

Good


Northumberland, Tyne and Wear 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)
RX4Z3	Hopewood Park	Crisis Resolution and Home Treatment Initial Response Team - South of Tyne Street Triage - South of Tyne 136 Suite	SR2 0NB
RX442	Queen Elizabeth Hospital	Crisis Resolution and Home Treatment	NE10 9RW

Summary of findings

		136 Suite	
RX4E4	St Nicholas Hospital	Crisis Resolution and Home Treatment at Ravenswood Clinic 136 Suite	NE6 5TX
RX4E2	St George's Park	Crisis Resolution and Home Treatment 136 Suite	NE61 2NU

This report describes our judgement of the quality of care provided within this core service by Northumberland, Tyne and Wear 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 Northumberland, Tyne and Wear NHS Foundation Trust and these are brought together to inform our overall judgement of Northumberland, Tyne and Wear 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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Summary of findings

Overall summary

We rated mental health crisis services and health-based places of safety as good because:

- The service had effective systems to assess, monitor, and manage risks to people who used services. There was a clear pathway for people to access services including those people who referred themselves to the crisis teams.
- People who used services received care which focused on their needs and was based on recovery. Care records were of a high standard and most people who used services felt fully involved in their care planning.
- There was good inter-agency working with Northumbria police. The introduction of the street triage service had led to a significant reduction in the number of people detained under section 136 of the Mental Health Act.
- Staff provided kind and compassionate care and treated people who used services with dignity and respect.
- Staff provided support to carers and with consent included them in their relatives care.
- Staff received feedback from incidents and complaints. There were systems in place for learning and sharing from incidents and complaints to be cascaded.

- Overall compliance with mandatory training was good. Where areas were low managers had actions in place to improve.
- Staff were receiving supervision and had had an annual appraisal. Managers had taken steps to improve compliance with supervision. The steps taken had made a difference.

However:

- The service had an action plan with environmental improvements needed for two of the health based places of safety. There was not a date for completion of some of these required actions.
- There were conflicting reports from staff regarding how many staff should be available for police to hand over a detained person in the health based places of safety.
- There was not access to a full range of disciplines in the crisis teams. Staff told us they would like more access to psychology, occupational therapy and social work support.
- Some professionals reported delays in accessing services via the telephone response service.
- Staff removed medication from their original containers for people to use in their own homes which constituted secondary dispensing.

Summary of findings

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

Are services safe?

We rated safe as good because:

- People who used services received an assessment of risk at initial triage or assessment. Staff updated risk assessments regularly. Families and carers were involved in risk assessment where appropriate.
- Staff were clear about their responsibilities in reporting incidents. Learning from incidents and complaints took place.
- Staff were aware of their responsibilities in safeguarding adults and children and made appropriate referrals.
- Staff and people who used services had quick access to a psychiatrist when needed.
- Staffing levels were appropriate to ensure the service operated 24 hours a day 365 days a year. Systems were in place to fill any gaps due to vacancies or staff sickness.
- Health based places of safety were discreet, quiet and secure.
- Overall compliance with mandatory training was good.

However:

- Staff removed medications from their original container for people to use in their own homes which constituted secondary dispensing.
- Some health based places of safety had outstanding environmental actions.
- There were very few facilities and equipment to carry out physical examinations in the health based places of safety.
- There were conflicting reports from staff regarding how many staff should be available for police to hand over a detained person in the health based places of safety.
- Staff who co-ordinated the health based places of safety were not trained in intermediate life support.

Good



Are services effective?

We rated effective as good because:

- People who used services received a comprehensive assessment of their needs. Care records were up to date. Care plans were person centred, holistic and recovery focused.
- The service demonstrated excellent inter-agency working with the police. Since implementation of the street triage team there had been a significant reduction to the numbers of people detained under section 136 of the Mental Health Act.

Good



Summary of findings

- Staff demonstrated a good understanding of the Mental Capacity Act and assessment of capacity was documented in care records.
- People detained under section 136 of the Mental Health Act received their rights.
- Use of the health based places of safety was monitored including reviewing timescales of people detained.
- Staff received annual appraisals and regular supervision.

However:

- The crisis teams did not have dedicated sessional times from a full range of disciplines including psychology, occupational therapy. One team did have social workers embedded in the team.

Are services caring?

We rated caring as good because:

- We observed warm, caring, and respectful interaction between staff and people who used services.
- We received positive feedback from people who used services and their carers. We were told that staff treated them with dignity and respect.
- People who used services received a questionnaire so they could tell staff about their experiences. Staff used the feedback to identify areas for improvement.
- Staff we spoke to were passionate about their job. Some told us it was a privilege to work with people who used services.

However:

- The health based place of safety at St Nicholas Hospital lacked a private area for Mental Health Act assessments to take place.
- Blind spots and ligature points in the health based place of safety at St Nicholas Hospital and St George's Park meant staff had to keep nearby to observe people which could compromise a person's dignity.

Good



Are services responsive to people's needs?

We rated responsive as good because:

- The services provided a 24hour a day 365 days a year service and accepted direct referrals from service users.
- Staff were available to assess people who needed services immediately. There was no exclusion criteria so all people who needed services could access the teams.

Good



Summary of findings

- The service took a proactive approach to re-engage people who did not attend their appointments.
- People who used services received accessible information on treatment, services, rights and how to complain.

However:

- Some professionals had experienced delays when phoning into the service.

Are services well-led?

We rated well-led as good because:

- Staff felt supported by their managers and morale was high.
- Managers provided good leadership and were aware of the areas highlighted as needing improvement in the health based places of safety.
- Staff received annual appraisals and most had attended mandatory training.
- Efforts to improve compliance with staff supervision had been successful and staff were now receiving regular supervision.
- Key performance indicators were used to gauge the performance of the service.
- Each team maintained their own risk register and were able to escalate risks to the trust's corporate risk register.
- The service participated in a multi-agency group with organisations involved in the operation of section 136 (e.g. police, acute trust, ambulance provider, commissioners, local authority). There was good working relationships with those organisations.
- The trust was a signatory in an inter-agency policy which included all relevant information from the Mental Health Act code of practice.

Good



Summary of findings

Information about the service

Northumberland, Tyne and Wear NHS Foundation Trust have five crisis and home based treatment teams and four health based places of safety.

The health based places of safety are specially designed units where people who are arrested under Section 136 of the Mental Health Act can be taken to by Police to have their mental health assessed in a safe environment.

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 are in immediate need of care or control in the interests of that person or to protect other people. The arrest enables the police to remove the person to a place of safety to receive an assessment by mental health professionals. This would usually be in 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 custody suite instead.

Under section 136, people could be detained for a period of up to 72 hours so they can be examined by doctors and assessed by an approved mental health practitioner to consider whether compulsory admission to hospital is necessary.

Crisis resolution and home based treatment teams provide short-term work to support patients at home when in a mental health crisis. They provide care and treatment at home to prevent hospital admission and support patients with an earlier discharge from hospital.

The five crisis teams and four health based places of safety in the trust offer a 24 hour, seven day a week service which was available 365 days per year.

In addition to the crisis teams and health based places of safety, Northumberland, Tyne and Wear NHS Foundation Trust also provide an initial response service and a street triage service. The initial response service provides a 24 hour telephone single point of access service for the South of Tyne area. Street triage is a service for people who come into contact with Northumbria Police, outside of custody, where it is thought there is a mental health component to the police contact.

This was the first inspection of this core service using the new methodology. We visited four of the five crisis and home based treatment teams, all four health based places of safety, the street triage team for the South of Tyne area and the initial response team for the South of Tyne area.

Our inspection team

Our inspection team was led by:

Chair: Paul Lelliot, Deputy Chief Inspector (Lead for Mental Health), CQC

Head of Hospital Inspection: Jenny Wilkes, CQC

Team Leaders: Brian Cranna, Inspection Manager, mental health (hospital) services, CQC,

Jenny Jones, Inspection Manager, mental health (hospital) services, CQC,

Sandra Sutton, Inspection Manager, acute (hospital) services, CQC

The team for this core service consisted of one CQC inspector and three specialists: two mental health nurses and a social worker.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

To fully understand 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, asked a range of other organisations for information and sought feedback from patients and carers at focus groups.

During the inspection visit, the inspection team:

- visited four of the five crisis and home based treatment teams
- visited all four of the health based places of safety suites and observed the environment
- visited one street triage team

- visited one initial response team
- accompanied five home visits and observed how staff were caring for patients
- spoke with 11 patients who were using the service
- spoke with six carers
- spoke with the managers for each team
- spoke with 31 other staff members; including doctors, nurses and pharmacists
- interviewed the police liaison lead, the clinical police liaison lead and the locality manager
- spoke with one GP and three approved mental health practitioners
- attended and observed two multi-disciplinary meetings, a learning disabilities crisis management meeting and a lessons learnt meeting
- looked at 26 care records of people who used services
- carried out a specific check of the medication management in the crisis teams
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We spoke with 11 people who were using services. We also looked at feedback from the service user satisfaction questionnaires. Overall, we found people who used services were very positive with the service they received. Staff were described as respectful and genuinely interested in people. People told us they could access a member of staff quickly when they needed to. People were involved in decisions about their care and most people said they had a copy of their care plan.

The majority of people who used services tended to see the same staff for their appointments. Four people said

they had seen a number of different staff and this had been challenging at times. People told us that when they did see different members of staff, the staff member usually knew all about them and was up to date.

We talked to six carers and reviewed carer feedback from the carer's questionnaires. Carers were also very positive about the service and said they felt included in their relatives care. Carers told us the team was always there when they needed them and they received a quick response when they needed to contact them, even when family members had been discharged.

Some carers also told us that it was difficult at times when they had to see different members of staff.

Good practice

The trust's street triage team had been operational since September 2014 and worked collaboratively with Northumbria Police. The service was based on national and local drivers to reduce the numbers of avoidable

section 136 detentions. The service also aimed to improve the outcome for people who were detained and also for those people who were cared for in the community.

Summary of findings

Since implementation detention levels had reduced to approximately 10% of their pre-street triage levels. The trust demonstrated excellent inter-agency working with the police. Staff, police and other stakeholders spoke overwhelmingly positively about the service.

An academic paper in collaboration with Newcastle University was awaiting publication.

Areas for improvement

Action the provider **SHOULD** take to improve

- The trust should review the procedures for medicines supply to ensure secondary dispensing does not occur.
- The trust should review its mandatory training requirements for staff who co-ordinated the health based places of safety to ensure they were trained in intermediate life support.
- The trust should ensure its planned improvements to the health based places of safety at St George's Park and St Nicholas Hospital takes place.
- The trust should ensure that all staff are aware that a minimum of two staff would be available for police to hand over a detained person in the health based places of safety.

Northumberland, Tyne and Wear 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 Street Triage Team – South of Tyne Initial Response Team - South of Tyne 136 Suite	Hopewood Park
Crisis Resolution and Home Treatment 136 Suite	Tranwell Unit, Queen Elizabeth Hospital
Crisis Resolution and Home Treatment at Ravenswood Clinic 136 Suite	St Nicholas Hospital
Crisis Resolution and Home Treatment 136 Suite	St George's Park

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.

Detailed findings

The trust had a central Mental Health Act office where staff could seek support or clarify any issues or concerns. Staff in the health based places of safety understood their roles in relation to section 136 of the Mental Health Act and had a good understanding of the legislation.

When patients were admitted via section 136 they had their rights read to them upon arrival. If staff felt that patients did not fully understand, they would read their rights periodically over the duration of their stay.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was mandatory in the trust and across the service 94% of staff had attended training.

Staff were aware of the trust policy for the Mental Capacity Act and demonstrated a good understanding of the assessment of mental capacity. In 25 of the 26 records we reviewed we saw evidence of how staff assessed mental capacity.

People had access to independent mental capacity advocates to support them. Information about advocacy services was provided to patients via leaflets and on notice boards.

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

Our findings

Crisis and home based treatment team

Safe and clean environment

The crisis teams generally visited people who used services in their own homes for assessment and treatment. Where there were concerns about risks, or when people who used services chose not to be seen at home, staff arranged visits in team bases, GP surgeries or accident and emergency departments.

The teams had rooms on site which they occasionally used for appointments. Some of these rooms were fitted with call bells which meant staff could raise the alarm if they felt unsafe. Where call bells were not fitted, staff had access to portable alarms which when activated alerted nearby ward staff that there was an incident and staff would respond.

All areas accessed by people who used services were clean and well maintained. The trust's annual patient-led assessments of the care environment assessments for 2015 scored above the England national average of 97%. The Tranwell unit had scored 98%, Hopewood Park had scored 98%, St Georges Park had scored 99% and St Nicholas Hospital had scored 100%.

Most sites did not have a dedicated clinic room as people who used services were usually seen at home. A physical assessment bag contained portable equipment for conducting physical assessments on home visits.

Safe staffing

We spoke with team managers about their staffing establishment. Work streams had examined what was needed in each area in order to provide an accessible service. Each team had a team leader and a clinical lead. A range of band six and band five qualified nurses provided triage, assessment and ongoing care. Support workers and call handlers supported the qualified nurses and ensured a responsive service. A number of vacancies existed across the teams but most had been filled and the teams were waiting for new staff to start.

Shift patterns were standardised across all teams and consisted of a long shift of 8am – 9pm and 8.45pm –

8.15am and short shifts of 8am – 3.15pm and 3.15pm – 9pm. The number of staff on each shift ranged between a minimum of six or a minimum of seven depending on the establishment of the team.

We looked at staffing rotas and the numbers of nurses planned on each shift matched the numbers on duty. We saw that sometimes teams had shortages due to sickness, vacancies or an increase in activity. Bank staff had been used on these occasions to ensure that the minimum staffing levels had been met. Some approved mental health practitioners we spoke with told us that the crisis teams appeared to be stretched and overloaded with inpatient discharges. We did not see evidence of this during our visit. However, some staff at the Ravenswood clinic and at St Georges Park told us that their teams had been recently short staffed but confirmed that a pool of regular bank staff were used.

An initial response service provided a single point of access for all services in the South of Tyne area. We were told that the call handler role could be quite stressful due to the number of calls and the intensity of it being a desk bound role. The manager for the team was awaiting a risk assessment to be undertaken to see how staff could be supported in this role.

Agency cover was never used for the service but regular bank staff were used who all had experience of working in crisis services.

Crisis teams managed the needs of the people who used services as a team and team members did not hold individual caseloads. This system enabled staff to be aware of all people who were receiving services including their care plan and risk assessment. This meant that if people who used services needed to see a different worker they would not have to repeat their history.

All staff told us they could access a psychiatrist quickly when needed. Each team had dedicated consultant psychiatrist cover. The Hopewood Park team had introduced seven days a week medical cover and we heard very positive feedback from the psychiatrist. The seven day

Are services safe?

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

service had been running for approximately two months. Positive feedback had been received from people who used services and we were told that there had been a 30% reduction in weekend admission to hospital.

All other teams used the on call medical cover out of hours and no problems were reported about access.

Mandatory training compliance across the core service was good (92%) with most areas achieving in excess of the trust standard of 85%. Areas falling below 85% were clinical risk training which scored 83% and clinical supervision training which scored 77%.

Assessing and managing risk to patients and staff

Staff used the function analysis of care environment risk assessment tool when assessing people which was a nationally accredited tool. People who used services received a risk assessment during their initial assessment. If the person was known to services historical risk assessments were sought to inform the current risk profile. We saw that risk was reviewed at every contact, if any incident arose or if the person deteriorated. All staff fed into risk assessments and formulation at the daily multidisciplinary team meetings.

We reviewed 26 care records and found every risk assessment was up to date and comprehensively completed. Initial assessments showed a comprehensive understanding of the person's risk. Risk formulation informed crisis plans which were incorporated into care plans.

We observed two multidisciplinary team meetings where risk was rated red, amber, green. We saw that people who used services who were considered as high risk were monitored by frequent visits.

People who were referred to the street triage team were triaged by a nurse and a police officer using a condensed version of the risk assessment tool. Following assessment they would be referred to the appropriate service which included the crisis teams. None of the crisis teams had a waiting list.

Staff had received safeguarding training and recorded safeguarding alerts on the incident reporting system. Staff knew the types of events or incidents which would trigger

an alert and 277 safeguarding incidents had been reported by the service between 01 April 2015 and 30 April 2016. Staff told us they would contact their manager or the trust's safeguarding lead if they needed advice.

All teams had 'at a glance' boards which provided a visual aid at the daily multidisciplinary team meetings. Home visits and tasks that were to take place that day were agreed. A multidisciplinary proforma used prompts to aid staff in their care and treatment. Prompts included safeguarding, 'think family' and physical health.

All teams had lone working procedures in place. Staff carried a lone worker electronic device and 'in and out' boards were in each team base. The shift co-ordinators had responsibility for checking staff on a daily basis. Audits of compliance of the lone worker device had revealed some areas of low use and all team managers had taken action to improve this. During home visits we observed staff signing in and out using the lone worker devices.

Initial assessments were conducted by two members of staff. Where concerns about risk continued staff undertook home visits in pairs.

We looked at the systems in place for medicines management. We spoke with staff who were responsible for medicines and also the pharmacists at the teams. Medicines were stored securely and were only accessible to authorised staff. There were appropriate arrangements for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). We observed that at St Georges Park there was not a controlled drugs book, although, there were no controlled drugs being stored at the time of inspection.

Prescription records were completed fully and accurately, and blank prescription forms were tracked through the service in line with national guidance. Medicines were administered by nurses using patient group directions that had been produced in accordance with legal requirements and national guidance.

An effective system was in place to reconcile (check) patients medicines on admission to the service, and we saw how this worked to ensure patients received the right treatment. We looked at 40 prescription charts and found they were up to date, legible and in line with the National Institute of Health and Care Excellence (NICE) guidance.

Are services safe?

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

Staff told us it was custom and practice to remove medicines from their labelled containers and leave them with patients to take in their own homes. This practice constituted secondary dispensing which increased the risk of medication errors.

Track record on safety

In the twelve months prior to our visit 16 serious incidents were reported by the service. All were categorised as an unexpected death of a person receiving services.

Two doctors we talked to told us about recent serious incidents of suicide, one saying it was a very traumatising experience. Thorough investigations and reflections on care had taken place. Care had not been criticised but recommendations and actions had been agreed in order to continually improve practice.

Nurses too told us about serious incidents and confirmed that 'after action reviews' took place and a serious incident panel monitored implementation of any actions. Staff felt supported and debriefed following serious incidents.

Reporting incidents and learning from when things go wrong

The trust used an electronic incident reporting system. All staff we spoke with understood what to report and knew how to report incidents. Examples of what incidents staff had reported included violence or threats of violence, self-harm and episodes of short staffing. Between 01 April 2015 and 30 April 2016 the service reported 1036 incidents which were both clinical and non clinical. More than half of these incidents were rated as no harm or minor harm. Staff were open about incidents and told us they explained to patients when things had gone wrong. There was a duty of candour policy and the electronic incident reporting system ensured duty of candour incidents were monitored.

Staff told us that learning from incidents was very well embedded in the service. Debriefings were offered and incidents were discussed at team meetings. We saw evidence of this in team meeting minutes. The level of detail recorded varied in the minutes across the teams.

We observed a lessons learnt meeting. The meeting was attended by about 20 staff which included nurses, medics and support staff from across the service. The findings from serious incidents and complaints were feedback to staff. Positive feedback and examples of good practice were also shared.

We heard of changes being made to practice following complaints. An example was a GP who had complained about access to physical health checks. In response the service ensured that ongoing training for physical health champions in each team was taking place. This enabled people who used services to receive a timely response to physical health care needs.

We were told that the information from the lessons learnt meetings was cascaded to other staff who had not attended. There was also a staff newsletter which was produced monthly following the trust's 'clinical standards group' which shared lessons learnt from incidents and investigations.

Health Based Places of Safety Safe and clean environment

All the health based place of safety suites were discreet, quiet and secure. Two suites, Hopewood Park and Tranwell unit were purpose built. The other two suites at St Georges Hospital and St Nicholas hospital were developed from former ward areas.

All areas were clean and well maintained. When gathering information from stakeholders we heard that sometimes the suites at the Tranwell Unit and St Nicholas hospital were not always clean. We saw cleaning schedules at the Tranwell Unit and were informed that domestic staff routinely cleaned the suites.

We observed a blind spot in the bedroom area at the Hopewood Park suite. There was no mirror to mitigate this and staff told us that they would observe the area from the doorway. There were blind spots in the bedroom area at St George's Park and this was mitigated with a mirror. St Nicholas Hospital suite had blind spots in the toilet area and staff told us they would mitigate this by supervision and observation. CCTV was in the entrance areas at Hopewood Park and St Nicholas Hospital suites only. All suites were under continuous supervision with a member of staff whilst patients were detained under section 136.

There were ligature point risks in some suites. A ligature point is a place where someone intent on self-harm might tie something to strangle themselves. The bathroom area at the St Georges Park suite had ligatures which staff were aware of and St Nicholas Hospital suite had ligatures in the toilet area. Staff mitigated this through patient observation.

Are services safe?

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

There was little or no equipment for staff to carry out physical examinations or monitor people's physical health in the health based places of safety. Staff told us that they would access equipment from the adjoining ward or in the case of the Tranwell Unit the adjoining electroconvulsive therapy suite. There was no defibrillator in two of the suites and again, staff told us that this would be access via the adjoining wards in the event of an emergency.

All the health based places of safety had access to a toilet and shower with the exception of the St Nicholas Hospital suite which only had a toilet and basin. The trust was reviewing the feasibility and benefits of putting a shower into this suite.

If people needed to wash and change staff told us clothing and toiletries were available from the wards.

All the health based places of safety had a separate area with facilities for professionals to make notes, use the telephone, or hold confidential conversations. Approved mental health professionals told us there was no private area for them to see the detained person at the St Nicholas Hospital suite. Not all suites had facilities such as air conditioning or adjustable lighting. The St Nicholas Hospital suite was described as being too cold in the winter and at night. In the summer it was sometimes too hot.

Staff had access to portable emergency alarms at all the suites and the St Nicholas suite also had panic strips on the wall which staff could raise alarm by pressing. When activated the alarms raised support from the neighbouring wards. All staff we talked to felt that adequate support would be provided quickly if the alarm was activated.

Safe staffing

A dedicated member of staff in each crisis team acted as co-coordinator for the health based places of safety 24 hours a day. We heard conflicting accounts regarding how many staff would be available to receive and remain with the detained person after the police had handed over. Two staff told us this was one person, however, managers and the clinical police liaison lead informed us that at no point would one staff member be left alone with the detained person. If police did not remain with the person then another member of staff would be provided by one of the wards or out of hours, by the duty contact manager.

Two crisis teams managed and provided dedicated staff to health based places of safety that were not on the same

site as the team. The Ravenswood clinic crisis team managed the health based place of safety at St Nicholas Hospital. Staff we talked to told us it would take approximately ten minutes to arrive at the suite from the crisis team office.

The health based place of safety at the Tranwell Unit was managed by the crisis team at Hopewood Park. Despite a crisis team being on site at the Tranwell Unit, the resource for the health base place of safety came from the Hopewood team. This journey could take up to forty minutes, however, staff told us that with the introduction of the street triage team it meant that they were always informed of and made aware that a person was being brought to the place of safety. This meant that the identified member of staff could get there in time for the persons arrival. In the event of not arriving at the place of safety before the arrival of the police and the detained person, staff from the Tranwell crisis team would receive the patient.

Two staff we spoke to at the Tranwell Unit told us that it was usual practice for the team themselves to support the 136 suite and they tended not to use the Hopewood identified staff member. This conflicting account of staffing possibly supported feedback received from approved mental health practitioners that nursing cover at the Tranwell health based place of safety was sometimes a problem.

Assessing and managing risks to patients

On arrival at the health based places of safety the detained person received an initial assessment and physical health screening.

The crisis teams were responsible for contacting an approved mental health professional and appropriate doctor to undertake an assessment of the detained person. A section 136 monitoring form was used to collect information including physical health screening, risk assessment, times of arrival and interviews with approved mental health practitioner and doctor.

Staff were aware of safeguarding protocols and understood how to make a safeguarding referral. The health based places of safety had not made any safeguarding referrals in the last 12 months.

Track record on safety

Are services safe?

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

There were no serious incidents relating to the health based places of safety in the past 12 months reported by the trust.

The trust had signed up to a crisis concordat. The crisis concordat was a nationwide scheme which provided a multi-agency approach to support people in crisis. The concordat included all emergency services working together with one of its main aims to avoid inappropriate admissions and to prevent people being admitted via section 136.

Reporting incidents and learning from when things go wrong

There were four incidents in relation to the health based places of safety between 1 April 2015 and 30 April 2016. These incidents were categorised as no harm and three related to service delivery. The service delivery incidents concerned the length of time a detained person waited for an assessment in the health based places of safety. Staff monitored and reviewed events if people waited over three hours for an assessment. One incident was categorised as low harm and related to a person self-harming in the suite.

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.

Our findings

Crisis and home based treatment team Assessment of needs and planning of care

The crisis teams had several main functions:

- Triaging telephone calls from people in crisis and assessing for the most appropriate service. This could range from signposting people to other services or arranging a Mental Health Act assessment.
- Providing face to face assessments for people in a crisis and providing home based treatment.
- Gatekeeping adult mental health inpatient beds and liaising with the bed management team if hospital admission was necessary.
- Facilitation of discharge from acute inpatient wards for people who did not need to remain in hospital but would benefit from intense community support.
- Management and facilitation of the health based places of safety

In all areas assessments were carried out by two staff. Following assessment staff told us that local resources would be used to refer patients to the service or agency which would best meet their needs. These included drug and alcohol services and the improving access to psychological therapies programme.

We reviewed 26 care records across four crisis teams. Records were held on the trusts secure electronic recording system, which was accessible to all staff. All assessments were comprehensive and focused on the whole person. Areas covered included presenting problems, physical and mental health history, personal history, social circumstances, medication, substance use, communication, mobility, employment and carers views.

Care plans were personalised and promoted independence. Crisis plans were incorporated into care plans and included trigger contact numbers. There was evidence that people who used services were involved in their care planning. When we spoke with people who used services all, with the exception of one person, told us they had been fully involved in their care planning. Two people who used services could not recall receiving a copy of their care plan.

Plans were holistic and recovery focused. We saw they were built on people's strengths and included aims and goals. Physical health assessments and ongoing monitoring were evidenced in 24 of the 26 records.

A lot of staff used digital dictation for recording progress in care records. Feedback about this was overwhelmingly positive with staff saying it enabled an effective use of time and ensured the electronic records were contemporaneous.

Best practice in treatment and care

The service followed national guidance including national institute of health and care excellence guidance on self-harm, personality disorder and antidepressant treatment.

We saw that clinical staff participated in audit. Medication compliance with national institute of health and care excellence guidance had taken place. Care records, drug charts and physical health monitoring was regularly audited and a multidisciplinary team audit was currently underway at the Ravenswood clinic to evidence its effectiveness.

Staff at Ravenswood clinic told us about a physical health clinic which was being planned in order to further improve services. Some staff were concerned that there were no resources to set this up.

People who used services had access to psychological therapies although one member of staff told us this was not always within timescales recommended by the national institute of health and care excellence guidance. Staff within the teams had a range of skills including mindfulness, cognitive behaviours therapy and family work for short term interventions. Staff told us they could refer people to other services for psychological therapies such as primary care.

People who used services were supported with housing, employment and benefit needs. Support workers liaised with housing staff and citizen's advice bureaux. They helped people get appointments and supported them to attend appointments. The teams had access to petty cash to provide immediate financial aid for people in crisis.

We saw the teams were using a range of recognised tools in enabling them to formulate more detailed assessments. These included the Beck depression inventory, the Lester tool for physical health monitoring and the personality diagnostic questionnaire.

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.

All teams used the health of the nation outcome monitoring tool.

Skilled staff to deliver care

Access to a full range of mental health disciplines across the teams varied. All teams had dedicated pharmacy support. St Georges Park had social workers embedded within the team. Hopewood Park was co-located with the out of hours local authority duty team.

No teams had dedicated psychology support but staff told us they could access a psychologist from the community teams if it was necessary. Medical and other staff told us they would like more access to occupational therapy, psychology and psychotherapy.

All newly appointed staff received a corporate induction followed by a local induction which ensured they received relevant information, instruction and support to enable them to fulfil their role.

Information provided by the trust prior to our visit showed that 91% of non-medical staff across the service had received an annual appraisal. Ninety five percent of medical staff had received an annual appraisal.

The trust policy for supervision was for qualified nurses to receive monthly clinical supervision and support workers to receive supervision every two months. Supervision information provided by the trust prior to our visit showed that compliance between 01 May 2015 and 30 April 2016 was Hopewood Park 89%, Tranwell Unit 50%, Ravenswood clinic 93% and St Georges Park 43%. Where compliance was low, managers told us the actions they had put in place to improve this. This included reviewing the process and arranging training. We saw timetables of planned and actual supervision and monitoring during team and business meetings. Staff we talked to told us they were receiving regular 1:1 supervision and some talked of beneficial group supervision which took place in some teams.

Managers and staff told us they received specialist training for their role. This included cognitive behaviour therapy, dialectal behaviour therapy awareness, cognitive analytical therapy, suicide prevention and perturbation training.

All teams held regular team meetings. Standing agenda items included performance information, service user and carer feedback and lessons learnt from incidents and complaints.

Multi-disciplinary and inter-agency team work

All teams held daily effective multidisciplinary team meetings seven days a week.

Approved mental health practitioners reported positive working relationships with teams and were overwhelmingly positive about the street triage service.

We spoke to the clinical police liaison lead that was the lead for the crisis concordat. Four local police and partner agency meetings took place across the trust which included crisis teams, local authorities, wards, community teams, acute trust and police liaison officers.

The concordat was discussed at each of these meetings along with lessons learnt and areas to improve upon. The local meetings fed into quarterly police and partnership meetings which were attended by the clinical commissioning groups and trust directors.

We spoke with a GP in the North of Tyne area who described the service as "an excellent resource". They told us that in the past it had been a challenge to refer a patient but there had been a radical improvement over the past two years. We were told that there was a good system of referring to the teams and GPs received regular feedback following referral and full formal written documentation on discharge. Ravenswood clinic had access to local crisis beds which the local authority had the lead for. The team told us they had a good working relationship with the local authority.

We heard that the initial response team in the South of Tyne area provided two telephone slots per day where GPs could call and talk directly to a consultant psychiatrist about a patient.

We talked with a police liaison officer who was very positive about the role and the relationship with the trust. We heard real examples of how patients and staff had been supported by the role. Police liaison officers visited the wards, responded to requests to speak with patients and provided advice.

Adherence to the MHA and the MHA Code of Practice

Information provided by the trust showed that 91% of staff had received mandatory Mental Health Act training. Staff we talked to demonstrated a good understanding of the act although they did not work with many people who were subject to the Mental Health Act. The teams supported

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.

people who were on community treatment orders. These were granted to patients under the Mental Health Act to allow them to live in the community. The responsibility for Mental Health Act issues tended to stay with the care-co-ordinator in the community mental health teams.

Administrative support and legal advice was available to staff from a central Mental Health Act team. Staff knew how to contact this team.

Street triage staff also provided support to community mental health teams if people on community treatment orders needed to return to hospital.

People who used services had access to independent mental health advocacy services if required. Independent mental health advocates are people who are independent of mental health services and can help people who use services have their opinions heard and make sure they know their rights under the law. Staff were aware of how to refer to the advocacy services.

Good practice in applying the MCA

Information provided by the trust showed that 94% of staff had received mandatory Mental Capacity Act training. Staff we talked to showed a good understanding of the Act and told us assessment of capacity would be done on a decision-specific basis. We observed that staff considered capacity and consent during multidisciplinary discussions. Capacity was recorded in 25 of the 26 records we reviewed.

Administrative support and legal advice was available to staff from a central Mental Health Act team who also supported the Mental Capacity Act. Staff knew how to contact this team.

Health Based Places of Safety

Assessment of needs and planning of care

When the service received a referral from the Police the street triage team or crisis team undertook an initial screening assessment in order to decide if a person appeared to be suffering from mental disorder. On arrival at the health based place of safety the band six nurse received a verbal and written handover from the police. A physical health check and risk assessment was then completed. Based on the risk assessment the police officer would either leave or remain with the detained person.

People received a full assessment by a doctor and an approved mental health practitioner. This ensured that appropriate arrangements for their ongoing care and treatment could be arranged.

Staff had access to the trust's electronic care records system. This meant if patients were previously known to the trust their information would be easily accessible.

Best practice in treatment and care

People detained under section 136 were usually brought to the most local health based place of safety. In the rare occasion that the suite was occupied the person would be taken to the nearest alternative place of safety. The trust had introduced street triage which worked in partnership with Northumbria Police. This service provided mental health advice and guidance in order to assist the police in their decision making process around managing risk. A significant reduction in people detained under section 136 of the Mental Health Act had been seen across the trust since the service was implemented.

An environmental safety audit of section 136 suites had been conducted in August 2015. The audit examined the environment and safety standards of the health based places of safety against Royal College of Psychiatry national standards and guidance. The compliance rate for the St Nicholas Hospital Suite was 90%, St George's Park was 84%, Hopewood Park was 92% and the Tranwell Unit was 78%. Actions were in place to improve on findings from the audit.

Skilled staff to deliver care

Staff who co-ordinated the health based places of safety were from the crisis and home based treatment teams. Staff we spoke to understood their roles and responsibilities under section 136.

Staff were trained in breakaway techniques and basic life support. National guidance advises staff are trained to intermediate life support level. The trust were aware of this risk and were considering if crisis team staff should attend intermediate support training.

Where the teams worked across different patient pathways, e.g. learning disabilities, children and young people and older people, 'scaffolding' services from these specialities supported crisis team staff. This meant that staff were supported in their roles and learning and upskilling from the scaffolding services took place.

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.

Multi-disciplinary and inter-agency team working

The trust had signed up to a crisis care concordant and there was an up to date joint agency policy in place. This meant there were agreements in place for joint working protocols. The trust had an action plan in place and we saw evidence that staff represented the service at multiagency operational meetings. Police liaison meetings took place monthly.

Adherence to the MHA and MHA Code of Practice

Information provided by the trust showed that 86% of staff who co-ordinated the health based places of safety were up to date with mandatory Mental Health Act training.

Staff had good working knowledge of the Mental Health Act and understood their responsibilities under Section 136 of the Act. People detained had their rights read and given to them by staff. The times and date of this was recorded for monitoring and audit.

If people were unable to understand their rights staff read their rights again until they felt people could fully understand.

Good practice in applying the MCA

Information provided by the trust showed that 86% of staff who co-ordinated the health based places of safety were up to date with mandatory Mental Capacity Act training. Staff appeared to have a good understanding of how capacity can fluctuate and knew where to seek additional support and advice if required.

Are services caring?

Good 

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

Our findings

Crisis and home based treatment team **Kindness, dignity, respect and support**

We observed kind, compassionate and respectful interactions between staff and people who used services. During home visits we saw staff being sensitive and responsive to concerns, for example a nurse discussed with the person the possibility of making a referral to the young carers service. We saw another nurse responding quickly to deterioration of a person by arranging a medication review.

We saw a nurse seeking consent and permission to speak with members of family. We saw evidence in care records that consent was always sought.

Staff maintained confidentiality. One person told us staff were discreet when visiting and didn't wear their trust identity badges in order not to alert neighbours that they were receiving services.

All people who used services we talked to told us staff were respectful and very caring. Staff were described as "wonderful", "the best I've had", "gone above and beyond" and "genuine". People who used services said they felt they were listened to and some told us their carer received 1:1 support as well.

Some people who used services gave some negative feedback about seeing different members of staff and punctuality of appointments but these were usually deemed as minor issues by people and their carers.

The involvement of people in the care they receive

We saw in care records that families and carers were routinely involved in assessments and care planning. Carers we spoke with told us they had been involved with care planning and had been offered support for themselves.

All crisis teams had identified carer champions who arranged for carer assessments to be conducted and signposted people to appropriate services such as carers groups.

Staff provided people who used services with a welcome pack on assessment which included information regarding what would happen next. Information about advocacy

services was also provided and we saw information on how to access advocacy displayed in public areas. Leaflets on illnesses and treatments were available to help people who used services make decisions about their care.

At discharge or transfer people who used services and their carers were asked to complete an anonymous satisfaction questionnaire. They received a stamped address envelope so they could return the questionnaire to the team. The satisfaction questionnaire asked for feedback on people's experience and we saw the feedback discussed in team meetings.

The trust had a central recruitment team which supported service user representatives to participate in recruitment of staff.

Health based places of safety **Kindness, dignity, respect and support**

Staff attempted to maintain the safety, dignity, and confidentiality of people detained under section 136. Entrance to the health based places of safety was discreet and out of view of the public. The St Nicholas Hospital suite had ligatures in the toilet area and St George's Park had ligatures in the bathroom area which meant staff had to be nearby to observe. This potentially could have compromised people's dignity. Approved mental health professionals told us there was also a lack of a private area in the St Nicholas suite for interviewing detained people.

Staff could provide drinks immediately. Additional food and drink was available 24 hours for people via the adjoining ward or catering services.

Interpreting services were available if this was required.

The involvement of people in the care they receive

Information on what to expect and access to advocacy services was displayed in some health based places of safety but not all. Managers told us that where information wasn't on display, this would be brought into the suite for people.

Information on how to provide feedback was given when people received their rights and information on what to expect. This included completing a form on the trust website or telephoning the complaints department. We did not see any feedback cards in the health based places of safety which is another way that people could provide feedback.

Are services responsive to people's needs?

Good 

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

Our findings

Crisis and home based treatment team

Access and discharge

Access to crisis services across the trust was available 24 hours a day seven days a week. Referrals could be made by anyone including self-referral. Referrals were taken by telephone by either crisis service staff or by initial response service staff.

The trust was aspiring to the provision of universal crisis services which covered all age ranges and disabilities. Presently, the crisis teams were mostly delivering services to people aged 16 and over, however, some areas were able to provide services to people over 65 years of age and to people with a learning disability. To support teams 'scaffolding services' were provided by older person's services, learning disabilities services and children and young person services for assessments.

One doctor we spoke with expressed concern about having to cover all aspects of care including learning disabilities and older people without the expertise, although the scaffolding service was in place to support this.

The trust's transformation programme, which was a project to improve patient pathways, had led to changes around how people accessed the service. This meant that in the North of Tyne area there was an initial response team and in the South of Tyne area there was an initial response service.

We spoke with staff from the initial response service which covered the South of Tyne area. The service provided a single point of contact for referrals to the trust and for people who used services who wanted to contact the crisis and home based treatment teams.

Qualified nurses in the initial response service provided crisis triage for urgent referrals or planned care referrals. Outcomes for people included referral to the crisis teams for assessment, referrals to other services where appropriate, such as drug and alcohol services or signposted and given advice.

The initial response service also handled telephone calls from people who used services who wanted to contact their clinician. The service operated 24hrs a day and staff told us they received approximately 4000 calls per week. One service user we spoke to told us they had used this

service but found themselves in a queue for the call to be answered so did not continue with the call. Some approved mental health practitioners told us that the teams were sometimes difficult to contact and that the initial response service sometimes took a long time to answer the telephone.

Between May 2015 and April 2016 the crisis teams received a total of 11,960 referrals. The street triage teams received 4134 referrals between June 2015 and April 2016. Referrals to street triage came from police officers only.

Despite the differences in how crisis services were managed it was clear that patients received effective and timely assessment in a crisis. Staff provided triage and assessment within agreed timescales. These were a rapid response of one hour for urgent referrals and within four hours for crisis assessments.

Between May 2015 and April 2016 the average length of time people who used services remained on caseload was: Hopewood Park 6.8 days, Tranwell Unit 4.9 days, Ravenswood clinic 3.8 days and St Georges Park 7.1 days. These figures included people receiving both crisis assessments and home treatment.

Staff told us they took active and responsive steps to engage people who were reluctant or who had difficulties in engaging with the service. This included the initial response team providing telephone follow up of people who did not attend appointments. The street triage team would also provide home visits for people who frequently did not attend their appointments to check on their welfare.

Approved mental health practitioners who we spoke with told us that crisis team staff would refer people for a Mental Health Act assessment if the patient refused access or didn't open the door to them when they conducted a home visit. Sometimes they felt this was inappropriate and felt that crisis staff were not assertive enough. This had been raised with the trust and an agreed protocol for mental health act assessments was planned to be developed.

The teams worked flexibly to meet the needs of people who used services and agreed the frequency of home visits depending on risk and needs. Sometimes this meant they contacted people to re-arrange visits due to other workload priorities and sometimes it meant different people visited. People who used services told us staff sometimes contacted them to change arrangements but they had

Are services responsive to people's needs?

Good 

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

been made aware that this may happen due to the nature of their work. A number of people who used services and some carers said they found this challenging and was one of the only negative things about the service. Wherever possible teams tried to make sure that the same members of staff visited the patient.

Staff offered people who used services flexibility in their appointments where possible and to suit individual circumstances. This included times of day and place of visits.

People who used services were usually offered appointment slots covering four hours. One person who used services told us that one of their appointments was due in the morning four hour slot. Half an hour from the end of the slot when the nurse hadn't arrived they received a telephone call to re-arrange to another day.

Crisis services provided a gatekeeping role for acute mental health beds and liaised with the trust bed management team to access a bed for people where home based treatment was not suitable. The teams also supported discharges from acute admission wards for patients who continued to experience acute mental health problems but no longer required continued hospitalisation. Some staff told us that the introduction of the bed management team had caused them to be less engaged with the wards. They were actively trying to improve relationships with the wards.

The trust proportion of admissions to acute wards gate kept by the crisis and home based treatment teams in the 12 months prior to our visit was consistently above the national average of 95%.

Staff we spoke with told us that discharge or transfer from the service was planned from the outset of contact.

The facilities promote recovery, comfort, dignity and confidentiality

All teams had access to rooms that staff could use to meet with people who did not want to be seen at home or for safety reasons. At Ravenswood clinic these were the doctors' offices. Although these appeared to have adequate sound proofing they were quite small and filled with normal office equipment.

Other teams had access to rooms in the hospital site where they were based. These interview rooms were spacious, comfortably furnished and had adequate sound-proofing to protect the confidentiality of the person using the service.

One person who used services said they had visited the St Georges Park site for an appointment. They told us that the waiting room felt very challenging and said it was "daunting" when not feeling well. The actual interview room used to see staff was described as private and comfortable.

Choice of gender of crisis team worker, choice of venue and time of visit where appropriate were offered to people. One manager told us that some people who used services had advanced decisions. In the past these had been hard to find on the electronic records system. An alert was now in place on the system.

Meeting the needs of all people who use the service

Staff had access to interpreters if and when needed. We saw information and leaflets on display in the entrance areas of each site including information on local services, mental health problems and guidance about how to complain.

Staff listened to people who used services and met their needs in individual ways. The Gateshead area had a large Jewish population and staff told us they were engaging with the local community. Staff told us they were further exploring how they could meet the needs of this population.

Where people were seen on trust premises we saw that adjustments for people requiring disabled access had been made.

Listening to and learning from concerns and complaints

The service received a total number of 20 complaints between 1 November 2015 and 30 April 2016. Three complaints were fully upheld and seven partially upheld. One complaint was referred to the parliamentary health ombudsman.

Seven complaints were in connection to the care and support of patients. Five complaints were about communication (style, with GP and relatives). Six

Are services responsive to people's needs?

Good 

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

complaints were in relation to a combination of discharge/ admittance of patient (three) and (three) for the attitude of staff. One complaint each around prescribing, breach of confidentiality and safeguarding.

Information about how to complain was available in the crisis team information leaflet. Staff were aware of how to handle complaints and told us they would always try to resolve any issues directly where possible. Most people who used services told us they knew how to complain.

During a home visit we saw a nurse dealing with a potential complaint from a person who used services. We observed a sincere apology and a clear explanation regarding what had happened. The person was given information on how to take the complaint forward but was satisfied with the action taken and the response.

The service had recorded five compliments received in the 12 months prior to our visits. These included two at Ravenswood clinic, two at St George's Park and one at Hopewood Park initial response team.

Health based places of safety

Access and discharge

The trust had a policy for the use of section 136 of the Mental Health Act. A clear flow chart was in place to support police in making decisions for appropriate admissions to the health based place of safety. The health based places of safety were an ageless service with no exclusion criteria.

The trust had introduced a street triage service in September 2014. Two street triage teams provided full trust cover across the North of Tyne and the South of Tyne areas. The teams worked collaboratively with Northumbria police and provided a seven day a week 10am – 3am service.

When police encountered a person in a public place who appeared to be in a mental health crisis the officer contacted the street triage team during its operational hours and the relevant crisis team or initial response service outside of these hours. Advice and support was given by the crisis and street triage team service. If section 136 was deemed necessary arrangements were made to convey the person to a health based place of safety.

If a person was discharged from the section 136 and deemed not to require hospital admission staff supported people to get home. This sometimes included arranging a taxi home paid for by the trust.

In the event of the section 136 suite having to be utilised by another patient, the trust were able to use an alternative health based place of safety within the trust.

In the three months prior to our visit the number of people detained under section 136 was St Nicholas Hospital 15, St Georges Park eight, Tranwell Unit seven and Hopewood Park one. This was a significant decrease to the same time last year which staff told us was due to the introduction of street triage.

The facilities promote recovery, comfort, dignity and confidentiality

All the health based places of safety had separate entrances for patients being detained under section 136. Car parking was available near the suite so that patients would not have to walk a great distance. This helped reduce stress and anxiety for people.

All suites had somewhere for the person to lie down, either on a bed or on a sofa. Clocks were visible in all suites and there was access to a telephone. There was a television in all suites which had been boxed in to maintain safety. The St Nicholas suite did not have a shower however the trust was reviewing the feasibility and benefits of putting a shower into this suite.

Most of the suites had tea and coffee making facilities with fresh milk available from the adjoining ward. Food could also be arranged via the adjoining wards or via main reception.

Meeting the needs of all people who use the service

The service did not exclude people on the basis that they had consumed alcohol or drugs or exclude on any other presenting behaviour.

We observed an inconsistency with regards to available information for people to access within the health based places of safety. Some suites had information on rights, what to expect, advocacy and how to complain. The Tranwell Unit suite had no information on display, but staff told us that they would bring information in for the person.

Listening to and learning from concerns and complaints

There had been no formal complaints relating to the health based places of safety in the 12 months prior to our inspection.

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.

Our findings

Crisis and home based treatment team

Vision and values

The trust had the following vision:-

‘Improve the wellbeing of everyone we serve through delivering services that match the best in the world’

The trust’s values were displayed at every site and were:-

- Caring and compassionate
- Respectful
- Honest and transparent

We reviewed the services operational policies and saw that the service aims and objectives reflected the organisations vision and values. We observed staff behave in a manner that supported the trust vision and values.

Staff were aware of who the senior managers were in the organisation and some spoke highly of the chief executive and the positive difference which had been made in the trust since their arrival.

Good governance

Staff were attending mandatory training and receiving annual appraisals. Supervision was taking place regularly. The service had identified previously low compliance with supervision and had taken steps to improve this which was evident during our visit.

Managers used key performance indicators to measure the progress of the teams’ activity. This included clinical information such as referrals, response activity and mental health cluster information. Information about staffing, training, and appraisal rates were also monitored and discussed in team meetings.

The service had an annual audit plan in place. We saw evidence of audits taking place and recommendations being acted on.

Each team had a risk register and managers told us they could escalate items to the corporate risk register.

Leadership, morale and staff engagement

Staff spoke very highly of their managers in the service and described them as supportive. Morale was high and a lot of staff said they “loved my job”. Some told us it was the best job they had had and felt it was very rewarding. Staff

acknowledged the work was often challenging and stressful due to the nature of the work. Stress levels were usually manageable and all the teams supported each other in times of pressure of work or staff sickness.

Staff reported no incidents of bullying or harassment within the teams. They were aware of the trust whistleblowing policy and felt confident to raise any concerns without fear of victimisation.

We saw a very supportive team approach across the service. This was reflected within staff interviews and feedback from management. The teams were also trying to improve relationships with other teams such as inpatient wards and community teams.

People who used services were encouraged to give feedback on their experiences via an anonymous questionnaire. They were provided with a stamped addressed envelope to return the questionnaire. We saw that staff reviewed, monitored and acted on the feedback received.

Effective clinical multidisciplinary team meetings took place. Clear governance structures were in place.

Staff we spoke to told us they felt able to contribute to service developments. Some told us the recent changes following the transformation programme had been a stressful time but all staff told us things had settled down and the teams were working well together. Staff told us that the trust encouraged feedback through “speakeasy” events and a website blog.

Commitment to quality improvement and innovation

We saw that feedback from people who used services and their carers was being sought through satisfaction questionnaires. This was then shared with staff and discussed in team meetings. This enabled the service to see any emerging trends or themes in order to identify if any change was needed.

Ravenswood clinic was the only team to hold the home treatment accreditation scheme award.

Health based places of safety

Vision and values

There were local joint protocols with agencies such as the police to protect people in mental health crisis.

Good governance

Are services well-led?

Good 

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

Staff from the crisis teams who were allocated to work in the health based places of safety had attended mandatory training. However, intermediate life support and management and prevention of violence training was not mandatory and hence staff had not received this training.

The service had safeguards in place which meant that staff who required assistance from the nearby inpatient wards could summon this immediately through the alarm systems. Emergency equipment and life support was also available via this route. Despite the safeguards in place, the service was re-considering staff training.

There were regular section 136 clinical meetings conducted to discuss areas of development and concern.

The trust collected data that supported the monitoring of the performance of the health based places of safety, this included timings in relation to length of stay in the suites

and delays in section 12 approved doctors. The trust had commissioned an audit of their health based places of safety in 2016. The audit measured against Royal College of Psychiatry national standards.

Leadership, morale and staff engagement

Staff understood their roles and responsibilities when working in the health based places of safety and felt supported by management. The clinical police liaison worker supported managers and had oversight of the issues in relation to the environment of the suites.

Commitment to quality improvement and innovation

We found that the trust had excellent links with partner agencies with an aim to reduce section 136 admissions. The introduction of the street triage initiative had significantly reduced the number of people detained under section 136.

An academic paper in collaboration with Newcastle University was awaiting publication.