Tees, Esk and Wear Valleys 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)
RX301	Trust Headquarters	Crisis resolution and home treatment service - Scarborough, Whitby, Ryedale	Y012 6DN
RX301	Trust Headquarters	Scarborough street triage team	Y012 6DN
RX301	Trust Headquarters	Health based place of safety - Scarborough	Y012 6DN
RX301	Trust Headquarters	Crisis resolution and home treatment service - Hambleton and Richmondshire	DL6 1JG
RX301	Trust Headquarters	Health based place of safety - Northallerton	DL6 1JG

Summary of findings

RX301	Trust Headquarters	Intensive home treatment service - Harrogate and Craven	HG2 7SX
RX301	Trust Headquarters	Crisis resolution and intensive home treatment service -South Durham and Darlington	DL2 2TS
RX301	Trust Headquarters	Health based place of safety - Durham	DH1 5RD
RX301	Trust Headquarters	Crisis resolution and home treatment service - Hartlepool	TS24 8LN
RX301	Trust Headquarters	Health based place of safety - Darlington at West Park	DL2 2TS
RX301	Trust Headquarters	Crisis resolution and intensive home treatment service - Redcar and Cleveland	TS10 5RS
RX301	Trust Headquarters	Health based place of safety - Middlesborough and Cleveland at Roseberry Park	TS4 3AF
RX301	Trust Headquarters	Crisis resolution and intensive home treatment service - Redcar and Cleveland	TS10 5RS
RX301	Trust Headquarters	Street triage team - Middlesborough and Cleveland at Roseberry Park	TS4 3AF

This report describes our judgement of the quality of care provided within this core service by Tees, Esk and Wear Valleys 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 Tees, Esk and Wear Valleys NHS Foundation Trust and these are brought together to inform our overall judgement of Tees, Esk and Wear Valleys 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?	**Outstanding** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

The crisis services and health based places of safety (HBPoS) provided safe care because crisis teams had safe staffing levels with manageable caseloads and individual risks were assessed and managed. The physical space of four of the health based places of safety provided good environments to assess people. The HBPoS at West Park Hospital was more limited but adequate. There was full consideration of ligature risks within the environments of the health based places of safety.

The crisis services and health based places of safety were effective. There was very good multidisciplinary working in most crisis teams. There was effective working with the acute wards to holistically plan people's transition between services through involvement with daily 'report out' and huddle meetings. Care and intervention plans were of a good standard with some outstanding comprehensive assessments and interventions. There were good systems in place for ensuring the hospitals duties under section 136 were met, including ensuring patients were informed of their rights whilst in the health based place of safety. There were effective street triage teams that worked with the police to divert people from custody.

The crisis services and health based places of safety were caring as there were positive comments from people, staff provided good respectful care and care interventions were holistic. People were asked if they would recommend the service to others through the innovative use of tablet computers to provide feedback on the street triage service. People's experiences were not routinely requested during or after being cared for in the health based place of safety.

Staff within the crisis teams worked well with the adult acute mental health wards to prevent inappriopriate admissions to inpatient beds. Crisis teams ensured that people did not stay in hospital longer than necessary and promoted early discharge. People were usually seen within 4 hours for a face to face assessment when referred into the crisis service and very quickly in the street triage during the hours of duty. People within the health based places of safety were seen quickly and where there were delays they usually related to the availability of assessing doctors (section 12 doctors) or approved mental health professionals external to the trust. This meant that the crisis services and health based places of safety were responsive to people's needs

The crisis services and health based places of safety were well led. Staff morale was good. Universally staff were complimentary about the support and involvement of their line manager, senior managers and the chief executive. Managers had effective meetings on a daily basis to promote patient flows and to ensure that patients received appropriate, timely services to meet their individual needs. Managers were committed to providing high quality services and services were audited to ensure that they were of a good quality.

Summary of findings

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

Are services safe?

Good

The crisis services/health based places of safety were judged as good in the safe domain because:

- crisis teams had safe staffing levels with manageable caseloads which helped keep people safe
- individual risks were assessed and managed. Risk assessments were comprehensive and recorded within electronic records with summary risk assessments.
- the physical space of four of the health based places of safety provided safe environments to assess people; the HBPoS at West Park Hospital was more limited but adequate. The environments of the health based places of safety provided safe care with full consideration of ligature risks.
- effective safeguarding arrangements were in place with proper consideration of adult and children's safeguarding.
- actions from incidents and patient alerts were regularly discussed in team meetings to ensure lessons were learnt.
- staff were managing medicines following appropriate guidance for the safe administration and management of medicines under patient group directions (PGD).

Are services effective?

Outstanding

The crisis services/health based places of safety were judged as outstanding in the effective domain because:

- There was very good multidisciplinary working in most crisis teams. Crisis teams worked effectively with the acute wards to holistically plan people's transition between services through involvement with daily report out and huddle meetings.
- Care and intervention plans were of a good standard with some outstanding comprehensive assessments and interventions.
- There was good evidence based practice including suicide prevention and compliance with various NICE guidelines such as the treatment of people with schizophrenia.
- There were very good systems in place for ensuring the hospitals' duties under section 136 were met, including ensuring that patients were informed of their rights whilst in the health based place of safety.
- Staff understood the issues of mental capacity and consent. Some teams encouraged advance directives to help people determine their future crisis care needs.

Summary of findings

- The two street triage teams were effective during their hours of operation in reducing people being brought in under police powers under section 136 and improving police response to people in mental distress overall.
- Crisis staff supported people to access planned short term admissions planned for upto 72 hours where this met people's needs for example people with borderline personality disorder.
- A clear assessment and physical health check was undertaken, usually by a paramedic, when patients' arrived into the health based places of safety and any ongoing physical health problems were followed up appropriately.

There was a commitment to multiagency working to improve the arrangements for conveyance and assessment when people were brought in under section 136. Where delays occurred these were beyond the full control of the trust including availability of assessing doctors and the response of AMHPs. People continued to receive physical health checks from their GP or community mental health team for basic physical health checks. In some cases this led to slight delays in people being administered medication for the first time until the necessary checks had been carried out.

Are services caring?

Good

The crisis services/health based places of safety were judged as good in the caring domain because:

- There were positive comments from people we spoke with about their experience of receiving care from crisis teams
- Staff provided good respectful care in all the interactions we saw.
- Care interventions were holistic and looked at social, family, employment and financial issues to help alleviate crisis.
- People were involved in identifying their crisis support needs. People were asked if they would recommend the service to others including innovative use of tablet computers to provide feedback on the street triage service.

In some teams it was not always clear that patients were given copies of their intervention plans. The involvement of people using the service in shaping the service was more limited. Feedback from people who had experienced the health based place of safety was not routinely requested.

Are services responsive to people's needs?

Good

The crisis services/health based places of safety were judged as good in the responsive domain because:

Summary of findings

- Staff within the crisis teams worked very well with the adult acute mental health wards to prevent inappropriate admission to inpatient beds. Crisis staff ensured people did not stay in hospital longer than necessary and promoted early discharge.
- People were usually seen within 4 hours for a face to face assessment when referred into the crisis service and very quickly in the street triage during the hours of duty.
- Staff were flexible to meet people's individual needs.
- People within the health based placed of safety were seen quickly. When there were delays they usually related to the availability of assessing doctors (section 12 doctors) or approved mental health professionals external to the trust.
- Information on a range of support organisations was available for patients to access and look at other means of support.
- People were made aware of the complaints policy. When complaints were raised these were responded to appropriately. Comments about one team's attitude made on NHS choices website had been responded to appropriately.

Informal complaints were not always collated at team level.

Are services well-led?

Good

The crisis services/health based places of safety were judged as good in the well led domain because:

- Staff provided care and treatment in line with the trust's stated values.
- Staff morale was very good and universally staff were complimentary about the support and involvement of their line manager, more senior line managers and the chief executive.
- Managers had effective meetings on a daily basis to promote patient flows and ensure that patients received appropriate and timely services to meet their individual needs.
- Managers were committed to providing high quality services and services were audited to ensure good quality services.
- We judged the service as good or outstanding in other domains. We only found minor issues and where we found them we found managers and staff were usually aware of these and working to address these.
- There was a commitment to quality improvement . Developments included improved health based places of safety environments, improved staffing levels in crisis services, innovative street triage services in two localities and proposed developments of an urgent mental health crisis assessment service to enable people self presenting at Roseberry Park to receive an appropriate and accessible service and alleviate pressures at the neighbouring district general hospital.

Summary of findings

Staff in some crisis and home treatment teams were working towards Royal College of Psychiatrists' accreditation and the street triage had been evaluated externally through academic research.	

Summary of findings

Background to the service

Tees, Esk and Wear Valleys NHS Foundation Trust provided a range of crisis mental health services to adults of working age within Durham, Darlington, Cleveland and North Yorkshire. These include crisis resolution and home treatment teams which provided short term work to help support people at home when in mental health crisis and support with earlier discharge from hospital. The teams aim to facilitate the early discharge of patients from hospital or prevent patients been admitted to hospital by providing either home or unit based support and treatment.

The trust has street triage teams in two localities (Teeside and North Yorkshire). Street triage workers accompany police officers to incidents where police believe people need immediate mental health support. The aims of these teams were that people get the medical attention or professional input quickly whilst also diverting people from inappropriate police custody or section 136 assessments. The triage teams consists of a level 6 mental health nurse and a support worker working 12 hours each day, 7 days a week.

The trust operates five health based places of safety across Durham, Darlington, Cleveland and North Yorkshire. The health-based place of safety (HBPoS) is a unit where people arrested under police powers under section 136 of the Mental Health Act are taken by the police for an assessment of their mental health for their safety.

Section 136 sets out the rules for the police to arrest people in a public place where they appear to be suffering from mental disorder and in immediate need of care or control, if necessary to do so in the interests of that person or for the protection of other people. The arrest enables the police to remove the person to a place of safety. This would usually be a health based place of safety unless there are clear risks, for example, risks of violence which would require the person being taken to a police cell instead. People could be detained for a period of up to 72 hours for the purpose of enabling them to be examined by doctors and assessed by an approved mental health practitioner to consider whether compulsory admission to hospital is necessary. The HBPoS offers a 24 hour, 7 day a week service, open 365 days per year.

Tees, Esk and Wear Valleys NHS Foundation Trust have been inspected on a number of occasions since registration. However the crisis services had not previously been inspected by the Care Quality Commission. In December 2013, we carried a Mental Health Act monitoring visit to look at the arrangements the trust had for supporting the admission and assessment under the Mental Health Act. This showed that the trust had good arrangements and positive inter agency working. We saw that there were issues with the availability of assessing (section 12) doctors, delays in the ambulance conveying people, issues with the management of people self presenting at Roseberry Park and patient involvement . The trust was in the process of providing an action statement explaining how they would improve, or work with partner agencies to improve, adherence to the Mental Health Act (1983) (MHA) and MHA Code of Practice.

Our inspection team

Our inspection team was led by:

Chair: David Bradley, Chief Executive, South West London and St Georges NHS Mental Health Trust

Team Leader: Patti Boden, Care Quality Commission

Head of Inspection: Jenny Wilkes, Care Quality Commission

The team included a CQC inspection manager and specialist advisors which consisted of a consultant psychiatrist, two nurse managers, two social work managers and a Mental Health Act reviewer.

Summary of findings

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 held about mental health crisis services and health based places of safety and asked other organisations to share what they knew. We carried out an announced visit on 20 and 21 January 2015 to the North Yorkshire services and visited

- The crisis and home treatment teams at Scarborough, Harrogate and Northallerton
- the street triage team at Scarborough and
- health based places of safety at Scarborough and Northallerton.

We carried out an announced visit on 27-29 January 2015 to the Durham Darlington and Tees services and visited

- The crisis and home treatment teams at Durham,
- the street triage team at Roseberry Park, Middlesborough and
- health based places of safety at Durham, Darlington and Middlesborough.

During the inspection visit, the inspection team:

- spoke with nine people who were using the service
- spoke with the managers or acting managers for each of the services
- spoke with 38 other staff members; including doctors, nurses and social workers
- observed seven clinical interventions through home visits or assessments taking place at the crisis team base
- attended and observed nine hand-over/multi-disciplinary meetings and 6 'report out' meetings.

We also:

- collected feedback from patients using comment cards.
- looked at 30 treatment records of patients and a number of records relating to section 136 episodes.
- carried out a specific check of the medication management.
- looked at a range of policies, procedures and other documents relating to the running of the service.

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?

What people who use the provider's services say

During the inspection, people had an opportunity to comment on the services they received on comment cards prior to the inspection. We received one comment card from a person receiving support from the crisis services. The card commented favourably on one particular crisis service with staff being helpful and friendly, staff treated patients with dignity and respect and appointments were easy to make and choices given.

During the observations of care provided by the crisis teams, people were complimentary about the support they were receiving.

The health based places of safety were not in use during our visit so we were not able to speak to people who were being assessed.

Summary of findings

Good practice

- There was effective inter agency working between the acute wards and the crisis teams to promote patient flow and facilitate discharge from hospital. This was principally through the daily 'report out' meetings on each ward where each patient was discussed using a visual display board looking at current care, risk factors and tasks set for staff for the day, including active involvement form the crisis teams to facilitate early discharge. This was proving effective in ensuring delayed discharges were minimised.
- The street triage teams were effective in diverting people from being brought in under police powers (section 136) and ensure, where appropriate, people received appropriate mental health care.
- The street triage team captured people's feedback instantly through using tablet devices.
- There were examples of outstanding crisis intervention care plans and risk assessments with very comprehensive and holistic information.
- Crisis staff supported people to access planned short term admissions to mental health in-patient services for up to 72 hours where this met people's needs for example for people with borderline personality disorder.
- There were excellent examples of some crisis teams encouraging advance directives to help people determine their future crisis care needs.
- A clear assessment and comprehensive physical health check was undertaken, usually by a paramedic, on arrival to the health based place of safety.
- Initiatives such as the retreat which allowed staff two days off off from clinical duties to learn basic meditation techniques and experience other relaxation techniques.
- Morale was very good. Universally staff were complimentary about the support and involvement of their line manager, more senior line managers and the chief executive.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust's crisis teams should consistently evidence patient involvement in their intervention plan and ensure people receive a copy of their intervention plan.
- The trust should ensure conditions of CTOs provide clarity about the lack of compulsion for treatment for mental disorder whilst people are in the community.

Tees, Esk and Wear Valleys 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
Crisis resolution and home treatment service - Scarborough, Whitby, Ryedale	Trust Headquarters
Scarborough street triage team	Trust Headquarters
Crisis resolution and home treatment service - Hambleton and Richmondshire	Trust Headquarters
Intensive home treatment service - Harrogate and Craven	Trust Headquarters
Health based place of safety - Scarborough	Trust Headquarters
Health based place of safety - Northallerton	Trust Headquarters
Crisis resolution and intensive home treatment service - South Durham and Darlington	Trust Headquarters
Health based place of safety - Durham	Trust Headquarters
Crisis resolution and home treatment service - Hartlepool	Trust Headquarters
Health based place of safety - Darlington at West Park	Trust Headquarters
Crisis resolution and intensive home treatment team - Redcar and Cleveland	Trust Headquarters

Detailed findings

Health based place of safety - Middlesborough and Cleveland at Roseberry Park	Trust Headquarters
Crisis resolution and intensive home treatment service - Redcar and Cleveland	Trust Headquarters
Street triage team - Middlesborough and Cleveland at Roseberry Park	Trust Headquarters

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.

The crisis and home treatment teams had approved mental health professionals (AMHP) integrated within the teams. This meant that when a person required a Mental Health Act assessment, an AMHP was available to arrange assessments within reasonable timescales. AMHPs we spoke with identified difficulties and delays in getting assessing (section 12) doctors to medically assess patients.

Staff had a good understanding of the duties placed on them when people were brought in on a section 136 to ensure they worked within the Mental Health Act (MHA), the Code of Practice and the guiding principles. Records showed that people had their rights under the MHA explained to them on admission to the heath based place of safety and these were repeated until patients understood their rights.

We reviewed a small sample of records relating to the care and treatment of patients subject to community treatment orders (CTOs) under the Mental Health Act. We found the service adhered to the Mental Health Act Code of Practice in relation to community treatment orders in most cases. We found that on occasions the conditions of the community treatment order stated that the patient must accept treatment when community patients cannot be compelled to take treatment in the community.

Mental Capacity Act and Deprivation of Liberty Safeguards

Overall we found that services were compliant with the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

People using the crisis teams lived in the community and therefore had a high degree of autonomy and independence to determine aspects of their daily lives.

Staff took practical steps to enable patients to make decisions about their care and treatment wherever possible. Staff understood the process to follow should they have had to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the MCA.

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

The crisis services/health based places of safety were judged as good in the safe domain because:

- crisis teams had safe staffing levels with manageable caseloads which helped keep people safe
- individual risks were assessed and managed. Risk assessments were comprehensive and recorded within electronic records with summary risk assessments.
- the physical space of four of the health based places of safety provided safe environments to assess people; the HBPoS at West Park Hospital was more limited but adequate. The environments of the health based places of safety provided safe care with full consideration of ligature risks.
- effective safeguarding arrangements were in place with proper consideration of adult and children's safeguarding.
- actions from incidents and patient alerts were regularly discussed in team meetings to ensure lessons were learnt.
- staff were managing medicines following appropriate guidance for the safe administration and management of medicines under patient group directions (PGD).

Our findings

Crisis resolution and home treatment service - Scarborough, Whitby, Ryedale

Street triage team - Scarborough

Crisis resolution and home treatment service - Hambleton and Richmondshire

Intensive home treatment service - Harrogate and Craven

Crisis resolution and intensive home treatment service - South Durham and Darlington

Crisis resolution and home treatment service - Hartlepool

Crisis resolution and intensive home treatment service- Redcar and Cleveland

Street triage team - Middlesborough and Cleveland at Roseberry Park

SAFE

Safe environment

Most of the crisis teams' work was done through visiting people in their own homes to provide an assessment and ongoing care and treatment to support people in mental health crisis. Where there were concerns about risks to staff, staff would visit in pairs or arrange to see patients in safer alternative venues. In these cases, people were offered interview rooms within the trust's hospitals (as most teams were located in offices next to in-patient wards), at other venues such as GP practices or the emergency department of the local general hospital. Interview rooms available to be used by the crisis teams within the trust's hospitals were clean, well maintained and safe environments. Staff were able to raise an alarm if they felt unsafe in interview rooms through an in-built alarm system.

Safe staffing

We spoke with the managers within the teams who organised the staff rota about staffing levels. We observed levels of staffing and skill mix and saw that there were appropriate staff on duty to meet the needs of people

accessing the crisis services The out of hours crisis function was managed through a duty system which was co-ordinated between the crisis teams. Staff we spoke with told us there were sufficient numbers of staff to deliver the care and support which people needed overall.

Crisis staff reported manageable caseloads which helped keep people safe. Staff were able to work within targets such as ensuring people were seen or offered an assessment of 4 hours of the referral being made.

There was no use of agency staff within the teams due to the specialist nature of the role. Sickness was reported as low within the crisis teams. Where sickness and short term absences needed to be covered, staff were available to provide overtime using a bank system. Although there were a small number of vacancies in some teams, action had been taken to recruit into these posts. The Intensive Home Treatment Service at Harrogate and Craven was recruiting additional nursing posts as part of the additional responsibilities soon to be taken on by this team when the the new health based place of safety is completed at Harrogate.

Each team had a dedicated consultant who was based within the crisis teams which meant that patients had rapid access to a psychiatrist when required.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.

Assessing and managing risk to patients and staff

Staff undertook risk assessment of patients at initial triage/ assessment and updated this regularly. Individual risks were assessed and managed on an ongoing basis. Risk assessments were comprehensive and recorded within electronic records with summary risk assessments used for an overview which could be referred to more quickly. Staff explored the risk of suicidal ideation and ensured that people were kept safe through increasing contact or arranging admission to hospital. Most crisis teams had an approved mental health professional within the team which helped ensure timely Mental Health Act assessments occurred either directly or through the duty system. AMHPs embedded within crisis services also aided the team's understanding of how staff could manage significant risks using legal powers to bring people into hospital compulsorily if needed.

People referred into the crisis services were usually seen within 4 hours of the initial referral. When taking a referral into the service, for example from a GP, staff checked whether people needed to be seen immeadiately. Where a person refused to be seen within the allotted 4 hour time frame, staff made alternative arrangements and checked whether people could be kept safe until they could be seen. None of the teams had a waiting list for crisis services. Crisis staff worked closely with people on the adult acute wards to provide intensive home treatment and early discharge.

Effective safeguarding arrangements were in place with proper consideration of adult and children's safeguarding. Staff were trained in safeguarding and knew how to make a safeguarding alert and do this when appropriate. Staff had a good understanding of safeguarding issues and any active safeguarding issues were flagged in patients' electronic notes and on the whiteboards in the office so staff were aware of these. Clear information about reporting safeguarding issues was displayed in office areas where staff were based. Safeguarding procedures were available on the trust intranet. The safeguarding leads for the trust visited each team at least twice a year to discuss safeguarding cases and raise the profile of safeguarding issues.

Staff recorded their whereabouts on the team noticeboard including their expected time of return. Teams had a code word so that people could alert and receive assistance in a urgent situations. Each team had a shift co-ordinator who ensured staff were safe including staff returning to the office or rang in following a home visit. Staff in the street triage teams were kept safe as their whereabouts were also monitored by the police control room and emergency police response was available via police radios. This meant that there were good personal safety protocols in place including lone working practices.

There were good medicines management practice. The crisis teams held a small amount of stock medication to provide treatment to people in a crisis. Staff were managing these medicines following appropriate guidance for the safe administration and management of medicines under patient group directions (PGDs). 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. Medicines were locked away appropriately. There was evidence of

checks and audit of stock medications and PGDs. We highlighted that cupboard for the storage of PGD medication at West Park Hospital could be imporved to provide more secure storage.

Track record on safety

There were no reported serious incidents categorised as severe that involved the death of patients receiving services of the community teams for the period 1 December 2013 to 30 November 2014.

There had been no incidents reported of serious harm involving the crisis teams since new regulations on duty of candour came in to force. These regulations ensure staff are open and transparent and explain to people if and when something goes wrong. Staff had a general awareness of the duty of candour requirements.

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 team managers and senior managers to review and grade the severity of incidents. Staff were aware of how to complete an 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. For example, we saw discussions and performance improvement requirements on one worker's supervision records following one serious incident. Staff within the street triage team in Scarborough talked about an apparent suicide incident which occurred with the person having been seen by street triage workers shortly before the incident. The risk assessments identified there had been discussions on suicidal ideation; staff were able to articulate their rationale for their assessments and showed they were able to work as reflective practitioners. Staff were receiving support to prepare reports for the inquest in this case. Staff were de-briefed and supported after a serious incident. Actions from incidents and patient alerts were regularly discussed in team meetings and at individual supervision to ensure lessons were learnt.

Health based places of safety:

Health based place of safety - Durham

Health based place of safety - Scarborough

Health based place of safety - Middlesborough

Health based place of safety - Darlington at West Park

Health based place of safety - Northallerton

Safe environment

The health based places of safety (HBPoS) across the trust provided a safe and a suitable environment for the assessment of patients detained under section 136 of the Mental Health Act 1983. The physical space of four of the health based places of safety provided good environments to assess people. The environments of the health based places of safety provided safe care with full consideration of ligature risks. he units consisted of a separate entrance leading to a small waiting area. There was an assessment room with a reclining chair. There was a separate toilet and shower . There was attention to providing a safe environment with all fixtures and fittings anti-ligature and heavy furniture to prevent these being thrown. The layout enabled staff to observe all areas at all times with curved mirrors to ensure there were no blind spots where necessary. The physical space of the HBPoS at West Park Hospital was more limited but adequate with limited space within the assessment room. The units were clean and well maintained with all of the furniture in good condition and well maintained.

Emergency equipment, including automated external defibrillators and oxygen, was in place and checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices and emergency medication were also checked regularly. Most staff had undertaken training in life support techniques.

There were alarms available in the units to summon additional staff if required from adjacent acute wards . Staff said that when the alarm was used staff responded very quickly. There had been no serious incidents.

Safe staffing

The health based places of safety were staffed by the crisis team as and when people were brought to the unit. The shift co-ordinator within the crisis teams ensured that appropriate staff were allocated to facilitate the assessments. 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. Provided there were two trust staff were in attendance and there were no significant risks indicated, then police were able to leave people within the health based place of safety for the assessment

Good

Are services safe?

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

to be carried out. Feedback from AMHPS and from the police indicated that the arrangements for staffing the units generally worked well. There was appropriate medical cover available from the trust to ensure that a timely response was available to people requiring assessment within the units.

Assessing and managing risk to patients and staff

The designated nurse would receive the detained patient and a process was in place for an approved mental health professional (AMHP) to be contacted regarding co-ordinating a MHA assessment. At the health based place of safety, a joint risk assessment by staff from the crisis teams and the police was completed for all people admitted. Throughout the detention period effective systems were in place to assess and monitor risks to individual patients to determine whether the police officer would be required to remain at the place of safety to provide support.

We saw completed mental and physical health assessments in all of the records that we reviewed. These included risk profiles completed with the police. When risk assessments had been conducted for patients and the risks were assessed as too high the police would either stay or the individual would be transferred to the police custody suite. As part of the locally agreed protocol police undertook a body search on all people before their arrival.

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

Regular multi-agency meetings were well established to oversee the operation of section 136 and the use of the health based places of safety. The analysis of incident data and areas for improvement were routinely discussed in these monitoring meetings. There were very occasional uses of police tasers when people were in the health based places of safety and these incidents had been discussed.

Staff we spoke with knew how to recognise and report incidents on the trust's electronic incident recording system. All incidents were reviewed by the crisis team managers and forwarded to the clinical governance team for the trust who maintained oversight. The system ensured senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these.

Staff and people using the service were provided with support and time to talk about the impact of serious incidents .

Are services effective?

Outstanding ☆

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

Summary of findings

The crisis services/health based places of safety were judged as outstanding in the effective domain because:

- There was very good multidisciplinary working in most crisis teams. Crisis teams worked effectively with the acute wards to holistically plan people's transition between services through involvement with daily report out and huddle meetings.
- Care and intervention plans were of a good standard with some outstanding comprehensive assessments and interventions.
- There was good evidence based practice including suicide prevention and compliance with various NICE guidelines such as the treatment of people with schizophrenia.
- There were very good systems in place for ensuring the hospitals' duties under section 136 were met, including ensuring that patients were informed of their rights whilst in the health based place of safety.
- Staff understood the issues of mental capacity and consent. Some teams encouraged advance directives to help people determine their future crisis care needs.
- The two street triage teams were effective during their hours of operation in reducing people being brought in under police powers under section 136 and improving police response to people in mental distress overall.
- Crisis staff supported people to access planned short term admissions planned for upto 72 hours where this met people's needs for example people with borderline personality disorder.
- A clear assessment and physical health check was undertaken, usually by a paramedic, when patients' arrived into the health based place of safety and any ongoing physical health problems were followed up appropriately.

There was a commitment to multiagency working to improve the arrangements for conveyance and assessment when people were brought in under section 136. Where delays occurred these were beyond the full control of the trust including availability of assessing doctors and the response of AMHPs. People continued to received physical health checks from their GP or community mental health checks for basic physical health checks. In some cases this led to slight delays in people being administered medication for the first time until the necessary checks had been carried out.

Our findings

Crisis resolution and home treatment service - Scarborough, Whitby, Ryedale

Street triage team - Scarborough

Crisis resolution and home treatment service - Hambleton and Richmondshire

Intensive home treatment service - Harrogate and Craven

Crisis resolution and intensive home treatment service - South Durham and Darlington

Crisis resolution and home treatment service - Hartlepool

Crisis resolution and intensive home treatment service- Redcar and Cleveland

Street triage team - Middlesborough and Cleveland at Roseberry Park

Assessment of needs and planning of care

We looked at thirty care records of people receiving crisis services; records were electronically stored. People had an appropriate crisis assessment completed as part of the assessment process. This included a risk assessment, people's social, cultural, physical and psychological needs and preferences. A crisis intevention 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 knowledge of current, evidence-based practice. Care and intervention plans recorded were of a good standard overall with some outstanding comprehensive assessments and intervention records.

Crisis intervention plans were solution focused. There was clear evidence of appropriate referral to other services such as other community teams, inpatient admission or

Are services effective?

Outstanding ☆

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.

discharge to primary care based on patient needs. Assessments of people focused on people's strengths, self-awareness, and support systems in line with recovery approaches.

Best practice in treatment and care

We found evidence which demonstrated the teams had implemented best practice guidance within their clinical practice. For example staff were following guidance on suicide prevention and integrated best practice into their risk assessments. Crisis staff enabled people to access short term admissions planned for upto 72 hours where this met people's needs for example people with borderline personality disorder. Crisis teams offered a range of short term interventions including solution focused therapy, family therapy, dialectical behavioural therapy and cognitive behavioural therapy.

People's physical health needs were considered alongside their mental health needs. This included monitoring symptoms, alerting the general practitioner or encouraging or making referrals to the appropriate health care professionals. People continued to received physical health checks from their GP or community mental health checks for basic physical health checks. In some cases this led to slight delays in people being administered medication for the first time until the necessary checks had been carried out.

Staff we spoke with were able to describe specific interventions they used to assist people with managing people's crises and distress such as anxiety management, psychological interventions, medication and relapse prevention work. The teams also provided a range of activities and therapeutic interventions to people to support their recovery including through support workers who assisted people with practical issues.

Some teams were progressing with accreditation of their service through the Royal College of Psychiatrist's home treatment accreditation scheme which aims to work with teams to assure and improve the quality of crisis resolution and home treatment services.

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 crisis teams generally included community mental health nurses, support workers, social workers, approved mental health professionals (AMHPs), occupational therapists, administrative support, consultant psychiatrists and more junior doctors including speciality doctors and higher trainees.

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 a small number of gaps in uptake of mandatory and specialist training with some mandatory training falling slightly below the expected 95% target.

Staff received regular clinical and managerial supervision. Staff told us that they found these sessions valuable and that they discussed complex or challenging clinical issues within these sessions to explore ways to improve the service they provided to people. Staff were knowledgable and committed to providing high quality and responsive crisis care.

Multi-disciplinary and inter-agency team work

There was good multi-disciplinary team (MDT) working with visible and active consultant psychiatrist input within the teams. Teams worked using an integrated health and social care model. Crisis teams consisted of nurses, social workers and support time recovery workers.

The teams had daily MDT meetings to review people who used the service. Medical staff were supportive and responsive, going out at their request to undertake joint assessments when concerns had been raised.

The teams had established positive working relationships with a range of other service providers such as the inpatient wards, general practitioners, and local services. The crisis teams had effective working with the acute wards to holistically plan people's transition between services through involvement with daily report out and huddle meetings. Crisis teams across Durham and Darlington worked closely with the trust's crisis house provided for people in these areas which offered short-term

Are services effective?

Outstanding ☆

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.

accommodation for people experiencing a mental health crisis. People could access the service for a maximum of seven nights, with non-nursing staff providing 24 hour emotional and practical support to assist people to resolve their crisis. Inspector colleagues visited the crisis house and saw effective inter team working between the crisis house and crisis teams. Mental health professionals from two crisis teams visited the crisis house daily, including weekends and holidays.

We saw that the crisis support teams provided staff at the service with information and professional input to ensure people's individual needs were met and to enable crisis house staff to keep people safe.

The trust worked closely with the local relevant police forces. The street triage team (STT) in Middlesborough and Scarborough worked closely with police to divert people who have had contact with the police to appropriate mental health services and reduce the need for people to be admitted under compulsory police powers (section 136) into the health based place of safety suite. The service they provided had a direct impact on reducing admissions into police custody and health based places of safety.

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. The crisis teams had approved mental health professionals (AMHPs) integrated within the teams. This meant that when a person required a Mental Health Act assessment, it could usually be arranged within reasonable timescales.

We reviewed a small sample of records relating to the care and treatment of patients subject to community treatment orders (CTOs) under the Mental Health Act. We found the trust adhered to the Mental Health Act Code of Practice in relation to community treatment orders in most cases. This included ensuring people were informed of their rights when on a CTO and systems to ensure that renewal of CTOs were considered at appropriate intervals. We found that on occasions the conditions of the community treatment order was worded that went beyond the scope of the CTO or could not be adhered to. For example we saw examples to infer that the patient must comply or accept treatment when community patients cannot be compelled to take treatment in the community.

Good practice in applying the MCA

Overall we found that services were compliant with the requirements of the Mental Capacity Act (MCA) 2005.

People using the community mental health services lived in the community and therefore had a high degree of autonomy and independence to determine aspects of their daily lives. Staff took practicable steps to enable patients to make decisions about their care and treatment wherever possible. There was good understanding of mental capacity and consent issues with some teams encouraging very comprehensive advance directives to help people determine their future crisis care needs. For example, one person told us that they were given information on advance statements and as a result drew up their own statement to help inform how they would like to be cared for in particular circumstances and this had been followed during a recent crisis episode.

Staff understood the process to follow should they have to make a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions, in accordance with the MCA.

Health based places of safety:

Health based place of safety - Durham

Health based place of safety - Scarborough

Health based place of safety - Middlesborough

Health based place of safety - Darlington at West Park

Health based place of safety - Northallerton

Assessment of needs and planning of care

Comprehensive assessments were completed in a timely manner. A clear assessment and physical health check was undertaken when people were brought in under police powers on a section 136. Physical health checks were usually undertaken through arrangements between the trust and the ambulance service. In most cases it was carried out by a paramedic who conveyed the person to the health based place of safety. This meant that people had baseline physical assessments before being admitted to the health based place of safety; it also helped to ensure people did not have any significant health problems and any ongoing physical health problems were followed up appropriately.

Are services effective?

Outstanding ☆

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.

Records relating to the section 136 episodes were stored securely and available to staff when they needed to. Care records contained up to date, personalised, holistic assessments. This included an overview report produced in paper format and details kept in the electronic records of any decision to admit people to hospital or for further follow up. This meant that information was readily available so staff could check any decisions made and also helped audit the use of section 136 and the use of the health based place of safety.

Best practice in treatment and care

People assessed in the health based place of safety were provided with an information pack explaining the powers and responsibilities under section 136. This ensured that people understand where they were, what the assessment process was and an explanation of their rights.

The trust had a separate protocol for children and younger people and liaison with the CAMHS service which included assessment by the on-call CAMHS consultant. There were similar arrangements for assessments to be carried out by the on-call learning disability consultant psychiatrist for people initially identified as having learning disabilities.

The trust had street triage teams in two localities. Street triage workers accompanied police officers to incidents where police believed people needed immediate mental health support. The aim of these teams were that people got the medical attention or professional input quickly whilst also diverting people from inappropriate police custody or section 136 assessments.

When we visited in December 2013 as part of a MHA monitoring visit, statistics showed that 294 people were seen by the street triage service at Roseberry Park between January and September 2014, of which only 3 people were subsequently brought in to the health based place of safety on a section 136 suite. There were 305 assessments in the Scarborough street triage team between April 2014 and January 2015 of which 17 led to using section 136. The representative of Cleveland Police told us that before the street triage service was available all 294 referrals would have probably have been taken to the place of safety under police powers.

An evaluation completed by a Northumbria University identified that when street triage was operational it provided an effective and responsive service. This showed that the street triage teams were proving to be effective during their hours of operation in reducing police being brought in under police powers under section 136 and improving police response to people in mental distress overall.

Skilled staff to deliver care

Qualified staff from the crisis teams usually undertook the co-ordination of admissions to the health based place of safety suites, operating as the section 136 coordinator.

The health based places of safety were next to the acute wards or the psychiatric intensive care units; so staff from these units could be called to assist where necessary. The crisis team at Harrogate was recruiting additional staff in part to ensure there was appropriate staffing levels to deliver the co-ordination of the health based place of safety facility being developed at that locality. There was guidance available to staff that included a checklist of action to be completed.

Where there were issues of delays, these usually were beyond the full control of the trust because they related to the availability of assessing doctors and response times of AMHPs.

Multi-disciplinary and inter-agency team work

There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act. This policy and procedure has been jointly agreed by relevant local authorities, police forces and ambulance Service which worked across the trust's geographical footprint. There was a commitment to multiagency working to improve the arrangements for conveyance and assessment when people were brought in under section 136.

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

There were local arrangements in place to ensure proper risk assessment before decisions were jointly made about the police officers leaving people and therefore passing responsibility for ensuring the assessment was completed wholly to trust staff. On the rare occasions when people needed to be transferred between health based places of safety, the rationale was recorded and checks made to ensure the 72 hour limit was not breached.

Are services effective?

Outstanding ☆

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

Staff described good working relationships between partner agencies as did the approved mental health professionals (AMHP) who felt that staff working in the health based places of safety were effective and efficient at making referrals and communicating information which helped to ensure timely assessments and minimise delays.

Adherence to the MHA and the MHA Code of Practice

Staff had a good understanding of the duties placed on them when people were brought in on a section 136 to ensure they worked within the Mental Health Act (MHA), the Code of Practice and the guiding principles.

Proformas reminded staff that consent to treatment rules for treatment for mental disorder meant that treatment could not be given to people whilst on a section 136 unless they agreed to it. Records showed that people had their rights under the MHA explained to them on admission to the heath based place of safety and these were repeated until patients understood their rights.

Information on Advocacy and Independent Mental Health Advocacy Services (IMHA) services were available to people. It wasn't always clear that people were routinely being provided with information on their right to legal support whilst under police powers.

Good practice in applying the Mental Capacity Act (MCA)

Staff were aware of the Mental Capacity Act 2005 and the implications this had for their clinical and professional practice. Most staff had received refresher training on this Act.

There was evidence in records that mental capacity issues relating to the assessment process and any decisions following the assessment were being reviewed. These assessments routinely took place by the AMHP to decide if the patient had capacity to consent to admission to hospital informally or whether powers under the Mental Health Act needed to be used. One person we spoke with told us how both the police and trust staff followed an advance directive where the person had determined their preferred crisis response.

Good

Are services caring?

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

Summary of findings

The crisis services/health based places of safety were judged as good in the caring domain because:

- There were positive comments from people we spoke with about their experience of receiving care from crisis teams
- Staff provided good respectful care in all the interactions we saw.
- Care interventions were holistic and looked at social, family, employment and financial issues to help alleviate crisis.
- People were involved in identifying their crisis support needs. People were asked if they would recommend the service to others including innovative use of tablet computers to provide feedback on the street triage service.

In some teams it was not always clear that patients were given copies of their intervention plans. The involvement of people using the service in shaping the service was more limited. Feedback from people who had experienced the health based place of safety was not routinely requested.

Our findings

Crisis resolution and home treatment service - Scarborough, Whitby, Ryedale

Street triage team - Scarborough

Crisis resolution and home treatment service - Hambleton and Richmondshire

Intensive home treatment service - Harrogate and Craven

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Crisis resolution and home treatment service - Hartlepool

Crisis resolution and intensive home treatment service- Redcar and Cleveland

Street triage team - Middlesborough and Cleveland at Roseberry Park

Kindness, dignity, respect and compassion

Due to the nature of the service, we were only able to speak to nine patients during our inspection. We observed positive interactions between community staff and people who used the service during home visits with people giving complimentary statements about the care they received.

People had an opportunity to comment on the services they received on comment cards prior to the inspection. We received one comment card from a person receiving support from within crisis services. The card commented favourably on one particular crisis service with staff being helpful and friendly, staff treated patients with dignity and respect and appointments were easy to make and choices given.

We saw in some teams a number of compliments made by patients into the standard of care people received.

We carry out an annual survey of community mental health patients by sending a questionnaire to patients receiving community mental health services in the trust. There were no significant issues of concern from the last survey in 2014. The trust was performing about the same in all major areas of questioning. The survey confirmed that most people surveyed knew about their crisis care plan . Results of the survey also confirmed that those who had contacted crisis services, the majority of people received the help they needed.

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 and to prevent the need for the person to be admitted into hospital. Staff provided a range of flexible support to people dependent on their needs. This included telephone contact and face to face visits with people in their own homes or at the community mental health teams during the daytime.

Care plans were written and reviewed, where possible, with the involvement of the person. Family, friends and advocates were involved as appropriate and according to the person's wishes. People 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

Good

Are services caring?

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

wishes. Records showed that people had received ongoing review of their crisis interventions. People were involved in identifying their crisis support needs. In some teams it was not always clear that patients were given copies of their intervention plans.

We observed a small number of clinical meetings between staff and people using the services of the crisis teams. Consultations were carried out in a participative manner with people given time to reflect on their experiences, progress and recovery.

There was evidence of involvement when the community services were reorganised. The ongoing and current involvement of people using the service in shaping the service were more limited. People were asked if they would recommend the service to others including innovative use of tablet computers to provide feedback on the street triage service Feedback from people who had experienced the health based place of safety was not routinely requested.

Health based places of safety:

Health based place of safety - Durham

Health based place of safety - Scarborough

Health based place of safety - Middlesbrough

Health based place of safety - Darlington at West Park

Health based place of safety - Northallerton

Kindness, dignity, respect and compassion

Staff working in the health based places of safety explained how they managed and supported the people being assessed in what were often confusing and distressing circumstances. Staff showed that they understood underpinning principles of providing dignified, respectful and compassionate care.

Staff explained how they attempted to calm people and begin to build a therapeutic relationship with people to fully support and assess people. We were unable to speak to anyone who had direct experience of using the health based place of safety. However on a recent MHA monitoring visit held in December 2014 to look at admission and assessment under the MHA, groups of users and carers were largely positive about their experiences of admission to hospital.

The involvement of people in the care they receive

Patients' rights whilst detained were routinely explained to them. There was access to information in different accessible formats. Interpreting and advocacy services were also available if necessary. People in the street triage team were asked if they would recommend the service to others including innovative use of tablet computers to provide instant feedback on the service. This showed positive experiences and comments from people.

Feedback from people who had experienced the health based place of safety was not routinely requested.

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

The crisis services/health based places of safety were judged as good in the responsive domain because:

- Staff within the crisis teams worked very well with the adult acute mental health wards to prevent inappropriate admission to inpatient beds. Crisis staff ensured people did not stay in hospital longer than necessary and promoted early discharge.
- People were usually seen within 4 hours for a face to face assessment when referred into the crisis service and very quickly in the street triage during the hours of duty.
- Staff were flexible to meet people's individual needs.
- People within the health based placed of safety were seen quickly. When there were delays they usually related to the availability of assessing doctors (section 12 doctors) or approved mental health professionals external to the trust.
- Information on a range of support organisations was available for patients to access and look at other means of support.
- People were made aware of the complaints policy. When complaints were raised these were responded to appropriately. Comments about one team's attitude made on NHS choices website had been responded to appropriately.

Informal complaints were not always collated at team level.

Our findings

Crisis resolution and home treatment service - Scarborough, Whitby, Ryedale

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Crisis resolution and home treatment service - Hartlepool

Crisis resolution and intensive home treatment service- Redcar and Cleveland

Street triage team - Middlesborough and Cleveland at Roseberry Park

Access, discharge and bed management

The service had a system in place which ensured that all new referrals were made through the access and assessment teams within the CMHTs. The crisis teams reviewed each new referral based upon the information they received and assessed and what further support and referral to other services was required.

Staff used a risk rating system to triage each referral made to the team. All referrals were usually seen within 4 hours. People were contacted by telephone on the day of referral and then an appointment was offered as soon as possible. There was a shift co-ordinator at each team who could ensure that people phoning into the crisis service could speak with a member of the team promptly and they would co-ordinate a visit or assessment quickly if a person needed this. Calls were answered promptly during our visit. This meant that the crisis teams were able to respond promptly to people in mental health crisis and ensure people received support when their mental health was deteriorating. People were seen very quickly in the street triage during their hours of duty.

The service was operated by staff on a locality basis at night . If people were in crisis, they were triaged to see whether they required a Mental Health Act assessment.

Good

Are services responsive to people's needs?

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

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 teams accepted referrals from a range of sources including self-referrals from people or their carers, GPs, the inpatient wards and between the different functions of the CMHTs.

The teams visited people in their own home or at the access and recovery 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 crisis teams were the gatekeepers for inpatient beds. Staff told us they sometimes had problems accessing beds for patients within their own locality when an inpatient admission was needed. This meant that on occasions people were admitted and treated in a different part of the trust.

The wards started to consider discharge arrangements as soon as people were admitted. This ensured people were only in hospital for the shortest possible time and ward staff looked at defining an indicative discharge date which was kept under regular review. The community teams had regular 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.

Community mental health teams had a philosophy which was based upon the principles of the recovery model. This meant that the teams focussed on assisting patients to remain within the community and avoid admission to hospital where possible. The home treatment function of the crisis and home treatment teams also facilitated the early discharge of some patients from hospital by offering them intensive support during the transition from hospital to the community to reduce the risk of them relapsing whilst promoting their recovery. This meant that crisis staff ensured people did not stay in hospital longer than necessary and promoted patients' early discharge.

A service which optimises recovery, dignity and confidentiality

Staff were committed to providing care to people which promoted people's privacy and dignity.

Care focused on people's holistic needs and not just on treating their mental distress or illness. For example care plans recorded and reviews observed, showed staff supporting people to consider issues of money and benefits, family issues, changes in life events and vocational and educational opportunities.

We observed staff assessing and providing crisis care to people and saw people were treated with dignity and respect on all the interactions.

Meeting the needs of all people who use the service

The staff within the crisis team had access to interpreting services which provided face to face and telephone interpreting services. 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 individual, cultural and religious beliefs were taken into account and respected as demonstrated by the content of the care plans and observation at clinical meetings.

Learning from concerns and complaints

We saw that complaints were well managed. The teams were proactive in their approach to gaining feedback from people who used the service.

People knew how to raise concerns and were given written information about making complaints. One community mental health team had slightly higher number of comments on NHS choices. We looked at the complaints in this service and saw that these complaints had been investigated appropriately. The complaints within each service were looked into and responded to. Where complaints were not upheld, managers would still look at what could be learned or improved.

Complaints and concerns which people had raised were discussed at the service meetings. We found evidence to show that managers had taken timely action in response to complaints which they had received. During a home visit, a consultant psychiatrist gave an apology to one person who expressed some dissatisfaction in relation to miscommunication by one particular crisis team. Complaints were therefore well managed.

Good

Are services responsive to people's needs?

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

Health based places of safety:

Health based place of safety - Durham

Health based place of safety - Scarborough

Health based place of safety - Middlesbrough

Health based place of safety - Darlington at West Park

Health based place of safety - Northallerton

Access, discharge and transfer

The trust had street triage teams in two localities. Street triage workers accompanied police officers to incidents where police believed people neededimmediate mental health support. The Scarborough triage team consisted of a level 6 mental health nurse and a support worker from 10.30 am to 10.30pm 7 days a week; the Middlesbrough triage team consisted of a level 6 mental health nurse and a support worker from 12 noon to 12 midnight 7 days a week. The teams generally dealt with between 3 and 4 incidents a day.

The development of the health based places of safety and joint working arrangements with the police forces reduced the numbers of people being assessed in police cells. 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.

People within the health based placed of safety were seen quickly and where there were delays they usually related to the availability of assessing doctors (section 12 doctors) external to the trust or approved mental health professionals.

The facilities promote recovery, dignity and confidentiality

Assessment we saw had been completed in a timely manner and well within the 72 hours required by the MHA and code of practice. We did not identify any additional or arbitrary restrictions when people were placed in the health based place of safety.

The environments of all the health based places of safety provided a dignified environment for the assessment of people. There was a separate entrance for parking immediately outside for police to bring people directly into the units which helped maintain the safe and dignified conveyance of people. The units provided clean and comfortable areas to carry out assessments including separate toilet and shower areas, appropriate furniture and a fully reclining comfortable chair available so where there were delays in assessments patients could make themselves comfortable. There were separate staff areas for staff to meet and discuss the assessment. Some of the health based places of safety environments did appear clinical and in appearance with bare walls and no wall art giving a spartan appearance. The health based of place of safety at Hartlepool had been decommissioned because it did not provide a suitable environment.

The trust were aware of the possibility of there being more than one person requiring the facility at any given time. However this occurred on an infrequent basis. We were told that a second section 136 detainee would be conveyed to another suite within the trust. The development of the health based place of safety at Harrogate would assist in ensuring that people in that part of North Yorkshire could receive assessment closer to home. Where people were not admitted following initial assessment, staff confirmed that the trust would pay for a taxi to return the person home if no suitable trust transport was available.

Meeting the needs of all people who use the service

The joint agency policy explained how the needs of people detained on section 136 would be managed and the appropriateness of the relevant places of safety. This included circumstances when the police custody suites were more appropriate than the health based places of safety within the trust.

Where children and young people and people with learning difficulties were accepted for Section 136 assessments and that specialist consultant psychiatrists were made available to assess them.

Staff confirmed that they had access to translation services and interpreters where required. A range of patient information readily available for those people placed in the health based places of safety. Records showed that everyone was given a leaflet about the powers and responsibilities of Section 136 of the Act as well as a verbal explanation. This leaflet was available in large print and picture bank versions; leaflets in other languages could be made available by the MHA department.

Good

Are services responsive to people's needs?

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

Listening to and learning from concerns and complaints

Information about raising concerns and complaints was available to people who were assessed in the health based place of safety units.

During 2013 and 2014 there had been no complaints received from people detained under Section 136.

Are services well-led?

Good

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

Summary of findings

The crisis services/health based places of safety were judged as good in the well led domain because:

- Staff provided care and treatment in line with the trust's stated values.
- Staff morale was very good and universally staff were complimentary about the support and involvement of their line manager, more senior line managers and the chief executive.
- Managers had effective meetings on a daily basis to promote patient flows and ensure that patients received appropriate and timely services to meet their individual needs.
- Managers were committed to providing high quality services and services were audited to ensure good quality services.
- We judged the service as good or outstanding in other domains. We only found minor issues and where we found them we found managers and staff were usually aware of these and working to address these.
- There was a commitment to quality improvement . Developments included improved health based places of safety environments, improved staffing levels in crisis services, innovative street triage services in two localities and proposed developments of an urgent mental health care service to alleviate self presenting people at Roseberry Park and alleviate pressures at the neighbouring district general hospital.

Staff in some crisis and home treatment teams were working towards Royal College of Psychiatrists' accreditation and the street triage had been evaluated externally through academic research.

Our findings

Crisis resolution and home treatment service - Scarborough, Whitby, Ryedale

Street triage team - Scarborough

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Crisis resolution and home treatment service - Hartlepool

Crisis resolution and intensive home treatment service- Redcar and Cleveland

Street triage team - Middlesborough and Cleveland at Roseberry Park

Vision and values

Staff were aware of the trust's vision and values. Staff were motivated and dedicated to give the best care and treatment they could to patients in receipt of community mental health services.

Good governance

We found the services were well managed. Staff had clear roles and a management structure that was understood by staff. We judged the service as good or outstanding in other domains. We only found minor issues and where we found them we found managers and staff were usually aware of these and working to address these.

The trust had a good governance structure in place to oversee the running of the crisis teams. The trust's quality and assurance groups provide the locality management governance boards within the trust who were responsible for quality and assurance. Crisis team managers reported into these teams monthly. The quality and assurance committee was a subcommittee of the trust board who were responsible overall for quality and assurance of the trust services provided.

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 trust had a patient safety group that evaluated the incident/alert management systems. They operated to ensure the effectiveness of the controls systems provided and monitored the implementation of the patient safety framework.

Staff mostly reported they had been appraised and supervised by their line managers and that they were supported by them as well as by their peers.

Crisis services participated in the national audit of psychological therapies (NAPT) in adult mental health, the national audit of schizophrenia and monitoring of patients prescribed lithium.

Leadership, morale and staff engagement

Universally staff were complimentary about the support and involvement of their line manager, more senior managers and the chief executive. The chief executive had engaged with many of the crisis teams. Initiatives supported staff morale and wellbeing such as 'the retreat' which allowed staff two days off off from clinical duties to learn basic meditation techniques and experience other relaxation techniques.

Staff morale was good with staff showing clear commitment to providing quality care which responded to people's needs. Staff reported they were able to raise concerns without fear of victimization and were aware of the trust whistleblowing policy.

Staff told us they had opportunities and were encouraged to undertake further education to support them in their job roles as well as being encouraged to attend outside conferences. Managers told us there was support for new managers and they were available to undertake a management qualification.

Commitment to quality improvement and innovation

There was a commitment to quality improvement with improved staffing levels in crisis services, innovative street triage services in two localities and the proposed development of an open access crisis assessment suite which will operate 24 hours a day, 365 days a year to provide mental health assessment to individuals with urgent mental health needs. Key elements of this development were to ensure people can self present at any time and to alleviate the pressures on the local acute trusts by providing an urgent mental health care facility rather than people needing to attend A&E departments (where appropriate)

Staff in some crisis teams were working towards Royal College of Psychiatry peer review accreditation and the street triage had been evaluated externally through academic research.

Health based places of safety:

Health based place of safety - Durham

Health based place of safety - Scarborough

Health based place of safety - Middlesbrough

Health based place of safety - Darlington at West Park

Health based place of safety - Northallerton

Vision and values

There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act. This policy and procedure has been jointly agreed by the trust, local police forces and relevant NHS ambulance service. The duties of all agencies were identified and set out to ensure that people receive timely and effective assessment.

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

Good governance

There was appropriate audits of the use of section 136 and the use of health based places of safety which were overseen and discussed through the trust's locality interagency operational groups. Section 136 MHA reports were discussed which included quantitative data on the use of section 136 (for example, how long the police remain at the trusts' health based places of safety, and how long it takes for clinicians to attend and assess) and qualitative data such as the correlation between the activity of the street triage team and s.136s implemented by Cleveland police. 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.

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 environments of the health based places of safety had recently been upgraded in line with the trust's capital investment programme to ensure that clinical areas provided areas that afforded dignified care and were fit for purpose.

Leadership, morale and staff engagement

The health based places of safety do not have regular staff based there. The management of the units were shared between the ward managers of the crisis and home treatment teams linked to the health based places of safety. Staff told us that they felt well supported by their managers and peers and that senior managers were accessible, approachable and encouraged openness. Staff were broadly aware of new regulations regarding duty of candour and their role in the process for any future incidents where patients experienced harm.

Commitment to quality improvement and innovation

We saw that there were good systems in place to monitor the service in order to improve the performance. We saw that the locality interagency operational groups monitored the performance of the service quality. The group regularly reviewed performance indicators, such as four-hour wait times, the number of times Section 136 was used, liaised with the services involved in assessments and reviewed the effectiveness of the HBPoS. The environments of the health based places of safety met or exceeded the Royal College guidance on the health based places of safety environment.

The trust identified the high numbers of self presenters at Roseberry Park and people presenting with mental health issues at the adjacent acute trust. The trust were developing a service funded by winter pressures money to alleviate pressures within acute emergency departments to provide an urgent care area which included the health based place of safety which would be staffed with dedicated staff to facilitate improved patient experience and provide appropriate and timely mental health assessments.

The street triage teams had been evaluated by Northumbria University and shown to provide responsive and effective care during their hours of operation.