts. These instances were reported as incidents and considered by the section 136 group.
- When a child or younger adult was admitted to the HBPOS unit then the other two places of safety were closed until the individual has been discharged or transferred elsewhere. For children/ younger adults or for individuals with a learning disability an appropriate specialist would be involved in the assessment as soon as could be arranged but that this isn't always possible during out of hour's periods.
- The HTT carried out a rapid review process on wards three times a week. This involved going to the wards twice a week and one telecom with the ward. The purpose was to go through patients and look at barriers to discharge and agree who required home treatment assessment. The HTT also acted as trouble-shooters for anyone placed out of area. All the home treatment teams had a process in place to have a call conference to discuss all patients amongst themselves. These processes meant that people's progress was continuously reviewed with a view to enable them to move to the least restrictive option.

Are services responsive to people's needs?

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

- There was a review of home treatment teams in 2008 which resulted in the home treatment teams being linked to named wards, this provided continuity of relationships with wards and patients.
- The HTT undertook joint visits with community mental health teams, learning disability teams, and child and adolescent mental health teams.
- Patients written to following discharge were invited to give feedback. Positive feedback was received
- The psychiatric assessment team were able to see same day referrals.
- The psychiatric liaison team were part of a pilot providing 24 hours service which ended in April 2014. Staff reported that the impact of this had reduced overnight stays in A&E. The pilot was reported to be a success. Trust was trying to expand service again albeit temporarily. Delays in seeing people at night or on wards, had an effect on the length of stay in the acute hospital. The service level agreement provided for the psychiatric liaison service and did not cover the mental health act provision. This meant that the psychiatric consultant had to step forward as the responsible clinician although it was not part of the service level agreement.
- There were self harm pathways established in the A&E for self harm. This included those who were assessed as low risk. The psychiatric liaison team were on site to triage them. If patients out of hours went home and the psychiatric liaison team would review their notes and telephone them to offer advice and an appointment. The team reported that the uptake of appointments were low.
- Medium and high risk patients arriving at the A&E would stay in hospital. This meant that these patients would stay in A&E until the next day. Patients requiring detention under the MHA would be seen by the

psychiatric assessment team. This meant that general nurses would have to look after people at night, the psychiatric assessment team were available to give advice overnight and there was an on call psychiatrist available by phone.

- Liaison nurses provided informal training for staff in A&E and junior doctors working in the department.

Meeting the needs of all people who use the service

- We saw leaflets called "caring with confidence" which promoted a free online interactive learning programme and a series of courses which could be downloaded. It provided contact information on the HTT and PAT, also what to do if they were not in receipt of treatment from the HTT.
- Crisis emergency numbers provided in a leaflet format so that patients knew what to do if their health deteriorated.
- Teams provide information leaflets such as information about medication and side effects, anxiety, depression. Leaflets in different languages had to be ordered if required.
- Staff had access to interpreting services and also used bi-lingual staff whilst waiting for an interpreter. Family members were not used as interpreters.

Listening to and learning from concerns and complaints

- Staff had received training in complaints procedures as part of mandatory training. The teams received very few complaints. Staff we spoke with explained the complaints procedures and knew how to handle complaints. Feedback from complaints and lessons learnt were discussed in supervision meetings and in team meeting

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

- The teams had clear vision and values that linked to the trusts vision.
- There was effective working within and between teams.
- Regular meetings occurred to look at performance.
- The local crisis concordat plan was in the early stages of development and teams were not aware of developments.
- Multi-agency working was occurring through individual joint agreements.

Our findings

Vision and values

- Staff had a clear vision of their roles in supporting people in their homes and ensuring the least restrictive options were considered. Staff we spoke with said that they were proactive about helping patients to overcome the immediate crisis. The teams' vision was linked to the trust vision.
- Team building days were held regularly involving all the crisis teams to develop their vision, values and team objectives.

Good governance

- We looked at minutes of the adult mental health Quality meeting which identified the top governance risks, reviewed governance reports, clinical pathways and policies and reducing the need for restrictive interventions.
- Governance systems were in place and working in that staff uptake of mandatory training and specialist training was good. Managerial supervision and appraisals was up-to-date. Staff had administrative support so that they could maximise shift time on direct care activities. Whilst incidents, complaints, safeguarding was low, staff understood the procedures and learning from these events was discussed at team meetings. MHA and MCA procedures were followed by the teams. Teams were able to submit items to the trust risk register.

- There were key performance indicators that were shared with team which were discussed in team and business meetings so that improvements and performance could be monitored.
- We saw general risk assessments that had been carried out relating to changes in shift patterns for staff to assess the risks of working long shift patterns and new shift patterns proposed.
- There was a section 136 HBPOS monitoring group which received information from all organisations involved and produced reports. These were shared on an exception basis with the trust Mental Health Act monitoring groups, joint information group and the clinical service review group. Concerns were escalated to the multi-agency working group and contract monitoring board.
- A multi-agency working group was a subcommittee of the Mental Health Act monitoring group. The group was chaired by a non-executive director and met four times a year. Information was considered from the different agencies.

Leadership, morale and staff engagement

- Staff we spoke with described the leadership as clear open, fair with clear lines of communication and structures that had clear accountability. Staff confirmed that middle managers were visible and supportive and provided a good environment to work in.
- Staff we spoke to said they were aware of the whistleblowing, grievance and bullying and harassment policies and felt confident to use them. One member of staff described how a staff member was supported in reporting something that had been of serious concern.
- Staff we spoke with reported being comfortable to talk to any of the team members about issues and said they felt valued and listened to.
- We saw team leader meeting minutes these showed that team working was good with other teams. There was an operational policy about interfacing interface with other teams. All the crisis teams met monthly and there were meetings with CMHTs.
- The HTT had a draft operational policy. The psychiatric liaison team were in the process of developing a strategy.

Commitment to quality improvement and innovation

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.

- The HTTs had achieved accreditation through the Royal College of Psychiatrists, the Redditch, Bromsgrove and Wyre Forest crisis assessment and home treatment were accredited as excellent in January 2014.
- Teams were expected to contribute to trust cost improvement programme by producing ideas that saved money and maintained quality. This was a formally documented process that was discussed in business meetings attended by team leaders. However staff we spoke with were not able to state if impact assessments were carried out against suggestions to ensure quality of care was not affected.

Partnership Working

- The national Crisis Care Concordat was being discussed at a senior level within the trust and with other stakeholders such as the local authority, police, ambulance and the acute trust. These discussions are involved three different user groups.
- The local crisis concordat plan was at draft stage awaiting finalisation. There was no single multi-agency partnership agreement in place. There were individual agreements in place with agencies relating to particular services.
- Governance arrangements across the health economy were unclear in relation to the crisis concordat. There were multi-agency working groups established and connections made to the health and wellbeing board regarding the local crisis concordat plan which the trust participated in.
- Staff anticipated minimal changes to the functioning of the HBPoS as the local crisis concordat began to influence crisis care, however expected referrals to fall as services improved as part of the local crisis concordat plan.
- We found that the crisis teams did not know what was happening in relation to the crisis concordat plan as information was not being cascaded down. Teams were not aware of the CQC crisis thematic data as it had not been brought to their attention.
- There was a good working relationship between the trust and police in relation to the HBPoS. A joint policy was in place and quarterly meetings occurred to look at the performance of the unit.
- We could find no evidence that service users or carers had been involved in the drawing up of the multi-agency policy for places of safety under sections 135 and 136 of the Mental Health Act. The trust operational service leads maintained contacts with the local authority, police, acute trust and ambulance service to discuss practical issues that arose.