Good

Leeds and York Partnership NHS Foundation Trust

Crisis Teams and Health Based Places of Safety

Quality Report

2150 Century Way
Thorpe Park
Leeds
West Yorkshire
LS15 8ZB
Tel: 0113 855 0520
Website: http://www.leedspft.nhs.uk/

Date of inspection visit: 30 September and 1 October 2014
Date of publication: 16 January 2015

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Trust Headquarters	RGD01	Crisis and Assessment Service	LS15 8ZB
Trust Headquarters	RGD01	Crisis and Access Service	LS15 8ZB
Becklin Centre	RGD02	Section 136 Suite, Becklin Centre	LS9 7BE
Bootham Park Hospital	RGDX4	Section 136 Suite, Bootham Park Hospital	YO30 7BY

This report describes our judgement of the quality of care provided within this core service by Leeds and York Partnership 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 Leeds and York Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Leeds and York Partnership 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 Crisis Teams and Health Based Places of Safety	Good 
Are Crisis Teams and Health Based Places of Safety safe?	**Requires Improvement** 
Are Crisis Teams and Health Based Places of Safety effective?	**Good** 
Are Crisis Teams and Health Based Places of Safety caring?	**Good** 
Are Crisis Teams and Health Based Places of Safety responsive?	**Good** 
Are Crisis Teams 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

Contents

Summary of this inspection

Page

Overall summary 4

The five questions we ask about the service and what we found 5

Background to the service 12

Our inspection team 12

Why we carried out this inspection 12

How we carried out this inspection 12

What people who use the provider say 13

Good practice 13

Areas for improvement 13

Detailed findings from this inspection

Locations inspected 15

Mental Health Act responsibilities 15

Mental Capacity Act and Deprivation of Liberty Safeguards 15

Findings by our five questions 16

Action we have told the provider to take 37

Summary of findings

Overall summary

We found that the crisis teams and health based places of safety had safe staffing levels,

assessed and managed risk to patients and staff and reported incidents and learned from when things go wrong. However the environment at the section 136 suite was unsafe due to inappropriate furniture, ligature points and medication management systems.

We found that the crisis teams and health based places of safety assessed the needs of people and planned care and followed best practice in treatment and delivery of care. There were skilled staff and multi-disciplinary and inter-agency team working in place. There was adherence to the MHA and the MHA Code of Practice. However, we found a lack of medical input in some teams and a lack of effective clinical audit.

We found that the crisis teams and health based places of safety involved people in the care they received and treated them with kindness, dignity, respect and support.

We found that the crisis teams and health based places of safety managed access, discharge and bed management effectively. We found that policies and procedures minimised restrictions and the needs of people who use the service were met responsively. We found that listening to and learning from concerns and complaints was not always in place.

We found that overall the crisis teams and health based places of safety were committed to quality improvement and innovation and that effective leadership, morale and staff engagement were in place. There were good governance systems in place and staff understood and followed the trust's vision and values. There were however issues around monitoring staff training and the management of quality and performance data.

Summary of findings

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

Are services safe?

Requires Improvement

At the section 136 suite at the Becklin Centre, Leeds, the furniture could potentially be used to cause injury. This had not been recognised as a risk. Also, the bathroom contained significant risks in that taps and door handles could be used as ligature points. There had been some measures put in place to reduce risk to people however these risks were still present with no plan to remove these potential ligature points.

The section 136 suite at Bootham Park Hospital, York, had a safe and suitable environment with access to emergency equipment.

At both section 136 suites there were appropriate staffing levels and skill mix of staff with effective working arrangements with medical staff and allied mental health professionals (AMHPS).

At both section 136 suites, a joint risk assessment undertaken by staff from the assessment and crisis team and the police was completed for all people admitted. A regular three monthly multi-agency meeting was well established to oversee the operation of the section 136 suite and discuss learning from any incidents.

We observed safe and clean interview rooms at both CAS teams.

Both CAS teams' staff had received appropriate training in safeguarding and were clear about safeguarding procedures.

Both CAS teams adhered to the trust's lone working policy and knew how to keep themselves and each other safe.

Both CAS teams followed an incident reporting system and demonstrated learning from incidents

Both CAS teams had appropriate staffing levels and skill mix of staff with effective working arrangements and AMHPS.

Both CAS teams had effective systems in place to assess and monitor risks to individual people.

At the CAS at the Becklin Centre, Leeds, we identified issues with medication and emergency equipment which meant unsafe practice was being carried out around dispensing and checking of medicines.

There was no dedicated medical input into some teams within the CAS at Bootham Park Hospital, York.

Summary of findings

Are services effective?

Good

Broadly, the section 136 suite at Bootham Park Hospital, York met the expectations of best practice guidance provided by the Royal College of Psychiatrists. However the safety of the environment of the suite at the Becklin Centre, Leeds did not meet the expectations.

Staff conducted good assessments and physical health checks on when people arrived at the section 136 suites. They ensured that any ongoing physical health problems were followed up appropriately.

Younger people were always assessed by a doctor who specialised in the care of children and adolescents. For people with a learning disability their assessment was usually undertaken by a doctor with experience of learning disability but access out of hours to such specialists was said to be problematic.

Qualified staff undertook the co-ordination of admissions to both section 136 suites, operating as the section 136 co-ordinator, and clear guidance was available to them, along with a checklist, when operating in this role.

Links with the police in the operation of section 136 and the suites were good. Good joint working relationships were in place at both a strategic and operational level and attendance at the three monthly monitoring meetings was good with representatives from a wide variety of agencies present.

Both CAS teams had effective assessment of needs and planning of care in place including up to date risk assessments. Care plans were goal oriented and had clear pathways of referral to other services.

Both CAS teams' care plans were written and reviewed, where possible, with the involvement of the person. Staff involved family, friends and advocates as appropriate and according to the person's wishes. However this was not always recorded in peoples care plans at the CAS in the Becklin Centre, Leeds.

Both CAS teams followed best practice in treatment and care. Some staff told us that performance data was not always useful for them and that a clinical dashboard was being developed to simplify this information. However we found that there had been no progress regarding the implementation of a clinical dashboard.

A full range of mental health disciplines provided input to the CAS teams, although there was a lack of AMHP input at the CAS at Bootham Park Hospital, York. There was evidence of effective multi-disciplinary team working. The teams had regular and effective MDT meetings to review people who used the service. The teams had established positive working relationships with a range of other service providers.

Summary of findings

Staff received regular clinical and managerial supervision. At the CAS at the Becklin Centre, Leeds there was weekly peer group supervision facilitated by a psychotherapist who was external to the team.

We saw that there were a number of clinical audits in place. However at the CAS at the Becklin Centre, Leeds there was no local audit programme in place to oversee audits being carried out including national audit commitments and local audits. Non-medical staff did not engage in any audit activity. We did not see any evidence of how shortfalls had been identified and learning had been implemented from audits.

The CAS at the Becklin Centre, Leeds worked closely with West Yorkshire Police and had provided joint training within the trust.

At CAS at the Becklin Centre, Leeds we saw that mental capacity was recorded in people's care plans within the holistic assessment. However there was no evidence of recording the steps that had been taken to assess mental capacity; only a tick box within the assessment which would be completed when initially completing the assessment. There was no evidence that mental capacity was being recorded on an ongoing basis or effectively assessed.

Are services caring?

Good

Staff were caring and responded to the needs of people admitted to the section 136 suite. The guidance and checklist available to staff managing people in the suite indicated an appropriate degree of concern for the welfare and safety of individuals who were being assessed.

Staff always explained rights to detained patients. For young people, we found evidence of the appropriate involvement of parents or carers.

At both CAS teams, people told us that they were treated with kindness, dignity and respect by staff. People felt that they were listened to and valued the service.

We observed positive interactions between a member of staff and a person who used the service. The person told us they were very happy with the service they were receiving and the support which was provided to them.

Staff provided a range of flexible support to people dependent upon their needs.

Summary of findings

Staff involved people fully in planning their care and provided opportunities for them to discuss their health, beliefs, concerns and preferences to inform their individualised care. Advocates were involved as appropriate and according to the person's wishes.

Staff we spoke with were able to describe specific interventions they used to assist people with managing their distress such as anxiety management, alcohol withdrawal, psychological interventions and relapse prevention work.

People had access to information in different accessible formats, interpreting and advocacy services if necessary.

Are services responsive to people's needs?

Good

At both section 136 suites people were assessed in a timely manner. The timely availability of staff also meant that the police were able to hand over individuals to health staff within an appropriate timescale. However, occasionally, when an individual had been assessed and deemed to require admission to hospital, there was a delay in determining where an appropriate bed could be found. This sometimes resulted in delayed transfer from the suite.

There was access to food and drink within the suites.

The joint section 136 policy was appropriate and had been signed up to by all necessary agencies. The policy set appropriate target times for the handover by the police and the response times of doctors and AMHPs. These were closely monitored and mostly met. The local guidance and checklist for the operation of the health based place of safety were clear and appropriate.

Staff routinely gave patients information explaining rights whilst detained under section 136. Staff told us that access to interpreters, whilst rarely used, was effective and readily available.

Information about the process of making a complaint was available within the suite.

In the section 136 suite at the Becklin Centre in Leeds, the lack of anywhere to lie down within the suite was problematic for people for whom this would be necessary. The furniture in the room was inappropriate.

For both CAS teams, the single point of access (SPA) team used a risk rating system to triage each referral made to the team. All urgent referrals (high risk) were seen within 24 hours.

The service advertised the telephone number for the single point of access (SPA) service in various community based settings such as local General Practitioners surgeries to enable people to contact the service directly.

Summary of findings

The CAS at the Becklin Centre, Leeds operated a pilot scheme called the street triage team (STT) which had reduced admissions into the section 136 suite by 28% since its introduction in December 2013.

The teams visited people in their own home or at the crisis and access team offices dependent upon their needs and level of risk. People were also supported by regular telephone calls or an agreed level of contact.

The teams had forged links with local voluntary organisations and carried out joint assessments.

The teams had daily contact with the acute wards to identify people who may be appropriate for early discharge with support from the team. This included providing support to people during leave periods from the ward.

Staff told us they sometimes had problems accessing beds within the trust when a person required an admission. This often meant that out of area placements had to be arranged.

We found evidence to show that the managers had taken timely action in response to complaints which they had received.

At the CAS team at the Becklin Centre, Leeds, some people told us that they had trouble getting through to the team in a timely way. We spoke with staff about this feedback and we were told that the team had a target to answer 90% of calls within 30 seconds. Waiting times for telephone calls were audited by the administrative staff on a monthly basis and performance against has been consistently between 85% and 95%.

At the CAS team at the Becklin Centre, Leeds, some people who we spoke who used the service told us that they were not always called back by the team at the time that had been agreed. In one instance this had been very important for the person in crisis to receive this call but it came a few hours later than expected. In this instance no explanation could be provided for the person not being called back on time, although a diary of logged calls and electronic records were in place to record all calls and staff duties for the day.

At the CAS team at the Becklin Centre, Leeds, none of the people that we spoke with that had accessed the service knew how to raise concerns and did not have written information about making complaints.

At the CAS team at the Becklin Centre, Leeds there was no proactive approach to gaining feedback from people who used the service. There was no evidence that changes had been made to the service based on people's feedback.

Summary of findings

Are services well-led?

Good

Management and staff were clear about the purpose and function of the section 136 suite. A clear multi-agency protocol was in place to oversee its operation, with all necessary agencies involved in the monitoring of operations.

The team manager had sufficient flexibility within the multi-functional team, to ensure that the suite was appropriately staffed when required. Where problems arose these were discussed and resolved either in the three monthly monitoring meeting or in discussion between appropriate senior staff in relevant agencies.

The section 136 suite had been subject to a scheduled Mental Health Act monitoring visit in August 2013 to check adherence to the Mental Health Act and Mental Health Act Code of Practice. Where issues were found, the trust provided an action statement with timescales to show how it would improve its processes to help secure adherence to the Mental Health Act and Code of Practice.

Staff spoken with were committed to the purpose and function of the section 136 suite and reported that they were supported by their managers in this regard.

The locally agreed joint policy on section 136 contained clear target response times for assessments to be undertaken, and these were monitored and discussed. The use of police cells as the place of safety and the rates of diversion was also monitored and addressed within the three monthly monitoring group.

Some staff were aware of the chief executive and board level leadership through the trust and were able to identify the trust values. Others told us that they did not feel involved with the senior managers within the trust.

The teams held weekly staff meetings that had an agenda which was focused on governance issues. These meetings linked into the directorate governance meetings which provided assurance that issues could be escalated and shared across services.

Staff we spoke with were clear about their responsibilities in relation to escalating any issues which may impact on the quality of the service they provided to the manager.

Staff told us that they received information they needed from the trust through their manager or via the internal intranet called Staffnet so they were kept informed of developments which may impact on their work.

Staff had an annual appraisal and were aware of their own personal development goals.

Summary of findings

Staff told us they had access to training to support them in their roles. This included specialist training in addition to mandatory training provided by the trust. However the data provided at trust level about training uptake showed significant gaps in training. The manager told us that training uptake was monitored locally through the electronic training records and local email reminders, but when we asked for an up to date list of training uptake this could not be provided.

There was therefore no effective system in place to ensure that policies and procedures were kept up to date.

The team was well-led at local level. All of the staff we spoke with told us that they felt proud working for the team and felt supported by their managers. Staff told us they felt comfortable discussing any issues they may have with colleagues within the team.

There was a whistleblowing procedure in place which staff were aware of and told us that they would raise any issues if they were unable to this this within the team.

It was not clear how performance data was locally driven or owned. Staff told us that performance data was not useful. It was therefore difficult to measure performance improvement locally or across services.

At the CAS at the Becklin Centre in Leeds, the service did not have an effective audit programme in place to monitor and review the quality of the service provided. There was no system in place to actively gather feedback from people using the service and implement changes as a result.

Summary of findings

Background to the service

The crisis and assessment service at the Becklin Centre, Leeds provides a 24 hour, seven day service for adults of all ages. The service aims to assess all people who are in crisis and presenting with significant risks to themselves and/or others and who may require acute mental health care. The crisis and assessment service integrates a single point of access (SPA) service and manages admissions to all acute inpatient wards and facilitates routine referrals to community mental health services. A pilot street triage team (STT) is integrated within the service. The service also operates a section 136 suite (the health based place of safety) where people who are detained by the police for their own safety can receive a mental health assessment.

Services

- Street triage team
- Single point of access team
- Section 136 suite

The crisis and access service (CAS) at Bootham Park Hospital, York provides a service for adults of all ages. The service aims to assess all people who are in crisis and presenting with significant risks to themselves and/or others and who may require acute mental health care. CAS integrates a single point of access (SPA) service and manages admissions to all acute admissions to community mental health services and the inpatient wards at Bootham Park Hospital. The service also includes an intensive home treatment team (IHTT) in the community for four days per week. A pilot liaison psychiatry service runs as part of the service which is based at York Hospital in the emergency department. The service operates a section 136 suite (the health based place of safety) where people who are detained by the police for their own safety can receive a mental health assessment.

Services

- Single point of access team
- Section 136 suite
- Liaison psychiatry
- Intensive home treatment team

Our inspection team

Our inspection team was led by:

Chair: Michael Hutt**,** Chief Operating Officer, Cumbria Partnership NHS Foundation Trust

Team Leader: Jenny Wilkes Head of Inspection - Hospitals Directorate (Mental Health), Care Quality Commission

The team included a CQC inspector and specialist advisors including a consultant psychiatrist, two qualified nurses, a social worker and a Mental Health Act reviewer.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

Prior to the inspection we reviewed a range of information we hold about the crisis teams and health based places of safety and asked other organisations to share what they knew. We carried out an announced visit on 31 September and 1 October 2014 to the two crisis teams, one at the Becklin Centre in Leeds, the other at Bootham Park Hospital in York. We also carried out an

Summary of findings

announced visit on 31 September and 1 October 2014 to the two health based places of safety, one at the Becklin Centre in Leeds, the other at Bootham Park Hospital in York.

During the visits we attended a staff handover meeting, a multi-disciplinary team meeting and a team business meeting. We spoke with 32 members of staff including managers, clinical leads, medical staff, nurses, support workers, administrative staff and therapists. We spoke with 10 people who use services by telephone. We reviewed care or treatment records of 10 people who use services. We visited one person in their home and observed a telephone call from the single point of access (SPA) telephone line.

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?

What people who use the provider's services say

We spoke with 10 people in total and each person told us they felt safe during or after contact with the crisis teams. We were not able to speak with people directly who had used the section 136 suite during this inspection.

People told us that they were treated with kindness, dignity and respect by staff. People felt that they were listened to and valued the service.

We were shown three emails from people who used the service with feedback about the service. These included positive comments about the staff.

People told us they were very happy with the service they were receiving and the support which was provided to them.

People told us they were fully involved in planning their care and had opportunities to discuss their health, beliefs, concerns and preferences.

People told us they were able to decide who to involve in their care and decisions about their care, and to what extent.

People told us they had access to information in different accessible formats, interpreting and advocacy services if necessary.

People using the CAS at the Becklin Centre, Leeds, told us that they had not been told how to make a complaint. People using the CAS at Bootham Park Hospital, York, told us that they had been informed.

People raised concerns about response times and being called back by the CAS at the Becklin Centre, Leeds.

Good practice

The CAS in the Becklin Centre, Leeds, operated a pilot scheme called the street triage team (STT) which had reduced admissions into the section 136 suite by 28% since its introduction in December 2013.

The CAS in the Becklin Centre, Leeds, worked closely with West Yorkshire Police and had provided joint training to staff within the trust and to the police.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

The provider must ensure that the seating is appropriate at the section 136 suite at the Becklin Centre, Leeds, as this could potentially be used to cause injury.

Summary of findings

The provider must ensure that the ligature points (sink taps and door handles) in the bathroom at the section 136 suite at the Becklin Centre, Leeds, are removed.

The provider must ensure that the Patient Group Directions (PGD) medication at the crisis and assessment service at the Becklin Centre, Leeds, is reviewed and brought in line with the trust policy and legal requirements.

Action the provider SHOULD take to improve

The provider should review the processes for checking emergency equipment and fridge temperatures at the CAS at the Becklin Centre, Leeds.

The provider should review the provision of dedicated medical input into all teams within the Crisis and Access Service (CAS) at Bootham Park Hospital, York.

The provider should review the local audit programmes and provide evidence of how shortfalls had been identified and learning had been implemented from audits.

The provider should review systems for informing people how to raise concerns and complaints at the CAS team at the Becklin Centre, Leeds.

Leeds and York Partnership NHS Foundation Trust

Crisis Teams and Health Based Places of Safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Crisis and Assessment Service	Trust Headquarters
Crisis and Access Service	Trust Headquarters
Section 136 Suite	Becklin Centre
Section 136 Suite	Bootham Park Hospital

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.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with were aware of the statutory requirements of the Mental Capacity Act.

We saw that mental capacity was recorded in people's care plans within the holistic assessment however there was no evidence of recording the steps that had been taken to assess mental capacity, only a tick box within the assessment which would be completed when initially completing the assessment. There was no evidence that mental capacity was being recorded on an ongoing basis or effectively assessed.

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

At the section 136 suite at the Becklin Centre, Leeds, the furniture could potentially be used to cause injury. This had not been recognised as a risk. Also, the bathroom contained significant risks in that taps and door handles could be used as ligature points. There had been some measures put in place to reduce risk to people however these risks were still present with no plan to remove these potential ligature points.

The section 136 suite at Bootham Park Hospital, York, had a safe and suitable environment with access to emergency equipment.

At both section 136 suites there were appropriate staffing levels and skill mix of staff with effective working arrangements with medical staff and allied mental health professionals (AMHPS).

At both section 136 suites, a joint risk assessment undertaken by staff from the assessment and crisis team and the police was completed for all people admitted. A regular three monthly multi-agency meeting was well established to oversee the operation of the section 136 suite and discuss learning from any incidents.

We observed safe and clean interview rooms at both CAS teams.

Both CAS teams' staff had received appropriate training in safeguarding and were clear about safeguarding procedures.

Both CAS teams adhered to the trust's lone working policy and knew how to keep themselves and each other safe.

Both CAS teams followed an incident reporting system and demonstrated learning from incidents

Both CAS teams had appropriate staffing levels and skill mix of staff with effective working arrangements and AMHPS.

Both CAS teams had effective systems in place to assess and monitor risks to individual people.

At the CAS at the Becklin Centre, Leeds, we identified issues with medication and emergency equipment which meant unsafe practice was being carried out around dispensing and checking of medicines.

There was no dedicated medical input into some teams within the CAS at Bootham Park Hospital, York.

Our findings

Health based place of safety – Becklin Centre, Leeds

Safe and clean ward environment

The section 136 suite comprised two interview rooms. Both were fitted with mirrors in the corners of the room to ensure that no blind spots were present. Observation of patients held in the room was therefore satisfactory. The rooms were large enough to enable the safe restraint of patients when this was necessary. Within the suite a separate room containing a toilet and shower was also available and a small kitchen to prepare drinks and snacks.

The seating in the interview rooms was inappropriate as it was covered in fabric that would have been difficult to clean. It was not fastened to the floor, which meant that it could potentially be used to cause injury. This had not been identified in the trust's risk register. Further, in neither interview room was there anywhere to lie down, which is important as people can be in the suite for up to 72 hours.

The bathroom contained significant risks in that taps and door handles could be used as ligature points. These had been identified in the trust's risk register and measures had been put into place to implement additional risk assessments for people to whom this posed a risk, but no corrective action was planned to remove the ligatures.

The section 136 suite was located adjacent to the CAS team office, which meant that a fully equipped clinic, with emergency drugs and resuscitation equipment was readily available.

Safe staffing

The section 136 suite was staffed by the CAS team as and when people were brought to the suite. Staff were clear

Requires improvement

Are services safe?

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

about their role and function in managing people in the suite and were able to respond in a timely manner when required. Feedback from approved mental health practitioners (AMHPs) and from the police indicated that the arrangements for staffing the suite worked well. Whenever staff were needed to use the suite, permanent staff would be allocated rather than bank or agency staff. There was appropriate medical cover available to the CAS to ensure that a timely response was available to people requiring assessment within the suite.

Assessing and managing risk to patients and staff

A joint risk assessment by staff from CAS and the police was completed for all people admitted to the suite. As part of the locally agreed protocol, police undertook a body search on all people before arrival at the suite. Staff were familiar with de-escalation techniques and told us that they used these in the first instance before restraining people.

Reporting incidents and learning from when things go wrong

A regular three monthly multi-agency meeting was well established to oversee the operation of the section 136 suite. The analysis of incident data and areas for improvement were routinely discussed in these monitoring meetings.

Health based place of safety – Bootham Park Hospital, York

Safe and clean ward environment

The section 136 suite comprised a large room in which to manage patients, with an en-suite toilet and bathroom. The suite also had a more comfortable room in which to interview patients when it was safe to do so, and a combined office/kitchen where drinks and snacks could be prepared. A combination of window panels in doors, mirrors in rooms and CCTV cameras meant that observation of the room in which the patients were present was facilitated and appropriate.

The furniture in the room where people were held was appropriate in that it was easy to clean and sufficiently heavy so as not to pose a potential threat of injury. A raised mattress was also provided in order that patients could rest and bedding was made available when required. There were no ligature risks evident in the room. However there were potential ligature risks in the corridor area where patients had access. We were informed that a thorough risk assessment would be undertaken before a patient would be transferred to the interview room, and if there was any doubt about the level of risk then the interview would be undertaken in the large room.

The suite was adjacent to the CAS which meant a fully equipped clinic, with emergency drugs and resuscitation equipment was readily available.

Safe staffing

The section 136 suite was staffed by the CAS team as and when people were brought to the suite. Staff were clear about their role and function in managing people in the suite and were able to respond in a timely manner when required. Feedback from AMHPS and from the police indicated that the arrangements for staffing the suite worked well. Whenever staff were needed to manage the suite, permanent staff would be allocated rather than bank or agency staff. There was appropriate medical cover available to the CAS to ensure that a timely response was available to people requiring assessment within the suite.

Assessing and managing risk to patients and staff

A joint risk assessment by staff from the CAS and the police was completed for all patients admitted to the suite. As part of the locally agreed protocol police undertook a body search on all people before their arrival at the suite. Staff were familiar with de-escalation techniques and told us that they used these in the first instance before restraining people.

Reporting incidents and learning from when things go wrong

A regular three monthly mutli-agency meeting was well established to oversee the operation of section 136 suite. The analysis of incident data and areas for improvement were routinely discussed in these monitoring meetings.

Crisis and Assessment Service – Becklin Centre, Leeds

Safe and clean environment

We observed all interview rooms where people who used the service met with the staff for assessments. We found these to be clean, well maintained and safe environments which enabled staff to raise an alarm if they felt unsafe. This could be done either through an in-built alarm system in the room or an alarm device carried on their person.

Requires improvement

Are services safe?

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

We spoke with five people who had used the service and each person told us that they felt safe during and after the contact they had had with the CAS.

We checked the clinic room including the storage of medications and resuscitation equipment and found a number of issues:

Some medication such as Lorazepam and Insulin was stored in a fridge. There was no system in place to ensure that fridge temperatures were being checked and documented by staff, including pharmacy staff, on a regular basis. This meant there was an increased risk that medications may not be stored at the correct temperature.

Patient Group Directions (PGDs) are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. There was no evidence of pharmacy audit of PGDs or the CAS stock of medications. Pharmacy input was required as part of the medicines management policy. Therefore the service was not following their policy correctly.

Nurses using PGDs to administer urgent medicines without a prescription were not named in the PGD and had not received the necessary training and assessment. This meant that medicines had been administered illegally on some occasions and that the PGDs did not meet legal requirements. We informed the CAS of this at our inspection who began to put measures in place to review practice around PGDs.

We were told by staff that the resuscitation bag was checked daily by two members of staff. However there was no documentation in place to show which pieces of equipment had been checked within the bag. This meant there was an increased risk to people as equipment was not being checked routinely and it was not possible to determine which equipment had been checked.

Safe staffing

We spoke with the clinical operations manager who organised the staff rota about staffing levels. We were shown how minimum staffing levels and skill mix were planned using an activity data tool collated by the team. We observed levels of staffing and skill mix and saw that there were appropriate staff on duty and planned for the upcoming months ahead.

Staff we spoke with told us there were sufficient numbers of staff to deliver the care and support which people needed overall. We were shown examples of when staffing levels had been increased due to demand such as the introduction of administrative staff support to 24 hours as identified by the single point of access (SPA) plan.

There was no use of agency staff within the team due to the specialist nature of the role. Where sickness and short term absences needed to be covered, we were told that staff were available to provide overtime using a bank system. Although there were some vacancies for band 6 staff, action had been taken to recruit into these posts. There was adequate medical cover during the day and night. A doctor could attend in an emergency and was available on call on the hospital site out of hours. During our visit we spoke with the dedicated consultant who was based within the CAS who told us the medical team worked well with the staff in the team.

Assessing and managing risk to patients and staff

The service had effective systems in place to assess and monitor risks to individual people. We reviewed the care records of five people using the service. Each person had an up to date risk assessment in their care records which included risks in relation to safeguarding and risk to themselves and others. Where a risk was identified, an ongoing care plan was in place to manage the risk. This included the number of staff required to assess the person and the preferred location that assessments would take place, dependent upon the risks identified and people's choice.

Staff told us that the team adhered to the trust's lone working policy. Each person had a risk assessment in place which identified possible risks related to the person's home environment which could impact upon care delivery. Where a risk had been identified, there was a plan in place to manage this which staff told us occurred in practice, for example staff visiting in pairs. Staff were able to explain the procedure for raising an alert if they felt unsafe when visiting somebody in their home. Staff told us that they used their mobile phones in case they required assistance or were running late to inform the shift co-ordinator of their whereabouts. There was a system in place to record staff movement when out of office and the shift co-ordinator was responsible for ensuring those out had returned safely.

Requires improvement

Are services safe?

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

Staff had received appropriate training in safeguarding and there was an identified safeguarding lead within the team. Staff we spoke with were clear about the procedure for identifying potential abuse, documenting and reporting this appropriately to their managers and to the local authority. We observed clear information about reporting safeguarding issues in the office areas where the staff were based. Staff also told us that the safeguarding procedures were available on the trust intranet called 'Staffnet' which they had been informed about during staff induction and supervision.

Reporting incidents and learning from when things go wrong

There was an incident reporting system in place which was completed following any incidents. This allowed the band 7 nurses to review and grade the severity of incidents. Staff were aware of how to complete an IR1 incident form and their responsibilities in relation to reporting incidents. Staff told us that guidance on incident reporting was available on Staffnet which was read as part of induction and training. Incidents were analysed by the clinical operations manager to identify any trends and appropriate action was taken in response to these. Any serious untoward incidents (SUIs) which were incidents that scored a risk rating of seven or above, would be reviewed by the clinical lead and the Risk Management Department. A 'fact finding' investigation would be assigned to another service to carry out a root cause analysis independently. Any actions form the investigation would be monitored by the trust's Risk Forum and Trust Incident Review Group.

The clinical operations manager attended a monthly 'clinical leadership group' with attendance from the trust risk manager. Minutes of these meetings were available for staff and key messages were fed back through the weekly 'team business meeting' to all staff in the crisis and assessment service. The meeting covered agenda items which included safeguarding, learning from incidents and safety alerts. Minutes of the meetings were made available for staff who were unable to attend the meetings. We also saw a monthly newsletter from risk management displayed in the office which fed back findings from trust wide SUIs. An example of learning from incidents was that 'alcohol withdrawal training' for staff was taking place on the day of our visit which we were informed was implemented as a result of an identified trend of near misses that had taken place in the service.

Crisis and Access Service- Bootham Park Hospital, York

Safe and clean environment

We observed all the interview rooms where people who used the service met with the staff for assessments. We found these to be clean, well maintained and safe environments which enabled staff to raise alarm if they felt unsafe. This could be done either through an in-built alarm system in the room or an alarm device carried on their person.

We spoke with five people in total and each person told us that they felt safe during or after the contact they had had with the CAS.

We checked the resuscitation equipment and found this to have been regularly checked and in working order. We checked the storage of medications and carried out an audit of medications and found that these had been correctly stored and any prescribing had been done by one of the two nurse prescribers or medical staff. There was no use of patient group directions (PGDs).

Safe staffing

We spoke with the service manager who organised the staff rota about staffing levels. We were shown how minimum staffing levels and skill mix were planned using activity data tool collated by the team. We observed levels of staffing and skill mix and saw that there were appropriate staff on duty and planned for the upcoming months ahead. Staff we spoke with told us there were sufficient numbers of staff to deliver the care and support which people needed overall.

There was no use of agency staff within the team due to the specialist nature of the role. Where sickness and short term absences needed to be covered, we were told that regular staff could provide overtime. Staff told us this put them under pressure but was manageable and that time off in lieu was granted in these cases.

There was adequate medical cover during the day and night and a doctor could attend in an emergency. This doctor was available on call and based on the hospital site out of hours. During our visit we spoke with the consultant within the team who told us the medical team worked well with the staff in the team.

Requires improvement

Are services safe?

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

Staff raised concerns that medical input was limited to the intensive home treatment element of the service and there was no dedicated medical input into the other services of the CAS such as single point of access, street triage team and liaison psychiatry. An example given to us was an SUI investigation where there had been a lack of responsible medical staff to take forward and sign off the investigation within the CAS, which had caused a delay in the investigation.

Assessing and managing risk to patients and staff

The service had effective systems in place to assess and monitor risks to individual people. We reviewed the care records of five people using the service. Each person had an up to date risk assessment in their care records which included risks in relation to safeguarding and risk to themselves and others. Where a risk was identified, an ongoing care plan was in place to manage the risk. This included the number of staff required to assess the person and the preferred location that assessments would take place, dependent upon the risks identified and people's choice.

Staff told us the team adhered to the trust's lone working policy. Each person had a risk assessment in place which identified possible risks related to the person's home environment which could impact upon care delivery. Where a risk had been identified, there was a plan in place to manage this; for example staff visiting in pairs. Staff were able to explain the procedure for raising an alert if they felt unsafe when visiting somebody in their home. Staff told us they used their mobile phones in case they required assistance or were running late to inform the shift co-ordinator of their whereabouts. There was a system in place to record staff movement when out of office and the shift co-ordinator was responsible for ensuring the staff out had returned safely.

Staff had received appropriate training in safeguarding and there was an identified safeguarding lead within the team.

Staff we spoke with were clear about the procedure for identifying potential abuse, documenting and reporting this appropriately to their managers and to the local authority. We observed clear information about reporting safeguarding issues in the office areas where the staff were based. Staff alsotold us that the safeguarding procedures were available on Staffnet which they had been informed about during staff induction and supervision.

Reporting incidents and learning from when things go wrong

There was an incident reporting system in place which was completed following any incidents. This enabled the service manager and clinical lead to review and grade the severity of incidents. Staff were aware of how to complete an IR1 incident form and their responsibilities in relation to reporting incidents. Incidents were analysed by the service manager to identify any trends and appropriate action was taken in response to these. Any serious untoward iIncidents (SUIs) which were incidents that scored a risk rating of seven or above, would be reviewed by the clinical lead and the risk management department. A 'fact finding' investigation would be assigned to another service to carry out a root cause analysis independently. Any actions form the investigation would be monitored by the trust's risk forum and trust incident review group.

The clinical operations manager attended a monthly clinical governance meeting with attendance from the trust risk manager. Minutes of these meetings were available for staff and key messages were fed back through the weekly team meeting to all staff in the CAS. The meeting covered agenda items which included safeguarding, learning from incidents and safety alerts. Minutes of the meetings were made available for staff who were unable to attend the meetings. Staff told us that they received information about incidents through Staffnet, trust communication in two weekly emails and a 'York Care Group' newsletter.

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

Broadly, the section 136 suite at Bootham Park Hospital, York met the expectations of best practice guidance provided by the Royal College of Psychiatrists. However the safety of the environment of the suite at the Becklin Centre, Leeds did not meet the expectations.

Staff conducted good assessments and physical health checks on when people arrived at the section 136 suites. They ensured that any ongoing physical health problems were followed up appropriately.

Younger people were always assessed by a doctor who specialised in the care of children and adolescents. For people with a learning disability their assessment was usually undertaken by a doctor with experience of learning disability but access out of hours to such specialists was said to be problematic.

Qualified staff undertook the co-ordination of admissions to both section 136 suites, operating as the section 136 co-ordinator, and clear guidance was available to them, along with a checklist, when operating in this role.

Links with the police in the operation of section 136 and the suites were good. Good joint working relationships were in place at both a strategic and operational level and attendance at the three monthly monitoring meetings was good with representatives from a wide variety of agencies present.

Both CAS teams had effective assessment of needs and planning of care in place including up to date risk assessments. Care plans were goal oriented and had clear pathways of referral to other services.

Both CAS teams' care plans were written and reviewed, where possible, with the involvement of the person. Staff involved family, friends and advocates as appropriate and according to the person's wishes. However this was not always recorded in peoples care plans at the CAS in the Becklin Centre, Leeds.

Both CAS teams followed best practice in treatment and care. Some staff told us that performance data was not always useful for them and that a clinical dashboard was being developed to simplify this information. However we found that there had been no progress regarding the implementation of a clinical dashboard.

A full range of mental health disciplines provided input to the CAS teams, although there was a lack of AMHP input at the CAS at Bootham Park Hospital, York. There was evidence of effective multi-disciplinary team working. The teams had regular and effective MDT meetings to review people who used the service. The teams had established positive working relationships with a range of other service providers.

Staff received regular clinical and managerial supervision. At the CAS at the Becklin Centre, Leeds there was weekly peer group supervision facilitated by a psychotherapist who was external to the team.

We saw that there were a number of clinical audits in place. However at the CAS at the Becklin Centre, Leeds there was no local audit programme in place to oversee audits being carried out including national audit commitments and local audits. Non-medical staff did not engage in any audit activity. We did not see any evidence of how shortfalls had been identified and learning had been implemented from audits.

The CAS at the Becklin Centre, Leeds worked closely with West Yorkshire Police and had provided joint training within the trust.

At CAS at the Becklin Centre, Leeds we saw that mental capacity was recorded in people's care plans within the holistic assessment. However there was no evidence of recording the steps that had been taken to assess mental capacity; only a tick box within the assessment which would be completed when initially completing the assessment. There was no evidence that mental capacity was being recorded on an ongoing basis or effectively assessed.

Our findings

Health based place of safety – Becklin Centre, Leeds

Assessment of needs and planning of care

A proforma was being used to record observations during the brief episode of care within the suite. We reviewed a

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.

sample of these records and found that they were completed well. A physical health check was undertaken on arrival to the suite and any ongoing physical health problems were followed up appropriately.

Best practice in treatment and care

The section 136 suite did not meet the expectations of best practice guidance provided by the Royal College of Psychiatrists. This was due to the safety of the environment (see section on safety).

The numbers of young people being assessed in the section 136 suite was increasing but younger people were always assessed by a doctor who specialised in the care of children and adolescents. For people with a learning disability their assessment was usually undertaken by a doctor with experience of learning disability but access out of hours to such specialists was said to be problematic.

Skilled staff to deliver care

Qualified staff undertook the co-ordination of admissions to the section 136 suite, operating as the section 136 co-ordinator. Clear guidance was available to them, along with a helpful checklist, when operating in this role.

Multi-disciplinary and inter-agency team work

Links with the police in the operation of section 136 and the suite were said to be very positive and this was confirmed by feedback received from the police. Good joint working relationships were in place at both a strategic and operational level and attendance at the three monthly monitoring meetings was good with representatives from a wide variety of agencies present.

Health based place of safety – Bootham Park Hospital, York

Assessment of needs and planning of care

A proforma was being used to record observations during the brief episode of care within the suite. We reviewed a sample of these records and found that they were completed well. A physical health check was undertaken on arrival to the suite and any ongoing physical health problems were followed up appropriately.

Best practice in treatment and care

Broadly, the section 136 suite met the expectations of guidance provided by the Royal College of Psychiatrists.

Younger people were always assessed by a doctor who specialised in the care of children and adolescents. For people with a learning disability their assessment was usually undertaken by a doctor with experience of learning disability but access out of hours to such specialists was said to be problematic.

Skilled staff to deliver care

Qualified staff undertook the co-ordination of admissions to the section 136 suite, operating as the section 136 co-ordinator. Clear guidance was available to them, along with a helpful checklist, when operating in this role.

Multi-disciplinary and inter-agency team work

Links with the police in the operation of section 136 and the suite were said to be very positive and this was confirmed by feedback received from the police. Good joint working relationships were in place at both a strategic and operational level and attendance at the three monthly monitoring meetings was good with representatives from a wide variety of agencies present.

Crisis and Assessment Service – Becklin Centre, Leeds

Assessment of needs and planning of care

We looked at five sets of care plans which were electronically stored using a system called 'Paris'. Each person had a comprehensive Functional Analysis of Care Environments (FACE) and holistic assessment completed as part of the assessment process. This included people's social, cultural, physical and psychological needs and preferences. This also included risk assessment from identified risks and a care plan was then developed with the person to meet their identified needs. The care plans we looked at were regularly reviewed, centred on the needs of the individual person and demonstrated a knowledge of current, evidence based practice.

Care plans were written and reviewed, where possible, with the involvement of the person, although it was not always recorded if the person had chosen not to be involved. The consent of the person had been sought in the care plans that we looked at. Family, friends and advocates were involved as appropriate and according to the person's wishes, although this was not always recorded when the person had chosen for others not to be involved.

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.

Care plans were goal oriented and had clear pathways of referral to other services such as community teams and inpatient admission, or discharge.

Best practice in treatment and care

We spoke with the Clinical Operations Manager who had knowledge of current best practice in the crisis field including elements of NICE guidance (NICE guideline CG136 – service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services; S1.5 Assessment and referral in a crisis). The single point of access referral criteria was based around best practice from mental health clustering guidance.

The service was able to offer information to people using the service about referral to psychological therapies as guided by NICE. However the psychological therapies service was provided by primary care and therefore the CAS team could not manage referral uptake and waiting lists. We could see that people had been referred through to psychology and psychotherapy using the same electronic system which was accessible by staff within the crisis and assessment service.

Staff told us they were able to refer people for their physical health needs to the appropriate health care professionals, such as physiotherapy services or to the person's general practitioner.

There were specific protocols in place for signposting people to the most appropriate services within the trust, for example people with a learning disability and people with dementia.

A system of measuring outcomes gave information about which referrals had been processed and rejected, and what pathway and discharge arrangements had been made. Some staff told us this data was not always useful for them and a clinical dashboard was being developed to simplify this information. However we found that there had been no progress to implement a clinical dashboard.

We saw there were a number of clinical audits in place including a PGD audit, an audit of the FACE risk assessments, audits of care plans for people being admitted to inpatient wards and response times for telephone pick-up. We asked to see the local audit programme to see the complete set of audits carried out. This included national audit commitments and local audits carried out by medical staff, however we were told that this was not available.

When we spoke to staff about which audits they were involved in they referred only to audits that were carried out by medical staff and managers, but told us that they no access or involvement in these.

We did not see any evidence of how shortfalls had been identified and learning had been implemented from audits, for example the PGD audits had not picked up on the correct procedure for dispensing medications and the FACE risk assessments had not picked up on shortfalls in recording involvement of people in their care plans. We therefore found that clinical audit was not effective.

Skilled staff to deliver care

A full range of mental health disciplines provided input to the team. There was evidence of effective multi-disciplinary team working within the service. The team included; nurses, support workers, AMHPs (two days per week), an occupational therapist, administrative support, a consultant psychiatrist and a core trainee, speciality doctor and a higher trainee. Staff told us that they had close working relationships with pharmacy.

Staff we spoke with confirmed they had an annual appraisal and were aware of their own personal development goals. Staff told us they had access to training to support them in their roles. This included specialist training in addition to mandatory training provided by the trust. Staff told us that their manager supported them to access specific training to meet the needs of people who used the service. The training records showed that staff had access to a range of training relevant to their role, however from the data that we were provided with at trust level about training uptake there were significant gaps in uptake of mandatory and specialist training.

Staff received regular clinical and managerial supervision as well as weekly peer group supervision facilitated by a psychologist who was external to the team. Staff told us that they found these sessions invaluable and that they discussed complex or challenging clinical issues within these sessions to explore ways to improve the service they provided to people.

Multi-disciplinary and inter-agency team work

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 team had regular MDT meetings to review people who used the service. Staff told us they usually had contact with the person's care co-ordinator on a weekly basis to promote joint working and continuity of care. Staff told us they had weekly input from a psychotherapist who they could discuss complex cases with. Staff told us medical staff were supportive and responsive, going out at their request to do joint assessments when concerns had been raised.

The team had established positive working relationships with a range of other service providers such as the inpatient wards at the Becklin Centre, home treatment teams, which were previously included in the service, general practitioners, and local independent early intervention services such as Aspire, local addiction services and crisis houses.

The team worked closely with West Yorkshire Police and had provided joint training within the trust. There was also a shadowing scheme in place for police cadets to work within the CAS and inpatient wards to gain a better knowledge of the mental health services in Leeds.

We observed a team handover on the morning of our inspection which was well attended by staff and included medical staff and the shift co-ordinator. We found this to be an effective system for communicating important information between staff such as risk, referrals and assessments, bed management and allocating task for the day.

Adherence to the MHA and the MHA Code of Practice

Staff we spoke with were aware of the statutory requirements of the Mental Health Act, Mental Capacity Act and Code of Practice.

We saw that mental capacity was recorded in people's care plans within the holistic assessment however there was no evidence of recording the steps that had been taken to assess mental capacity, only a tick box within the assessment which would be completed when initially completing the assessment. There was no evidence that mental capacity was being recorded on an ongoing basis or effectively assessed.

Crisis and Access Service- Bootham Park Hospital, York

Assessment of needs and planning of care

We looked at five sets of care plans which were electronically stored using a system called 'CPD'. Each person had a comprehensive safety assessment and management process (SAMP) risk assessment and holistic assessment completed as part of the assessment process. This included people's social, cultural, physical and psychological needs and preferences. This also included specific risk assessments from any identified risks, such as falls or nutrition and a care plan was then developed with the person to meet their identified needs. The care plans we looked at were regularly reviewed, centred on the needs of the individual person and demonstrated a knowledge of current, evidence based practice.

Care plans were written and reviewed, where possible, with the involvement of the person. The consent of the person had been sought in the care plans that we looked at. Family, friends and advocates were involved as appropriate and according to the person's wishes.

Care plans were goal oriented and had clear pathways of referral to other services such as community teams and inpatient admission, or discharge.

Best practice in treatment and care

The service was able to offer information to people using the service about referral to psychological therapies as guided by NICE. This service was managed by the York care group, but we were told that the CAS team could not manage referral uptake and waiting lists. We could see that people had been referred through to the IAPT service using the same electronic system which was accessible by staff within the crisis and assessment service.

Staff told us that they were able to refer people on for their physical health needs such as physiotherapy services or to the person's general practitioner.

There were specific protocols in place for signposting people to the most appropriate services within the trust; for example people with a learning disability and people with dementia.

A system of measuring outcomes gave information about which referrals had been processed and rejected, and what pathway and discharge arrangements had been made. Some staff told us that this data was not always useful for them and that a clinical dashboard was being developed to simplify this information, however we found that there had been no progress to implement a clinical dashboard.

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.

We saw that there were a number of clinical audits in place including 136 timeframes and timeframes for transfers of care. We asked to see the local audit programme to see the complete set of audits being carried out including national audit commitments and local audits being carried out by medical staff. We did not see any evidence of how shortfalls had been identified and learning had been implemented from audits.

Skilled staff to deliver care

A full range of mental health disciplines provided input to the team. There was evidence of effective multi-disciplinary team working within the service. The team included; nurses, support workers, an occupational therapist, administrative support, a consultant psychiatrist and a duty registrar. Staff told us that they had close working relationships with pharmacy. There were no dedicated AMHPs within the team. Staff told us that this could often cause delay and duplication in the assessment process.

Staff we spoke with confirmed they had an annual appraisal and were aware of their own personal development goals. Staff told us they had access to training to support them in their roles. This included specialist training in addition to mandatory training provided by the trust. Staff told us that their manager supported them to access specific training to meet the needs of people who used the service. We saw that there was two hours per week dedicated to in-house training sessions. The training records showed that staff had access to range of training relevant to their role.

Staff received regular clinical and managerial supervision. Some staff told us that they lacked a forum for reflecting on clinical practice but there was a plan in place to introduce this after having spoken with the service manager.

Multi-disciplinary (MDT) and inter-agency team work

The team had regular MDT meetings to review people who used the service. We observed an MDT meeting taking place during the inspection. Issues such as risk, safeguarding, care planning including physical health, people's social interventions and cultural and religious needs were discussed. Early discharge planning was considered at the meeting as well as average lengths of stay and case load allocations. There was appropriate attendance at the meeting including the consultant psychiatrist. Staff told us that they usually had contact with the person's care co-ordinator on a weekly basis to promote joint working and continuity of care.

The team had established positive working relationships with a range of other service providers such as the inpatient wards at Bootham Park Hospital, community mental health teams, General Practitioners, the police, and local independent early intervention services, local addiction services and crisis houses.

Team handovers were taking place during our inspection visit. Staff told us that handovers were invaluable for raising issues such as risk, referrals and assessments, bed management and allocating tasks for the day.

Adherence to the MHA and the MHA Code of Practice

Staff we spoke with were aware of the statutory requirements of the Mental Health Act, Mental Capacity Act and Code of Practice. We saw that capacity was recorded in people's care plans within the holistic assessment.

Good

Are services caring?

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

Summary of findings

Staff were caring and responded to the needs of people admitted to the section 136 suite. The guidance and checklist available to staff managing people in the suite indicated an appropriate degree of concern for the welfare and safety of individuals who were being assessed.

Staff always explained rights to detained patients. For young people, we found evidence of the appropriate involvement of parents or carers.

At both CAS teams, people told us that they were treated with kindness, dignity and respect by staff. People felt that they were listened to and valued the service.

We observed positive interactions between a member of staff and a person who used the service. The person told us they were very happy with the service they were receiving and the support which was provided to them.

Staff provided a range of flexible support to people dependent upon their needs.

Staff involved people fully in planning their care and provided opportunities for them to discuss their health, beliefs, concerns and preferences to inform their individualised care. Advocates were involved as appropriate and according to the person's wishes.

Staff we spoke with were able to describe specific interventions they used to assist people with managing their distress such as anxiety management, alcohol withdrawal, psychological interventions and relapse prevention work.

People had access to information in different accessible formats, interpreting and advocacy services if necessary.

Our findings

Health based place of safety – Becklin Centre, Leeds

Kindness, dignity, respect and support

Interviews with staff who would work in the section 136 suite indicated a caring response to the needs of people in what are often fraught circumstances. A timely response to people when they were first admitted allowed an appropriate handover from the police to be effective.

The involvement of people in the care they receive

The guidance and checklist available to staff managing people in the section 136 suite indicated an appropriate degree of concern for the welfare and safety of individuals who were being assessed. Patients' rights whilst detained were routinely explained to people. For young people, evidence of the appropriate involvement of parents or carers was also in place.

Health based place of safety – Bootham Park Hospital, York

Kindness, dignity, respect and support

Interviews with staff who would work in the section 136 suite indicated a caring response to the needs of people in what are often fraught circumstances. A timely response to people when they were first admitted allowed an appropriate handover from the police to be effective.

The involvement of people in the care they receive

The guidance and checklist available to staff dealing with people in the section 136 suite indicated an appropriate degree of concern for the welfare and safety of individuals who were being assessed. Patients' rights whilst detained were routinely explained to people.

Crisis and Assessment Service – Becklin Centre, Leeds

Kindness, dignity, respect and support

We spoke to five people on the telephone about the service. We listened to a follow-up phone call to a person who used the service.

People told us that they were treated with kindness, dignity and respect by staff. People felt that they were listened to and valued the service. Comments included: "I feel safe knowing that someone is there to talk to", "they've really helped me, they are lovely."

We were shown three emails from people who used the service with feedback about the service. Comments

Good

Are services caring?

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

included: "absolutely wonderful, extremely helpful, I would not have been able to make it through the night without the help received from the team" and "I was respected, listened to and even offered a drink to take home."

We visited one person who used the service in their own home with a member of staff. We observed positive interactions between the member of staff and the person who used the service. The person told us they were very happy with the service they were receiving and the support which was provided to them.

The involvement of people in the care they receive

The service provided support to people who were experiencing an acute crisis and deterioration in their mental health to prevent the need for the person to be admitted into hospital. Staff provided a range of flexible support to people dependent upon their needs. This included telephone contact and face to face visits with people in their own homes or in the Becklin Centre.

People were fully involved in planning their care and had opportunities to discuss their health, beliefs, concerns and preferences to inform their individualised care. People were able to decide who to involve in their care and decisions about their care, and to what extent. Family, friends and advocates were involved as appropriate and according to the person's wishes.

Staff we spoke with were able to describe specific interventions they used to assist people with managing their distress such as anxiety management, alcohol withdrawal, psychological interventions and relapse prevention work.

People had access to information in different accessible formats, interpreting and advocacy services if necessary. We were given examples by staff where interpreters had been accessed to support people whose first language was not English to attend assessments.

Crisis and Access Service- Bootham Park Hospital, York

We spoke to five people on the telephone about the service.

People told us that they were treated with kindness, dignity and respect by staff. People felt that they were listened to and valued the service. Comments included: "very caring, kind and understanding", "they got to the heart of the matter, this process was helpful and very reassuring", "I think the service has been first rate", "I was very impressed with the team- they know my background very well" and "they are the only people I can talk to. If it was not for them I wouldn't be here now."

The involvement of people in the care they receive

The service provided support to people who were experiencing an acute crisis and deterioration in their mental health to prevent the need for the person to be admitted into hospital. Staff provided a range of flexible support to people dependent upon their needs. This included telephone contact and face to face visits with people in their own homes or at Bootham Park Hospital.

People were fully involved in planning their care and had opportunities to discuss their health, beliefs, concerns and preferences to inform their individualised care. People were able to decide who to involve in their care and decisions about their care, and to what extent. Family, friends and advocates were involved as appropriate and according to the person's wishes.

Comments included: "they plan for each day which has given me some control in my life", "they are always there when I need them.", "they are like my family", "they involve me in the care plan", "they write everything down which helps me think more clearly", "it has been good for my situation that they have met me away from my home so I could go for walks along the river. They get me out and about." and "within one hour I saw the team after I was referred. They have visited me on a daily basis."

Staff we spoke with were able to describe specific interventions they used to assist people with managing their distress such as anxiety management, alcohol withdrawal, psychological interventions and relapse prevention work.

People had access to information in different accessible formats, interpreting and advocacy services if necessary. We were given examples by staff where interpreters had been accessed to support people whose first language was not English to attend assessments. People's cultural and religious beliefs were taken into account and respected as demonstrated by the content of the care plans and observation at the MDT meeting.

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

At both section 136 suites people were assessed in a timely manner. The timely availability of staff also meant that the police were able to hand over individuals to health staff within an appropriate timescale. However, occasionally, when an individual had been assessed and deemed to require admission to hospital, there was a delay in determining where an appropriate bed could be found. This sometimes resulted in delayed transfer from the suite.

There was access to food and drink within the suites.

The joint section 136 policy was appropriate and had been signed up to by all necessary agencies. The policy set appropriate target times for the handover by the police and the response times of doctors and AMHPs. These were closely monitored and mostly met. The local guidance and checklist for the operation of the health based place of safety were clear and appropriate.

Staff routinely gave patients information explaining rights whilst detained under section 136. Staff told us that access to interpreters, whilst rarely used, was effective and readily available.

Information about the process of making a complaint was available within the suite.

In the section 136 suite at the Becklin Centre in Leeds, the lack of anywhere to lie down within the suite was problematic for people for whom this would be necessary. The furniture in the room was inappropriate.

For both CAS teams, the single point of access (SPA) team used a risk rating system to triage each referral made to the team. All urgent referrals (high risk) were seen within 24 hours.

The service advertised the telephone number for the single point of access (SPA) service in various community based settings such as local General Practitioners surgeries to enable people to contact the service directly.

The CAS at the Becklin Centre, Leeds operated a pilot scheme called the street triage team (STT) which had reduced admissions into the section 136 suite by 28% since its introduction in December 2013.

The teams visited people in their own home or at the crisis and access team offices dependent upon their needs and level of risk. People were also supported by regular telephone calls or an agreed level of contact.

The teams had forged links with local voluntary organisations and carried out joint assessments.

The teams had daily contact with the acute wards to identify people who may be appropriate for early discharge with support from the team. This included providing support to people during leave periods from the ward.

Staff told us they sometimes had problems accessing beds within the trust when a person required an admission. This often meant that out of area placements had to be arranged.

We found evidence to show that the managers had taken timely action in response to complaints which they had received.

At the CAS team at the Becklin Centre, Leeds, some people told us that they had trouble getting through to the team in a timely way. We spoke with staff about this feedback and we were told that the team had a target to answer 90% of calls within 30 seconds. Waiting times for telephone calls were audited by the administrative staff on a monthly basis and performance against has been consistently between 85% and 95%.

At the CAS team at the Becklin Centre, Leeds, some people who we spoke who used the service told us that they were not always called back by the team at the time that had been agreed. In one instance this had been very important for the person in crisis to receive this call but it came a few hours later than expected. In this instance no explanation could be provided for the person not being called back on time, although a diary of logged calls and electronic records were in place to record all calls and staff duties for the day.

At the CAS team at the Becklin Centre, Leeds, none of the people that we spoke with that had accessed the service knew how to raise concerns and did not have written information about making complaints.

Good

Are services responsive to people's needs?

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

At the CAS team at the Becklin Centre, Leeds there was no proactive approach to gaining feedback from people who used the service. There was no evidence that changes had been made to the service based on people's feedback.

Our findings

Health based place of safety – Becklin Centre, Leeds

Access, discharge and bed management

The development of the section 136 suite had significantly reduced the numbers of people being assessed in police cells and had been strongly welcomed by the police. Arrangements meant there was seldom a delay in ensuring that people were assessed in a timely manner under section 136. The timely availability of staff also meant that the police were able to hand over individuals to health staff within an appropriate timescale.

However, occasionally, when an individual had been assessed and deemed to require admission to hospital, there was a delay in determining where an appropriate bed could be found. This could result in delayed transfer from the suite, and the non-availability of the suite for other people needing assessment. We were told that very occasionally the police had to wait outside with people for the suite to be available.

The environment optimises recovery, comfort and dignity

The lack of anywhere to rest or sleep within the suite was problematic for people for whom this would be necessary. The furniture in the room was inappropriate (see section on safety). There was access to food and drinks within the suite.

Policies and procedures minimise restrictions

The joint section 136 policy was appropriate and had been signed up to by all necessary agencies. The policy set appropriate target times for the handover by the police and the response times of doctors and AMHPs, and these were closely monitored and broadly met. The local guidance and checklist for the operation of the section 136 suite were clear and appropriate.

Meeting the needs of all people who use the service

Information explaining people's rights whilst detained under section 136 was routinely given to people. Access to interpreters, whilst rarely used, was said by staff to be effective and readily available.

Listening to and learning from concerns and complaints

Information about the process of making a complaint was available within the suite.

Health based place of safety – Bootham Park Hospital, York

Access, discharge and bed management

The development of the section 136 suite had significantly reduced the numbers of people being assessed in police cells and has been strongly welcomed by the police. Current arrangements mean there was seldom a delay in ensuring that people are assessed in a timely manner under section 136. The timely availability of staff also meant that the police were able to hand over individuals to health staff within an appropriate timescale.

However, occasionally, when an individual had been assessed and deemed to require admission to hospital, there was a delay in determining where an appropriate bed could be found, resulting in delayed transfer from the place of safety, and the non-availability of the suite for other people needing assessment. We were told that very occasionally the police had to wait outside with people for the suite to be available.

The environment optimises recovery, comfort and dignity

The section 136 suite provided an appropriate environment in which to assess people under section 136 of the Mental Health Act. There was access to drinks and staff within the suite

Policies and procedures minimise restrictions

The joint section 136 policy was appropriate and had been signed up to by all necessary agencies. The policy set appropriate target times for the response times of doctors and AMHPs, and these were closely monitored and broadly met. The local guidance and checklist for the operation of the section 136 suite were clear and appropriate.

Meeting the needs of all people who use the service

Good

Are services responsive to people's needs?

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

Information explaining people's rights whilst detained under section 136 were routinely given to people. Access to interpreters, whilst rarely used, was said by staff to be effective and readily available.

Listening to and learning from concerns and complaints

Information about the process of making a complaint was available within the suite.

Crisis and Assessment Service – Becklin Centre, Leeds

Access, discharge and bed management

The service had a system in place which ensured that all new referrals were made through the single point of access (SPA) Team. The SPA team reviewed each new referral based upon the information they received and assessed and what further support and referral to other services was required.

The SPA team used a risk rating system to triage each referral made to the team. All urgent referrals (high risk) were seen within 24 hours. Moderate risk referrals were contacted by telephone on the day of referral and an appointment was offered for them to be seen by the team within three days. Low risk referrals would be contacted by letter or phone and offered an appointment by the community mental health teams (CMHTs) to be seen within two weeks.

The service advertised the telephone number for the SPA service in various community based settings such as local General Practitioners surgeries to enable people to contact the service directly. There was an open referral system in place meaning that any person could self-refer and any external organisations could refer on. Referral could be made by telephone, fax or online. The team accepted referrals from a range of sources including self-referrals from people or their carers, General Practitioners, the inpatient wards and CMHTs.

The service operated 24 hours a day, seven days a week, 365 day a year. Telephone calls were triaged through an externally managed telephone system with eight active telephone lines.

Some people told us they had trouble getting through to the team in a timely way, sometimes receiving an engaged tone. We reviewed similar comments about the service on 'Patient Opinion', a website used by the public to give their feedback about their experiences of using the service, and in feedback from 'Healthwatch' and focus groups we held in advance of the inspection.

We spoke with staff about this feedback and we were told that he team had a target to answer 90% of calls within 30 seconds and waiting times for telephone calls were audited by the administrative staff on a monthly basis and performance against has been consistently between 85% and 95%.

Some people who we spoke who use the service told us they were not always called back by the team at the time that had been agreed. In one instance this had been very important for the person in crisis to receive this call but it came a few hours later than expected. In this instance no explanation could be provided for the person not being called back on time, although a diary of logged calls and electronic records were in place to record all calls and staff duties for the day.

The team visited people in their own home or at the crisis and access team offices dependent upon their needs and level of risk. People were also supported by regular telephone calls or an agreed level of contact.

The team had forged links with local voluntary organisations and carried out joint assessments with an early intervention service called 'Aspire'.

The SPA team were the gatekeepers for inpatient beds at the Becklin Centre. The team had daily contact with the acute wards to identify people who may be appropriate for early discharge with support from the team. This included providing support to people during leave periods from the ward. Staff told us they sometimes had problems accessing beds within the trust when an inpatient admission was needed. This often meant that out of area placements had to be arranged, specifically psychiatric intensive care unit (PICU) beds. This had been recognised by the team and was included as a high risk on the trust's strategic risk register and there was a specific referral protocol in place to ensure the welfare of the person being referred in the rare instance that this took place.

A pilot scheme called the street triage team (STT) was integrated within the CAS which ran daily from 3pm until 1am and worked closely with West Yorkshire Police. The function of the scheme was to reduce the need for people to be admitted into the section 136 suite and the inpatient

Good

Are services responsive to people's needs?

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

beds. Staff we spoke with told us they felt the service they provided had a direct impact on reducing admissions into the 136 suite. We looked at the level of admissions into the section 136 suite since the STT had been introduced in December 2013 and saw that there had been a 28% reduction in admissions. The team planned to extend this to a 24 hour service.

Learning from concerns and complaints

Complaints and concerns which people had raised were discussed at the service's monthly care group meeting and then in the weekly business team meetings. We found evidence to show that the manager had taken timely action in response to complaints which they had received.

None of the people that we spoke knew how to raise concerns and did not have written information about making complaints. We were told by the manager that information leaflets and a crisis card would be given to people who had been seen in person. However this was not done routinely. Information was not posted out to people if only telephone contact had been made. The written information also did not contain specific details about how to complain or the Patient Advice and Liaison Service (PALS) within the trust.

The team was not proactive in its approach to gaining feedback from people who used the service. Although the clinical operations manager checked the 'Patient Opinion' website and had responded to all submissions about the service, there was no system in place for actively seeking feedback about the service. There was no evidence that changes had been made to the service based on people's feedback.

Crisis and Access Service- Bootham Park Hospital, York

Access, discharge and bed management

The service had a system in place which ensured that all new referrals were made through the single point of access (SPA) team. The SPA team reviewed each new referral based upon the information they received and assessed what further support and referral to other services was required.

The SPA team used a RAG (Red, Amber, and Green) risk rating system to triage each referral made to the team. All urgent referrals (high risk) were seen within 24 hours. Moderate risk referrals were contacted by telephone on the day of referral and an appointment was offered for them to be seen by the team within three days. Low risk referrals would be contacted by letter or phone and offered an appointment by the CMHTs to be seen within two weeks.

The service advertised the telephone number for the single point of access (SPA) service in various community based settings such as local general practitioners surgeries to enable people to contact the service directly. There was an open referral system in place meaning that any person could self-refer and any external organisations could refer on. Referral could be made by telephone, fax or online. The team accepted referrals from a range of sources including self-referrals from people or their carers, general practitioners, the inpatient wards and CMHTs.

The service operated 24 hours a day, seven days a week, 365 day a year. Telephone calls were triaged through an externally managed telephone system with eight active telephone lines. The Intensive Home Base Treatment team operated four days per week during normal working hours.

The team visited people in their own home or at the crisis and access team offices dependent upon their needs and level of risk. People were also supported by regular telephone calls or an agreed level of contact.

The team had forged links with local voluntary organisations and the police.

The SPA team were the gatekeepers for beds at Bootham Park Hospital, which meant they had oversight and control over admissions. The team had daily contact with the acute wards to identify people who may be appropriate for early discharge with support from the team. This included providing support to people during leave periods from the ward. Staff told us they sometimes had problems accessing beds within the trust when an inpatient admission was needed. This often meant out of area placements had to be arranged, specifically bed in the psychiatric intensive care unit (PICU). This had been recognised by the team and was included as a high risk on the trust's strategic risk register and there was a specific referral protocol in place to ensure the welfare of the person being referred in the rare instance that this took place.

Learning from concerns and complaints

Good

Are services responsive to people's needs?

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

Complaints and concerns which people had raised were discussed at the service's monthly care group meeting and then in the weekly business team meetings. We found evidence to show that the manager had taken timely action in response to complaints which they had received.

All of the people that we spoke with knew how to raise concerns and had been given written information about making complaints. Information leaflets and PALS leaflets were available at the service. We were told this these were given to all people making contact with the service.

The team was proactive in its approach to gaining feedback from people who used the service through measures such as the family and friends test, patient related outcome measures (PROMS), 'Patient Opinion' website and the short warwick edinburgh mental well being scale (SWEMWBS). Evidence that changes had been made to the service based on people's feedback and complaints was in place.

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

Management and staff were clear about the purpose and function of the section 136 suite. A clear multi-agency protocol was in place to oversee its operation, with all necessary agencies involved in the monitoring of operations.

The team manager had sufficient flexibility within the multi-functional team, to ensure that the suite was appropriately staffed when required. Where problems arose these were discussed and resolved either in the three monthly monitoring meeting or in discussion between appropriate senior staff in relevant agencies.

The section 136 suite had been subject to a scheduled Mental Health Act monitoring visit in August 2013 to check adherence to the Mental Health Act and Mental Health Act Code of Practice. Where issues were found, the trust provided an action statement with timescales to show how it would improve its processes to help secure adherence to the Mental Health Act and Code of Practice.

Staff spoken with were committed to the purpose and function of the section 136 suite and reported that they were supported by their managers in this regard.

The locally agreed joint policy on section 136 contained clear target response times for assessments to be undertaken, and these were monitored and discussed. The use of police cells as the place of safety and the rates of diversion was also monitored and addressed within the three monthly monitoring group.

Some staff were aware of the chief executive and board level leadership through the trust and were able to identify the trust values. Others told us that they did not feel involved with the senior managers within the trust.

The teams held weekly staff meetings that had an agenda which was focused on governance issues. These meetings linked into the directorate governance meetings which provided assurance that issues could be escalated and shared across services.

Staff we spoke with were clear about their responsibilities in relation to escalating any issues which may impact on the quality of the service they provided to the manager.

Staff told us that they received information they needed from the trust through their manager or via the internal intranet called Staffnet so they were kept informed of developments which may impact on their work.

Staff had an annual appraisal and were aware of their own personal development goals.

Staff told us they had access to training to support them in their roles. This included specialist training in addition to mandatory training provided by the trust. However the data provided at trust level about training uptake showed significant gaps in training. The manager told us that training uptake was monitored locally through the electronic training records and local email reminders, but when we asked for an up to date list of training uptake this could not be provided.

There was therefore no effective system in place to ensure that policies and procedures were kept up to date.

The team was well-led at local level. All of the staff we spoke with told us that they felt proud working for the team and felt supported by their managers. Staff told us they felt comfortable discussing any issues they may have with colleagues within the team.

There was a whistleblowing procedure in place which staff were aware of and told us that they would raise any issues if they were unable to this this within the team.

It was not clear how performance data was locally driven or owned. Staff told us that performance data was not useful. It was therefore difficult to measure performance improvement locally or across services.

At the CAS at the Becklin Centre in Leeds, the service did not have an effective audit programme in place to monitor and review the quality of the service provided. There was no system in place to actively gather feedback from people using the service and implement changes as a result.

Our findings

Health based place of safety – Becklin Centre, Leeds

Vision and values

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.

Management and staff were clear about the purpose and function of the section 136 suite. A clear multi-agency protocol was in place to oversee the operation of the section 136 suite, with all necessary agencies involved in the monitoring of operations.

Good governance

The team manager had sufficient flexibility within the multi-functional team, to ensure that the section 136 suite was appropriately staffed when required. Where problems arose these were discussed and resolved either in the three monthly monitoring meeting or in discussion between appropriate senior staff in relevant agencies.

The section 136 suite had been subject to a scheduled Mental Health Act monitoring visit in August 2013 to check adherence to the Mental Health Act and Mental Health Act Code of Practice.

We checked the outstanding actions during our latest inspection:

- There remained only one shower and so the suite could not be classed as single sex. However, there would usually only be one person in the suite at a time. Also the suite was to be transferred to the new crisis assessment unit once completed.
- The problems identified with access to the shower for those of limited mobility remained. The suite was however due to be transferred to the new crisis assessment unit once completed.
- The issue about whether people could be accompanied by a family member or friend whilst interviewed seems unresolved. The response talks about developing guidance which we were not given and it is unclear whether the guidance would allow for others to sit in on the interview.

Where issues were found, the trust provided an action statement with timescales to show how it would improve its processes to help secure adherence to the Mental Health Act and Code of Practice.

Leadership, morale and staff engagement

Staff spoken with were committed to the purpose and function of the section 136 suite and reported that they were supported by their managers in this regard.

Commitment to quality improvement and innovation

The locally agreed joint policy on section 136 contained clear target response times for assessments to be undertaken, and these were monitored and discussed. The use of police cells as the place of safety and the rates of diversion was also monitored and addressed within the three monthly monitoring group.

Health based place of safety – Bootham Park Hospital, York

Vision and values

Management and staff were clear about the purpose and function of the section 136 suite. A clear multi-agency protocol was in place to oversee the operation of the suite, with all necessary agencies involved in the monitoring of operations.

Good governance

The team manager had sufficient flexibility within the multi-functional team, to ensure that the health based place of safety was appropriately staffed when required. Where problems arose these were discussed and resolved either in the three monthly monitoring meeting or in discussion between appropriate senior staff in relevant agencies.

Leadership, morale and staff engagement

Staff spoken with were committed to the purpose and function of the section 136 suite and reported that they were supported by their managers in this regard.

Commitment to quality improvement and innovation

The locally agreed joint policy on Section 136 contained clear targets and response times for assessments to be undertaken, and these were monitored and discussed. The use of police cells as the place of safety and the rates of diversion was also monitored and addressed within the three monthly monitoring group.

Crisis and Assessment Service – Becklin Centre, Leeds

Vision and values

Some staff were aware of the chief executive and board level leadership through the trust and were able to identify the trust values. Some staff told us that they kept up with

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.

executive level staff through Twitter. Some staff told us that they did not identify with the senior managers within the trust and felt that they only attended when something had gone wrong, such a clinical incidents and complaints.

Good governance

The team held weekly staff meetings that had an agenda which was focused on governance issues. These meetings linked into the directorate governance meetings which provided assurance that issues could be escalated and shared across services. Staff we spoke with were clear about their responsibilities in relation to escalating any issues which may impact on the quality of the service they provided to the manager. Staff told us they felt well supported in their roles, and felt able to raise concerns and report and learn lessons from incidents. They told us they would be listened to, and the information acted upon appropriately.

Staff told us that they received information they needed from the trust through their manager or via the internal intranet called Staffnet so they were kept informed of developments which may impact on their work.

The service did not have an effective audit programme in place to monitor and review the quality of the service provided. There was no system in place to actively gather feedback from people using the service and implement changes as a result.

Staff we spoke with confirmed they had an annual appraisal and were aware of their own personal development goals. Staff told us they had access to training to support them in their roles. This included specialist training in addition to mandatory training provided by the trust. However the data provided at trust level about training uptake showed significant gaps in training. The manager told us that training uptake was monitored locally through the electronic training records and local email reminders, but when we asked for an up to date list of training uptake this could not be provided.

Staff received regular peer group supervision facilitated by a psychotherapist from another service. Staff told us they discussed complex or challenging clinical issues within these sessions to explore ways to improve the service they provided to people.

We found that some of the policies and procedures that were in use were not up to date and required reviewing in 2013. This included the service specification document. We noted that there had been changes in clinical practice such as the referral pathway which had not been updated in the document. We spoke with the clinical operations manager about this and this was attributed to staff absence. There was therefore no effective system in place to ensure that policies and procedures were kept up to date.

Leadership, morale and staff engagement

The team was well-led at local level. They were motivated to continually improve and develop the service. All of the staff we spoke with told us they felt proud working for the team. All the staff we spoke with told us that they felt supported by their manager and felt they could approach them if needed. Staff told us that their manager was very accessible and contactable. They told us they worked closely with the doctors within the team who provided them with specialist medical advice, support or supervision as needed. Staff told us they felt the team had a healthy culture where they felt comfortable discussing any issues they may have with colleagues within the team.

There was a whistleblowing procedure in place which staff were aware of and told us they would raise any issues if they were unable to this this within the team.

Commitment to quality improvement and innovation

We looked at the use of quality data across the service used to monitor systems within the team were effective. However; it was not clear from speaking with staff how this information was used to improve performance. Staff told us that a dashboard had been in development but was not yet in place and the system in place did not provide them with useful data about performance. The information was generated by information imputed into a computer data base. It was not clear how this was locally driven or owned. We also found there was a lack of locally driven audits taking place on all the wards we visited or bench-marking. It was therefore difficult to measure performance improvement locally or across services.

Crisis and Access Service- Bootham Park Hospital, York

Vision and values

Some staff were aware of the chief executive and board level leadership through the trust and were able to identify the trust values. Some staff told us that they kept up with executive level staff through social media. Some staff told

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.

us that they did not identify with the senior managers within the trust and felt that they only attended when something had gone wrong, such a clinical incidents and complaints.

Good governance

The team held weekly staff meetings that had an agenda which was focused on governance issues. These meetings linked into the directorate governance meetings which provided assurance that issues could be escalated and shared across services. Staff we spoke with were clear about their responsibilities in relation to escalating any issues which may impact on the quality of the service they provided to the manager. Staff told us they felt well supported in their roles, and felt able to raise concerns and report and learn lessons from incidents. They told us they would be listened to, and the information acted upon appropriately.

Staff told us they received the information they needed from the trust through their manager or via the internal intranet called Staffnet so they were kept informed of developments which may impact on their work.

Staff we spoke with confirmed they had an annual appraisal and were aware of their own personal development goals. Staff told us they had access to training to support them in their roles. This included specialist training in addition to mandatory training provided by the trust. However the data provided at trust level about training uptake showed significant gaps in training. The manager told us that training uptake was monitored locally through the electronic training records and local email reminders, but when we asked for an up to date list of training uptake this could not be provided.

Leadership, morale and staff engagement

The team was well-led at local level. They were motivated to continually improve and develop the service. All of the staff we spoke with told us that they felt proud working for the team. They felt supported by their manager and felt they could approach them if needed. Staff told us that their manager was very accessible and contactable. Staff told us they felt the team had a healthy culture where they felt comfortable discussing any issues they may have with colleagues within the team.

Staff told us that the medical input within the CAS team was lacking and often felt they need more with specialist medical advice, support and supervision.

There was a whistleblowing procedure in place which staff were aware of and told us that they would raise any issues if they were unable to this this within the team.

Commitment to quality improvement and innovation

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that people were protected against the risk of receiving inappropriate or unsafe care in the Health based place of safety at the Becklin Centre, Leeds. Rationale: The seating in the interview rooms was inappropriate as it was not fastened to the floor, which meant that it could potentially be used to cause injury. This had not been identified in the trust's risk register. The bathroom contained significant risks in that taps and door handles could be used as ligature points. These had been identified in the trust's risk register and measures had been put into place to implement additional risk assessments for people to whom this posed a risk, but no corrective action was planned to remove the ligatures. This was a breach of Regulation 9.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider did not have sufficiently robust systems in place for the management of medicines and people were not protected against the risks associated with this in the Crisis and Assessment Team, at the Becklin Centre, Leeds. Rationale: Patient Group Directions (PGDs) are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

Compliance actions

There was no evidence of pharmacy audit of PGDs or the CAS stock of medications. Pharmacy input was required as part of the medicines management policy. Therefore the service was not following their policy correctly.

Nurses using PGDs to administer urgent medicines without a prescription were not named in the PGD and had not received the necessary training and assessment. This meant that medicines had been administered illegally on some occasions and that the PGDs did not meet legal requirements.

This was a breach of Regulation13.