Good

Sussex Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX2E7	Department of Psychiatry	CHRT	BN21 2UD
RX2E7	Department of Psychiatry	Section 136 Suite	BN21 2UD
RX2PO	Langley Green Hospital	North West Sussex Crisis Resolution and Home Treatment Team	RH11 7EJ
RX2PO	Langley Green Hospital	Section 136 Suite	RH11 7EJ
RX277	Meadowfield Hospital	Maple Ward Place of Safety	BN13 3EF
RX277	Meadowfield Hospital	CRISIS Team	BN13 3EF
RX213	Mill View Hospital	Crisis home treatment team	BN3 7HZ

Summary of findings

RX213	Mill View Hospital	Brighton urgent response team	BN3 7HZ
RX213	Mill View Hospital	Place of safety (Section 136 suite)	BN3 7HZ
RX213	Mill View Hospital	Mental health liaison team	BN3 7HZ
RX26N	Oakland's Centre for Acute Care	CRISIS Team	PO19 6GS
RX2L6	Woodlands	Section 136 Suite	TN37 7PT

This report describes our judgement of the quality of care provided within this core service by Sussex 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 Sussex Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Sussex 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 the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Overall summary

We rated Sussex Partnership NHS Foundation Trust as good because:

The layout and furniture of the 136 suites was designed to promote patient's safety, and privacy and dignity as far as possible. There was equipment and alarms to deal with medical and psychiatric emergencies. There were generally enough staff on duty to provide services. All patients had a risk assessment carried out when they were seen by the crisis teams, or seen in the 136 suites. Patients working with the crisis teams had their level of risk reviewed regularly. Staff knew how to identify and report safeguarding concerns. Staff knew how to report incidents. Incidents were reviewed, but the lessons learned from them were not always fed back to staff. Staff were offered debriefing when serious incidents occurred.

Patients were assessed by the crisis teams or on admission to the 136 suites. This included an assessment of their mental and physical health care needs, which resulted in a plan of care to meet their needs, or in them being referred for further care or discharge. There were gaps in the monitoring of key information about patients in the 136 suites, such as arrival and discharge times or outcome of the assessment. The crisis teams had taken part in a national review of crisis services across the country, and used this to improve practice. Patients were cared for by a multidisciplinary team of staff, who had regular meetings and handovers to share information and review patients' needs and care plans. Staff worked with other organisations outside the trust, such as the police, GPs, and local authorities. Staff from the crisis teams were working with the police as part of a "Street Triage" initiative, which reduced the number of people detained and brought to the 136 suites by the police. Inconsistencies in training records made it difficult to determine if staff had received their mandatory training. The trust was aware of this and had plans to address this. Staff used the Mental Health Act and its Code of Practice correctly. Staff had an understanding of the assessment of capacity. Not all staff had completed training in the Mental Health Act or the Mental Capacity Act.

Patients were positive about the care they received from the crisis services. Staff spoke about patients in a caring and respectful manner, and took account of their individual needs and preferences. Patients using the crisis services were given information about what to expect from the service, and the options available to them. Care plans were developed in consultation with the patient.

There were gaps in the monitoring of key information about patients in the 136 suites, such as arrival and discharge times or outcome of the assessment. Patients could access emergency care 24 hours a day. The crisis teams were not accessible 24 hours a day, but were available outside office hours which included weekends. The crisis teams were the "gatekeepers" for the inpatients beds, and determined if patients required admission to hospital, or if alternative care and support could be provided. The 136 suites were designed to keep people safety and protect their privacy and dignity as far as possible. Information and interpretation services were available for patients who did not speak English. Patients were given information about how to complain, and staff knew how to manager complaints. However, although lessons learnt from significant complaints were shared across the trust, it was not clear how the service ensured that local complaints were shared with staff.

- Staff were committed to providing high quality care for patients, although they were not all clear about the trust's vision and strategy for the service. Staff found their local managers approachable and supportive, and local managers felt they had the authority to carry out their roles effectively. The trust monitored the quality of its service, but the local and corporate monitoring was not joined up, and did not always work effectively to provide accurate information from which improvements could be made. This was a particular issue with regards to ensuring all staff had received mandatory training. There were gaps in the monitoring of how long people had spent, and the outcome of their assessment, in the 136 suites. Staff felt able to raise suggestions or concerns about the service without fear of reprisal. Staff and teams had taken part in projects and research to improve outcomes for patients, and the better use of resources. This reducing the number of patients unnecessarily admitted to an acute hospital and a court diversion scheme for potential offenders who may have mental health problems.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

The layout and furniture of the 136 suites was designed to promote patient's safety, and privacy and dignity as far as possible. There was equipment and alarms to deal with medical and psychiatric emergencies. There were generally enough staff on duty to provide services. All patients had a risk assessment carried out when they were seen by the crisis teams, or seen in the 136 suites. Patients working with the crisis teams had their level of risk reviewed regularly. Staff knew how to identify and report safeguarding concerns. Staff knew how to report incidents. Incidents were reviewed, but the lessons learned from them were not always fed back to staff. Staff were offered debriefing when serious incidents occurred.

Are services effective?

Good

We rated effective as **good** because:

Patients were assessed by the crisis teams or on admission to the 136 suites. This included an assessment of their mental and physical health care needs, which resulted in a plan of care to meet their needs, or in them being referred for further care or discharge. There were gaps in the monitoring of key information about patients in the 136 suites, such as arrival and discharge times or outcome of the assessment. The crisis teams had taken part in a national review of crisis services across the country, and used this to improve practice. Patients were cared for by a multidisciplinary team of staff, who had regular meetings and handovers to share information and review patients' needs and care plans. Staff worked with other organisations outside the trust, such as the police, GPs, and local authorities. Staff from the crisis teams were working with the police as part of a "Street Triage" initiative, which reduced the number of people detained and brought to the 136 suites by the police. Inconsistencies in training records made it difficult to determine if staff had received their mandatory training. The trust was aware of this and had plans to address this. Staff used the Mental Health Act and its Code of Practice correctly. Staff had an understanding of the assessment of capacity. Not all staff had completed training in the Mental Health Act or the Mental Capacity Act.

Are services caring?

Good

We rated caring as **good** because:

Patients were positive about the care they received from the crisis services. Staff spoke about patients in a caring and respectful

Summary of findings

manner, and took account of their individual needs and preferences. Patients using the crisis services were given information about what to expect from the service, and the options available to them. Care plans were developed in consultation with the patient.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

There were gaps in the monitoring of key information about patients in the 136 suites, such as arrival and discharge times or outcome of the assessment. Patients could access emergency care 24 hours a day. The crisis teams were not accessible 24 hours a day, but were available outside office hours which included weekends. The crisis teams were the “gatekeepers” for the inpatients beds, and determined if patients required admission to hospital, or if alternative care and support could be provided. The 136 suites were designed to keep people safety and protect their privacy and dignity as far as possible. Information and interpretation services were available for patients who did not speak English. Patients were given information about how to complain, and staff knew how to manager complaints. However, although lessons learnt from significant complaints were shared across the trust, it was not clear how the service ensured that local complaints were shared with staff.

Are services well-led?

Good

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

- Staff were committed to providing high quality care for patients, although they were not all clear about the trust’s vision and strategy for the service. Staff found their local managers approachable and supportive, and local managers felt they had the authority to carry out their roles effectively. The trust monitored the quality of its service, but the local and corporate monitoring was not joined up, and did not always work effectively to provide accurate information from which improvements could be made. This was a particular issue with regards to ensuring all staff had received mandatory training. There were gaps in the monitoring of how long people had spent, and the outcome of their assessment, in the 136 suites. Staff felt able to raise suggestions or concerns about the service without fear of reprisal. Staff and teams had taken part in projects and research to improve outcomes for patients, and the better use of resources. This reducing the number of patients unnecessarily admitted to an acute hospital and a court diversion scheme for potential offenders who may have mental health problems.

Summary of findings

Information about the service

The trust has health-based places of safety, or section 136 suites, on five sites: the Department of Psychiatry, Langley Green Hospital, Meadowfield Hospital, Mill View Hospital, and Woodlands.

There are crisis or home treatment teams based at: the Department of Psychiatry, Langley Green Hospital, Meadowfield Hospital, Mill View Hospital, and Oakland's Centre for Acute Care. There is also an urgent response team at Mill View Hospital.

Services within the trust have been inspected by the Care Quality Commission. However, the places of safety/ section 136 suites and crisis response teams had not been specifically inspected. The section 136 suites had been reviewed for their compliance against the Mental Health Act.

Our inspection team

The teams that inspected the mental health crisis services and health-based places of safety consisted of 17 people: two experts by experience, four inspectors, four Mental Health Act reviewers, four nurses, a psychiatrist, an occupational therapist and a manager. There were also two staff from CQC who were observing the inspection.

Why we carried out this inspection

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

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all five health-based places of safety/section 136 suites, five crisis response/home treatment teams, an urgent response team and a mental health liasion team
- spoke with five patients who were using the service, including some in their own homes
- spoke with the managers or acting managers for each of the wards
- spoke with the matrons and general managers with responsibility for these services
- spoke with 38 other staff members; including doctors, nurses, social workers and therapists
- attended and observed five multidisciplinary handover meetings, 2 staff focus groups, and a bed management meeting.

We also:

- Looked at 38 treatment records of patients

Summary of findings

- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

The patients we spoke with who used the crisis services were positive about their experiences, and the support they had received.

We did not speak with any patients who had used the 136 suites.

Good practice

A member of trust staff was available to the police on patrol, to offer advice and support if they found someone who appeared to be suffering from mental health problems. This was called the "Street Triage" initiative, and had been effective in reducing the number of people detained under Section 136 of the Mental Health Act, and the number of people referred to the crisis response team.

The A&E liaison team and the Brighton urgent response team won the 2013 Guardian Healthcare Innovation award for the Brighton urgent response project in both A&E and in responding to GP referrals in the community.

The project led to a 50% reduction in the number of patients with mental health problems being admitted to the observation ward at the Royal Sussex County Hospital.

The A&E liaison team was participating in research overseen by the National Institute of Health Research looking into predicting the risk of repeat self-harming.

The Court Diversion Service was one of ten national trial sites where people with mental health problems, who were under suspicion of committing an offence, were helped to access appropriate care and support. Trust staff were based across all courts and custody suites in Sussex and worked closely with the police, courts, probation and youth offending services.

Areas for improvement

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

The trust should review its collection and use of information about patients assessed in the 136 suites, and ensure that patients are not only held in the suites for longer than necessary.

The trust should review how it provides and records training for staff, so that it is assured that all its staff have received the necessary training to provide safe and effective care. This should include staff training needs in relation to the Mental Health Act, and the Mental Capacity Act/Deprivation of Liberty Safeguards.

Monitoring of the use of the 136 suites should be reviewed, so that the information produced is correct, and this can be used to improve the experience of patients brought to the suites, and ensure they are not subject to unnecessary delays.

Sussex Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
CHRT, Section 136 Suite	Department of Psychiatry Langley Green Hospital Meadowfield Hospital Millview Hospital Oakland's Centre for Acute Care Woodlands
North West Sussex Crisis Resolution and Home Treatment Team, Section 136 Suite	Langley Green Hospital
CRISIS Team, Maple Ward Place of Safety	Meadowfield Hospital
Crisis home treatment team, Brighton urgent response team, Place of safety (Section 136 suite), Mental health liaison team	Millview Hospital
CRISIS Team	Oakland's Centre for Acute Care
Section 136 Suite	Woodlands

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Staff could access the trust's policies on the Mental Health Act and its Code of Practice. There was a central Mental Health Act administration team that staff contacted for advice, and who monitored the implementation of the Act.

There were Approved Mental Health Practitioners (AMHPs) in the crisis teams. These carried out Mental Health Act assessments when necessary, and they were a source of advice to other staff. If patients were on Community Treatment Orders (CTOs) and needed to be recalled to hospital, this was managed through the crisis teams.

The training records showed that not all staff had completed training in the Mental Health Act. However, this was part of a broader issue about the recording and monitoring of training by the trust. The staff we spoke with had an understanding of the Act, and where they could seek advice if needed.

Information was recorded about how long patients spent in the 136 suite, and what the outcome of their assessment was. This was not consistently recorded, so it was not always possible to tell how long a person had been in the suite, or what the outcome was.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff could access the trust's policies on the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), "best interest" decision making, and capacity assessments. Staff could seek advice about DoLS from the Mental Health Act (MHA) administration office, or from the local authority lead in the DoLS safeguarding team.

A patients capacity was assessed as part of their mental state examination, but this was not always recorded in detail. Staff told us that most patients had capacity to consent to treatment, and that if a patient was assessed as lacking capacity, this information would be passed onto their GP.

The training records showed that not all staff had completed Mental Capacity Act (MCA) training. However, this was part of a broader issue about the recording and monitoring of training by the trust. Some of the staff we spoke with described the MCA eLearning and half day workshops they had attended. Most of the staff we spoke with had an understanding of capacity.

Good

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

We rated safe as **good** because:

The layout and furniture of the 136 suites was designed to promote patient's safety, and privacy and dignity as far as possible. There was equipment and alarms to deal with medical and psychiatric emergencies. There were generally enough staff on duty to provide services. All patients had a risk assessment carried out when they were seen by the crisis teams, or seen in the 136 suites. Patients working with the crisis teams had their level of risk reviewed regularly. Staff knew how to identify and report safeguarding concerns. Staff knew how to report incidents. Incidents were reviewed, but the lessons learned from them were not always fed back to staff. Staff were offered debriefing when serious incidents occurred.

Our findings

Mental health crisis services and health-based places of safety

Safe and clean ward environment

- The layout of the 136 suites allowed staff to observe patients to ensure their safety whilst they were in the suite. The furniture was designed so that it did not present a risk to patients or staff, and ligatures had been in the main patient room and bathroom in the suite.
- The 136 suites had a separate entranced, and there was an office, main patient room, and bathroom and toilet facilities specifically for the suite.
- There was emergency resuscitation and medical equipment available in or near the suites.
- Staff had emergency alarms, so they could call for support if necessary.
- The 136 suites and the areas where patients were seen in the crisis teams were clean.

Safe staffing

- All the crisis teams were staffed by nurses, doctors, social workers and health care assistants. There were also psychologist and occupational therapists or assistants in some of the teams. Some of the teams had staff vacancies, and others had shortages because of staff sickness or long term leave. These were covered by bank staff or permanent staff working additional shifts. Staff told us that patient care was a priority and that when the service was short it was usually supervision and training that was cancelled.
- The 136 suites had staff allocated from the inpatient wards. Each unit had different arrangements for this, but they covered the staff's time so that the wards were not left short. A qualified nurse was allocated to work in the 136 suites, and to coordinate the assessment. A patient was always supervised in the suite, and this would often be by a health care assistant.
- All the 136 suites were joined to or near inpatient wards, so additional staff were called for assistance when necessary.

Assessing and managing risks to patients and staff

- Patients had a risk assessment carried out before they were seen by the crisis services or in the 136 suites. When patients were seen by the teams, staff carried out a further risk assessment. This took account of patient's previous risk history as well as their current mental state.
- In the crisis teams comprehensive risk assessments were completed and reviewed regularly which included at multidisciplinary team meetings. The assessments used a recognised tool, and followed a zoning or "RAG (red amber green) rating" system to make the level of risk clearly identifiable. All patients were rated as "red" (the highest level of risk) for the first 72 hours of contact with the team. The level of risk was then reviewed regularly, and adjusted as necessary. Each patient was discussed at the daily staff handover, and their level of risk and care plan reviewed.
- The assessment information was fed into patient's care plans, and influenced the care they received. For example, how frequently they were visited, and whether this was face to face or by telephone. If a patient was

Good

Are services safe?

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

unavailable, staff followed them up to make sure they were safe. For example, a patient had not been in when staff had visited, so they made several more attempts to get in touch with them until they established that the patient was safe.

- The trust had a safeguarding policy, which followed the county-wide multi-agency policies. Not all staff had completed safeguarding training, but those we spoke with demonstrated that they could identify safeguarding concerns, and knew what action to take in response. There were safeguarding leads within or accessible by the teams, and staff knew who they were and how to contact them for advice.
- The trust had a lone working policy. The staff we spoke with were familiar with these, and gave examples of what they did to keep one another safe. For example, if they had particular concerns about a patient they may visit in pairs, or arrange for the patient to be seen at the office.

Track record on safety

- Where serious incidents had occurred within the teams, serious incident investigations had been completed and dated action plans implemented. For example, following incidents in one of the crisis teams the assessment of patients had been improved. This now included identifying if patients had household cleaners or other chemicals in their home, and if this presented a risk.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to recognise and report incidents on the trust's electronic recording system. All incidents were reviewed by the manager, and forwarded to senior managers and the trust's patient safety team for further review. The system ensured that senior managers within the trust were alerted to incidents in a timely manner and could monitor the investigation and response to these. The action taken was also recorded on the electronic system.
- Staff we spoke with told us that they did not always receive feedback after they had reported an incident. Significant incidents were discussed in staff meetings and handovers, but it was not all staff were at every meeting. Managers told us that lessons learnt from incidents were shared at the regular managers meetings facilitated by the matron and general manager for their services. Staff were offered debriefing following serious incidents.

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

We rated effective as **good** because:

Patients were assessed by the crisis teams or on admission to the 136 suites. This included an assessment of their mental and physical health care needs, which resulted in a plan of care to meet their needs, or in them being referred for further care or discharged. The crisis teams had taken part in a national review of crisis services across the country, and used this to improve practice. Patients were cared for by a multidisciplinary team of staff, who had regular meetings and handovers to share information and review patients' needs and care plans. Staff worked with other organisations outside the trust, such as the police, GPs, and local authorities. Staff from the crisis teams were working with the police as part of a "Street Triage" initiative, which reduced the number of people detained and brought to the 136 suites by the police. Inconsistencies in training records made it difficult to determine if staff had received their mandatory training. The trust was aware of this and had plans to address this. Staff used the Mental Health Act and its Code of Practice correctly. Staff had an understanding of the assessment of capacity. Not all staff had completed training in the Mental Health Act or the Mental Capacity Act.

Our findings

Mental health crisis services and health-based places of safety

Assessment of needs and planning of care

- Patients' needs were assessed and interventions were delivered in line with their individual care plans. Patients seen by the crisis teams and in the 136 suites had a physical health assessment. Physical health needs, including nutrition, were followed up by the crisis teams.
- Care records differed across the sites, and although they contained the necessary information, it was not always easy to find. The attitude of staff in the crisis teams and the care we observed was positive and person centred. However, this was not always reflected in the care records. The care records in the crisis teams included an assessment of each patient's needs, with a care plan that responded to this. The care plans and assessments were reviewed regularly, and the care plans changed as necessary.
- There was a mixture of paper and electronic documentation in the 136 suites, and in the crisis services, which staff told us could make finding information difficult. However, the care records were stored securely and were readily available for staff when needed.
- Prior to admissions patients were risk assessed for their suitability for the unit and then a junior doctor undertook a health assessment to ensure they were medically fit to be detained. This examination did not include a mental health assessment which was undertaken later by the Approved Mental Health Professional (AMHP) and Section 12 doctor.
- We inspected one of the trust's mental health liaison teams, which was based at the Royal Surrey County Hospital. The liaison team based in the Accident and Emergency (A&E) department were meeting the target of responding to all referrals within one hour, following triage in the main A&E department. After assessment the team discharged or moved patients onto mental health services within a four hour period. They were meeting this target of over 85%. The liaison team were able to assess and accept patients on behalf of the crisis and urgent response teams from Mill View Hospital. This meant that people did not have to be assessed twice to access crisis team services.

Best practice in treatment and care

- The crisis services had taken part in the University College Hospital London Core Fidelity Review. The review measured the performance of crisis teams against one another, and identified areas of good practice and for improvement. The services had a further assessment and this showed that improvement had been made within the services.
- NICE guidance was followed when prescribing medication.
- Patients had access to psychological interventions, provided by different staff within the crisis team.

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.

Patients who required psychology input accessed this through community services, but the psychologists in the crisis teams would be involved in the assessment and planning process.

- All people using the crisis services were assessed using the Health of the Nation Outcome Scales (HoNOS). These covered 12 health and social domains and enabled clinicians to build up a picture overtime of how patients had responded to care and treatment.
- Staff participated in a range of clinical audits to monitor the effectiveness of services provided. Reflective practice sessions were available for staff, to evaluate the effectiveness of their work with patients.
- A member of trust staff was available to the police on patrol, to offer advice and support if they found someone who appeared to be suffering from mental health problems. This was called the "Street Triage" initiative, and had been effective in reducing the number of people detained under Section 136 of the Mental Health Act, and the number of people referred to the crisis response team.

Skilled staff to deliver care

- The crisis service included doctors, nurses, psychologists, occupational therapists, social workers and support workers. They were all took part in the assessment, planning and working with patients.
- The uptake and recording of mandatory training was inconsistent across the services. Local records and corporate records did not reflect one another, so it was difficult to determine if staff had completed the training. Most of the staff we spoke with told us they were up to date with their mandatory training. They told us it could be difficult to find time to attend refresher training when the service was busy, so attendance at these may be delayed.
- Staff had access to supervision and appraisal. The uptake and frequency of this varied between teams. Most teams had regular supervision and were up to date with their appraisals.
- The trust had identified that staff training, learning and development was a concern and had in place a strategy to address the issues. This included launching a new induction programme, to redefine core training, commission a learning management system and a plan to ensure that the majority of staff had completed core training within the next eighteen months.

Multi-disciplinary and inter-agency team work

- The crisis teams had weekly multidisciplinary clinical review meetings. Handovers between staff took place twice a day within the crisis teams.
- The crisis teams visited the wards most days and worked closely with the ward teams to assess which patients may be suitable for early discharge. The crisis teams undertook joint visits with patients' care coordinators.
- Staff in the 136 suites were in contact with the police prior to accepting a patient. In the Brighton area we saw that a monthly liaison meeting was held with the police looking primarily at use of the place of safety however also all incidents involving the police and any general security issues at any site. This also happens in North West Sussex.
- The trust worked with the local authorities, NHS trusts, police and ambulance services to monitor and review the use of the 136 suites. The mental health liaison team had positive working relationships with staff in the acute hospital it was based in.
- GPs received timely discharge summaries from the crisis teams.

Adherence to the Mental Health Act and Code of Practice

- Staff could access the trust's policies on the Mental Health Act and its Code of Practice. There was a central Mental Health Act administration team that staff contacted for advice, and who monitored the implementation of the Act.
- There were Approved Mental Health Practitioners (AMHPs) in the crisis teams. These carried out Mental Health Act assessments when necessary, and they were a source of advice to other staff. If patients were on Community Treatment Orders (CTOs) and needed to be recalled to hospital, this was managed through the crisis teams.
- The training records showed that not all staff had completed training in the Mental Health Act. However,

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.

this was part of a broader issue about the recording and monitoring of training by the trust. The staff we spoke with had an understanding of the Act, and where they could seek advice if needed.

- Information was recorded about how long patients spent in the 136 suite, and what the outcome of their assessment was. This was not consistently recorded, so it was not always possible to tell how long a person had been in the suite, or what the outcome was.

Good practice in applying the Mental Capacity Act

- Staff could access the trust's policies on the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), "best interest" decision making, and capacity assessments. Staff could seek advice about DoLS from the Mental Health Act (MHA) administration office, or from the local authority lead in the DoLS safeguarding team.
- A patients capacity was assessed as part of their mental state examination, but this was not always recorded in detail. Staff told us that most patients had capacity to consent to treatment, and that if a patient was assessed as lacking capacity, this information would be passed onto their GP.
- The training records showed that not all staff had completed Mental Capacity Act (MCA) training. However, this was part of a broader issue about the recording and monitoring of training by the trust. Some of the staff we spoke with described the MCA eLearning and half day workshops they had attended. Most of the staff we spoke with had an understanding of capacity.

Good

Are services caring?

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

Summary of findings

We rated caring as **good** because:

Patients were positive about the care they received from the crisis services. Staff spoke about patients in a caring and respectful manner, and took account of their individual needs and preferences. Patients using the crisis services were given information about what to expect from the service, and the options available to them. Care plans were developed in consultation with the patient.

Our findings

Mental health crisis services and health-based places of safety

Kindness, dignity, respect and support

- Patients were positive about the care they received from the crisis services. Staff spoke about patients in a caring and respectful manner, and took account of their individual needs and preferences.

The involvement of people in the care they receive

- Patients were given a "Welcome Pack" that included information about what to expect from the crisis services, and the care and support that was available to them. Staff discussed patients' needs and choices with them during the initial 72 hour assessment period, and then devised a care plan in consultation with the patient.
- Staff took account of patients' needs and circumstances when planning care. For example, by working around a patient's other commitments such as hospital appointments, social events or the "school run".
- Staff involved patients' carers and families where appropriate, and the crisis teams carried out or referred people for carer's assessments. Families and carers were also given information about carers' support groups.
- Information was available about services provided by the trust and other organisations. For example, information booklets and leaflets were on display, and provided to patients, about the trust's out of hours helpline. There was also information about support groups and independent advocacy services.

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

We rated responsive as **good** because:

There were gaps in the monitoring of key information about patients in the 136 suites, such as arrival and discharge times or outcome of the assessment. Patients could access emergency care 24 hours a day. The crisis teams were not accessible 24 hours a day, but were available outside office hours which included weekends. The crisis teams were the "gatekeepers" for the inpatients beds, and determined if patients required admission to hospital, or if alternative care and support could be provided. The 136 suites were designed to keep people safety and protect their privacy and dignity as far as possible. Information and interpretation services were available for patients who did not speak English. Patients were given information about how to complain, and staff knew how to manager complaints. However, although lessons learnt from significant complaints were shared across the trust, it was not clear how the service ensured that local complaints were shared with staff.

Our findings

Mental health crisis services and health-based places of safety

Access, discharge and bed management

- The trust had five places of safety or section 136 suites, all located in hospitals. Patients were not always admitted to the health-based place of safety closest to their home. Patients were sometimes moved between police custody suites and 136 suites before accessing appropriate care close to their home.
- Information was recorded about how long patients spent in the 136 suite, and what the outcome of their assessment was. This was not consistently recorded, so it was not always possible to tell how long a person had been in the suite, or what the outcome was. From the information available this showed that most patients who were brought to the 136 suites were not admitted to hospital or detained under the Mental Health Act. The trust's target for completing assessments was six hours, but where this information was recorded the trust was not meeting this on most occasions. Most patients had their assessment completed within 24 hours. Staff told us that here were often delays in patients being assessed in the 136 suite due to lack of availability of AMHPs and Section 12 doctors. The service had been unable to access AMHPs at night, which led to delays, but this had now been resolved.
- Each crisis team offered extended hours (outside office hours, including weekends), but not a 24 hour service. However, patients could access an emergency service 24 hours a day, which included the telephone helpline, and an on call doctor.
- The crisis teams were the "gatekeepers" for beds on the inpatient wards. They assessed patients to determine if admission was necessary, or if alternative care and support could be provided. They worked with the wards to determine if they could provide support for current inpatients, so that they could be discharged safely as soon as possible.
- Patients typically stayed under the care of the crisis teams for up to six weeks, with discharge planning initiated within the first week.

The ward optimises recovery, comfort and dignity

- The 136 suites were part of an inpatient ward, but were in a separate and secure area of the ward. They had a place for the person to lay down, with access to a ligature free toilet and shower. There was a clock in the suite so patients could see the time and the windows were suitably glazed or had privacy film to ensure patients privacy. The layout of the suites allowed staff to observe patients to ensure their safety whilst admitted to the suite.
- Patients were given food and drink whilst they were in the 136 suites.
- The crisis team worked flexibly with patients to promote their privacy and dignity. For example, male staff would not routinely visit female patients on their own. There was flexibility as to where staff visited patients. For example, if a patient found it difficult to meet with staff at home, they may arrange meetings in cafes or at the hospital instead.

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.

- Some information leaflets were readily available in different languages. Staff told us that if they needed information in a different language they would find it on the internet. Interpreters could be accessed if necessary.
- Services in the crisis teams were accessible by people in wheelchairs. The 136 suites did not have disabled toilets within them because of the ligature risks. Patients would have to be escorted out of the suite to the disabled toilets elsewhere in the hospital.

Listening to and learning from concerns and complaints

- Information about how to complain was on display in patient areas and on the trust's website. The trust's website also had information about the Patient Advice and Liaison Service (PALS) which supported patients in raising concerns. Patients using the crisis services were given information about how to make a complaint as part of their introductory "Welcome Pack".
- Staff knew how to handle complaints from patients. Crisis teams were aware of the "Family and Friends" test and told us how they received monthly feedback about how well they were doing.
- "Report and learn" bulletins were sent to staff and gave information about some of the complaints that had been received across the trust. However, this was not specific to services and appeared sometime after the event. Significant issues which included complaints were discussed in team meetings. However, it was not clear how the service ensured that local complaints were shared with staff.

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

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

Staff were committed to providing high quality care for patients, although they were not all clear about the trust's vision and strategy for the service. Staff found their local managers approachable and supportive, and local managers felt they had the authority to carry out their roles effectively. The trust monitored the quality of its service, but the local and corporate monitoring was not joined up and did not always work effectively to provide accurate information, from which improvements could be made. This was a particular issue with regards to ensuring all staff had received mandatory training. There were gaps in the monitoring of how long people had spent and the outcome of their assessment, in the 136 suites. Staff felt able to raise suggestions or concerns about the service without fear of reprisal. Staff and teams had taken part in projects and research to improve outcomes for patients and the better use of resources. This reducing the number of patients unnecessarily admitted to an acute hospital and a court diversion scheme for potential offenders who may have mental health problems.

Our findings

Mental health crisis services and health-based places of safety

Vision and values

- The trust's vision and strategies for the service were on display in many of the clinical and office areas. Not all the staff we spoke with were familiar with the trust's vision and strategy, but they told us they were committed to providing high quality care for patients.
- Staff knew who their local managers were, such as the matrons and general managers, and most staff told us they found them supportive.

Good governance

- The trust had governance systems for monitoring the quality of its services. This included in relation to staffing, incidents, and complaints. However, information that was collected corporately and the lessons learnt from this were not always effectively shared with local services. The records of local services were often separate, and contained different information, to those that were maintained corporately.
- For example, the uptake and recording of mandatory training was inconsistent across the services. Local records and corporate records did not reflect one another, so it was difficult to determine if staff had completed the training. This also made it difficult to determine when refresher training was due. The trust had identified this as an area of concern and had implemented a plan to improve training and the recording of training information. For example, the staff induction had been increased by a day so that it included more mandatory training.
- Monitoring of the use of the 136 suites was recorded, but there were gaps in the records across all the suites. This meant that it was not possible to effectively monitor this information, and identify and address any areas where patients were held for unnecessarily long periods of time.
- Local managers felt that they had sufficient authority to carry out their roles effectively.

Leadership, morale and staff engagement

- Staff in the crisis teams were mostly positive about the service they provided and felt that they were well supported by colleagues and managers in their team.
- Staff felt able to raise suggestions or concerns about the service without fear of reprisal. Staff were aware of the whistleblowing policy. Some staff gave examples of when they had raised concerns, and this had been responded to positively.
- Staff were kept up to date about developments in the trust through regular bulletins.

Commitment to quality improvement and innovation

- The A&E liaison team and the Brighton urgent response team won the 2013 Guardian Healthcare Innovation award for the Brighton urgent response project in both A&E and in responding to GP referrals in the community. The project led to a 50% reduction in the number of patients with mental health problems being admitted to the observation ward at the Royal Sussex County Hospital.

Are services well-led?

Good

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

- The A&E liaison team was participating in research overseen by the National Institute of Health Research looking into predicting the risk of repeat self-harming.
- The Court Diversion Service was one of ten national trial sites where people with mental health problems, who were under suspicion of committing an offence, were helped to access appropriate care and support. Trust staff were based across all courts and custody suites in Sussex and worked closely with the police, courts, probation and youth offending services.
- The crisis services had taken part in the University College Hospital London Core Fidelity Review. The review measured the performance of crisis teams against one another, and identified areas of good practice and for improvement. The services had a further assessment and this showed that improvement had been made within the services.