Humber NHS Foundation Trust

Community-based crisis services

Quality Report

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Beverly Road,
Hull
Tel: 01482 301700
Website: www.humber.nhs.uk

Date of inspection visit: 20th-23rd May 2014
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Miranda House	RV945	Hull Community Crisis Home Treatment Team	HU3 2RT
Willerby Hill	RV936	East Riding Community Crisis Home Treatment Team	HU13 9NW

This report describes our judgement of the quality of care provided within this core service by Humber 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 Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber 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.

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 Home Treatment services provided by Humber NHS Foundation Trust aim to provide care and treatment for people experiencing a severe mental health difficulty in their own home to prevent the need for hospital admission. They also help people to be discharged from hospital early, where suitable.

We found that these services were delivered safely. Learning about incidents and accidents was shared through team meetings and handovers.

The teams operated a Single Point of Access (SPA) referral system. The SPA used a 'risk-rated matrix' to prioritise new referrals to ensure that people received the level of support they needed, based on urgency of their need and associated risk factors. The teams had a clear care pathway which focused on assisting people in their recovery.

Care plans we looked at were centred on the needs of the individual and reflected the use of current, evidence-based practice. There was good partnership working within the multi-disciplinary team and with external stakeholders such as GPs, voluntary agencies and specialist mental health teams.

There were some differences in the level of service that was provided to people by the two teams, due to one serving a urban community and the other a rural one. This meant that people receiving support from the Hull team could be visited at home up to four times a day, whereas some people receiving support from the East Riding team living in remote areas were only visited once a day when more frequent visits were preferred.

Staff told us they felt well-supported in their roles, and felt able to raise concerns and report incidents.

Staff had a positive, learning and transparent culture and they were committed and motivated to continually improve and develop the services.

Summary of findings

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

Are services safe?
Staff had received training in safeguarding adults at risk and knew when and how to report any safeguarding concerns or incidents.

The service had effective systems to assess and monitor risks to people, which included each person having their own risk assessment and management plan in place.

Staff were able to give us examples of how they could, or did, adhere to specific trust policies to keep people safe. For example; 'Lone Working' and 'Whistleblowing' policies.

Are services effective?
The teams had a clear care pathway which focused on assisting people in their recovery. The care plans we looked at were centred on the needs of the individual and demonstrated knowledge of current, evidence-based practice.

The teams had been awarded the Home Treatment Accreditation Scheme (HTAS) award from the Royal College of Psychiatrists (RCP). The award is given to services which have been assessed as meeting set quality standards.

Are services caring?
People were fully involved in planning their care, and could discuss their health, beliefs, concerns and preferences with staff.

Staff supported people to participate in social and community activities to maintain and develop their networks and to help them recover.

Staff supported people's carers and family members. People's family members, friends and advocates were involved in the person's care as appropriate and according to the person's wishes.

Are services responsive to people's needs?
The teams had a clear 'care pathway' to help people access the service. They also linked well with the acute wards to identify people they could support to be discharged early from hospital.

There were differences in the level of service which was provided to people by the two teams. This was related to the commissioning arrangements for the service and the geographical location of the area's the teams covered. Between 8.00pm and 8.00am the Hull CRHT team provided a Trust wide service;providing telephone support and home visits if clinically indicated to service users on

Summary of findings

Hull and East Riding home treatment caseload. The team also undertook face to face crisis assessments through the night. These could be in service users' homes, police stations, minor injury units or the local Accident and Emergency Department.

Staff were working to develop their skills to respond to people's changing needs and provide them with the most appropriate care.

Are services well-led?

Staff told us that they felt well supported by their managers and were proud to work for the service. They also said that the manager was a visible presence in the teams.

All staff we spoke with told us the teams had a positive learning, transparent culture and they were committed and motivated to continually improve and develop the services.

Summary of findings

Background to the service

Humber NHS Foundation Trust provides a range of mental health and learning disability services for children, young adults, adults and older adults as well as providing a range of community services for people in Hull and East Riding. The trust also provides inpatient, community and day clinics as well as specialist services to a population of about 600,000 in urban, rural and coastal areas. Living within Hull and East Riding, and also to a wider geographical area in some of their specialist services

The Crisis Home Treatment Teams serve the adult population of Hull and East Riding. The service aims to provide care and treatment for people experiencing a severe mental health difficulty in their own home to prevent the need for hospital admission. They also help people to be discharged from hospital early, where suitable.

Services

- The Hull Crisis Home Treatment Team is based at Miranda House
- The East Riding Home Treatment Team is based at College House.

These services have not been previously inspected by CQC.

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell CEO Oxford Health NHS Foundation Trust

Team Leaders: Surrinder Kaur and Cathy Winn, Inspection managers, Care Quality Commission

The team included inspectors and a variety of specialists: CQC Inspectors, Mental Health Act Commissioners, a Social Worker Specialist Advisor, and an Expert by Experience, a Consultant Psychiatrist Specialist Advisor, a Student Nurse and an Occupational Therapist Specialist Advisor.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health and community health inspection programme.

How we carried out this inspection

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

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

Before visiting the teams, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 20 to 23 May 2014. We talked with people who used services. We observed how people were being cared for and reviewed care or treatment records of people who used services. We met with people who used services and carers, who shared their views and experiences of the core service.

Summary of findings

What people who use the provider's services say

Before the inspection, we used focus groups to speak with people who used the service. During the inspection, we spoke with people who used the service. Overall, people told us they were very positive about their experiences of care.

Humber NHS Foundation Trust

Community-based crisis services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Hull Crisis Home Treatment Team	Miranda House
East Riding Crisis Home Treatment Team	College House

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.

We found that the services adhered to the Mental Health Act 1983 and were aware of the proper use of the Mental Health Act (1983) Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that services were compliant with the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

Staff had received training in safeguarding adults at risk and knew when and how to report any safeguarding concerns or incidents.

The service had effective systems to assess and monitor risks to people, which included each person having their own risk assessment and management plan in place.

Staff were able to give us examples of how they could, or did, adhere to specific trust policies to keep people safe. For example; 'Lone Working' and 'Whistleblowing' policies.

Our findings

Hull Crisis Home Treatment Team

Track record on safety

There were clear systems and policies in place for staff to follow regarding the reporting of safeguarding incidents to keep people safe and safeguard people from possible abuse. Staff were aware of their responsibilities in relation to escalating and reporting any safeguarding concerns they may have. The staff we spoke with told us they would have no hesitation in escalating concerns to their manager or through external reporting systems as appropriate.

Learning from incidents and Improving safety standards

The team had an electronic incident reporting system in place which was completed following an incident which allowed the manager to review and grade the severity of incidents. Staff were aware of how to use the system and their responsibilities in relation to reporting incidents. Incidents were analysed by the manager to identify any trends and appropriate action was taken in response to these. The trust had weekly operational risk management meetings which the electronic incident reporting system fed into. Minutes of these meetings were available for staff.

We found evidence to demonstrate that safety alerts were received and actioned by the manager.

The team held regular meetings with staff and handovers. The meetings covered agenda items which included safeguarding, learning from incidents and safety alerts. Minutes of the meetings were made available for staff that were unable to attend the meetings.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Staff had received appropriate training in safeguarding adults at risk and there was an identified safeguarding lead within the team. The trust had a 'Whistleblowing' policy in place which staff were aware of. The policy provided detailed information to guide staff on how they could raise and escalate concerns within the trust anonymously if they wished to do so.

The service had safe systems in place for the handling, storage and disposal of medication. This included the use of lockable cases which staff used to transport medication from the team base to people who used the service.

Assessing and monitoring safety and risk

The service had effective systems in place to assess and monitor risks to individual people. Each person had a risk assessment in their care records which included risks in relation to safeguarding and risk to themselves and others. Where a risk was identified, a care plan was in place to manage the risk. This included the number of staff required to visit the person in their home dependent upon the risks identified.

Understanding and management of foreseeable risks

Staff told us that the team adhered to the trust's 'Lone Working Policy'.

Each person had a risk assessment which identified possible risks related to the person's environment which could impact upon care delivery. Where a risk had been identified, there was a plan in place to manage this. For example; where it was documented in a person's care records that they required more than one member of staff to visit due to identified risks, staff told us this was always followed in practice. There was a system in place to record staff movement when out of office and the duty worker was responsible for ensuring those out had returned safely.

Are services safe?

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

East Riding Crisis Team

Track record on safety

There were clear systems and policies in place for staff to follow regarding the reporting of safeguarding incidents to keep people safe and safeguard people from possible abuse. Staff were aware of their responsibilities in relation to escalating and reporting any safeguarding concerns they may have. The staff we spoke with told us they would have no hesitation in escalating concerns to their manager or through external reporting systems as appropriate.

Learning from incidents and Improving safety standards

The team had an electronic incident reporting system in place which was completed following any incidents which allowed the manager to review and grade the severity of incidents. Staff were aware of how to use the system and their responsibilities in relation to reporting incidents. Incidents were analysed by the manager to identify any trends and appropriate action was taken in response to these. The manager attended weekly operational risk management meetings with attendance from the trust risk manager. Minutes of these meetings were available for staff.

We found evidence to demonstrate that safety alerts were received and actioned by the manager.

The team held regular meetings with staff and handovers. The meetings covered agenda items which included safeguarding, learning from incidents and safety alerts. Minutes of the meetings were made available for staff who were unable to attend the meetings.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Staff had received appropriate training in safeguarding and an identified safeguarding lead within the team. The trust had a 'Whistleblowing' policy in place which staff were aware of. The policy provided detailed information to guide staff on how they could raise and escalate concerns within the trust anonymously if they wished to do so.

The service had safe systems in place for the handling, storage and disposal of medication. This included the use of lockable cases which staff used to transport medication from the team base to people who used the service.

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The service had effective systems in place to assess and monitor risks to individual people. Each person had a risk assessment in their care records which included risks in relation to safeguarding and risk to themselves and others. Where a risk was identified, a care plan was in place to manage the risk. This included the number of staff required to visit the person in their home dependent upon the risks identified.

Understanding and management of foreseeable risks

Staff told us that the team adhered to the trust's 'Lone Working Policy'. Each person had a risk assessment which identified possible risks related to the person's environment which could impact upon care delivery. Where a risk had been identified, there was a plan in place to manage this which staff told us occurred in practice.

Staff told us that due to the rural geographical location which the team covered, staff had all been issued with mobile phones in case they required assistance or were running late to inform the team co-ordinator of their whereabouts. There was a system in place to record staff movement when out of office and the duty worker was responsible for ensuring those out had returned safely.

Are services effective?

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 teams had a clear care pathway which focused on assisting people in their recovery. The care plans we looked at were centred on the needs of the individual and demonstrated knowledge of current, evidence-based practice.

The teams had been awarded the Home Treatment Accreditation Scheme (HTAS) award from the Royal College of Psychiatrists (RCP). The award is given to services which have been assessed as meeting set quality standards. This meant the teams sought opportunities to have the quality of their service reviewed by others.

Our findings

Hull Crisis Home Treatment Team

Assessment and delivery of care and treatment

Each person had a comprehensive assessment completed as part of the assessment process which included people's social, cultural, physical and psychological needs and preferences. This also included a risk assessment. A care plan was then developed with the person to meet their identified needs under the framework of the Care Programme Approach (CPA).The care plans we looked at were centred on the needs of the individual person and demonstrated a knowledge of current, evidence based practice. Care plans were written and reviewed, where possible, with the involvement of the person. The consent of the person had been sought in the care plans that we looked at. Family, friends and advocates were involved as appropriate and according to the person's wishes. We saw evidence to show that staff proactively engaged with carer's by offering carers' assessments to identify their needs' and assisted them to access any support they may need.

Outcomes for people using services

The service was aimed at reducing the need for people to be admitted into hospital and to facilitate the early discharge of people from hospital by providing support and treatment during the discharge process. Staff we spoke with told us they felt the service they provided had a direct impact on reducing acute admissions to hospital and facilitating early discharge from hospital for people.

We were told by the manager that on average, people received support from the team for three months although this varied dependant on the person's wishes and needs.

The team had been accredited the Home Treatment Accreditation Scheme (HTAS) of the Royal College of Psychiatrists (RCP). The award is given to services which have been assessed as meeting set standards which cover area's such as; staffing, service provision, care plans, transfer between services and interventions people receive. This meant the teams sought opportunities to have the quality of their service reviewed by others.

The manager told us the team referred to the, 'Mental Health Crisis Care Concordat' (February 2014) publication by HM Government to ensure they were following best practice guidance. They were able to explain to us how they had used the guidance to improve the service provided.

This demonstrated that the service was committed to providing positive outcomes for people based upon evidence based practices.

The results from the exit questionnaire survey which the team sent to people, who had used the service, were overall very positive with people reporting high levels of satisfaction with the service received.

Staff, equipment and facilities

Staff we spoke with told us there were sufficient numbers of staff to deliver the care and support which people needed overall. They said the 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 range of training relevant to their role. Training some staff had completed included; nurse prescribing, trauma and drug and alcohol capable practitioner training. The staff we spoke with told us that they felt well supported by their manager.

Multi-disciplinary working

There was evidence of effective multi-disciplinary team working within the service. The team included; nurses, health care assistants, a social worker who was also an Approved Mental Health Practitioner (AMHP), consultant psychiatrist, staff grade doctor and a nurse prescriber.

The team had daily contact with the acute wards to identify people who may be suitable for early discharge from hospital with support from the team. The team had

established MDT meetings to review people who used the service. Staff told us that they usually had contact with the person's care co-ordinator on a weekly basis to promote joint working and continuity of care.

Staff told us they could discuss complex cases with a psychologist who provided them with monthly peer group supervision.

Medical staff were supportive and responsive to the crisis staff, going out at their request to do joint assessments when concerns had been raised. Staff told us that they had access to the on-call doctor out of hours.

The team had established positive working relationships with a range of other service providers such as the trauma team, General Practitioners, perinatal services and eating disorder team.

Mental Health Act

The service had a social worker within the team who was also an Approved Mental Health Professional (AMHP). In addition, they had access to a consultant psychiatrist who was approved under Section 12 of the Mental Health Act.

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

East Riding Crisis Home Treatment Team

Assessment and delivery of care and treatment

The service had a system in place which ensured that all new referrals were made through the, 'Single Point of Access' (SPA) Team between 8.00am-6.00pm. The SPA team reviewed each new referral based upon the information they received and assessed whether the person required support from the CRHHT team. The SPA team used a Red (emergency), Amber (urgent) and Green (routine) RAG matrix rating system to triage each referral made to the CRHHT team. All referrals where people were triaged as Red were seen within four to 24 hours by the SPA team. People triaged as Amber were contacted by telephone on the day of referral and an appointment was offered for them to be seen by the SPA team within five days of referral. People triaged as Green were contacted by letter or phone and offered an appointment within 30 days of referral by the SPA team.

Each person had a comprehensive assessment completed as part of the assessment process which included people's social, cultural, physical and psychological needs and preferences. This also included a risk assessment. A care plan was then developed with the person to meet their identified needs under the framework of the Care Programme Approach (CPA).The care plans we looked at were centred on the needs of the individual person and demonstrated a knowledge of current, evidence based practice. Care plans were written and reviewed, where possible, with the involvement of the person. The consent of the person had been sought in the care plans that we looked at. Family, friends and advocates were involved as appropriate and according to the person's wishes. We saw evidence to show that staff proactively engaged with carer's by offering carers' assessments to identify their needs' and assisted them to access any support they may need.

Outcomes for people using services

The service is aimed at reducing the need for people to be admitted into hospital and to facilitate the early discharge of people from hospital by providing support and treatment during the discharge process.

Staff we spoke with, however, told us that due to the rural geographical location the team covered, it was not always possible to provide more than one visit a day to some people. We were told by the manager that on average, people received support from the team for three months although this varied dependant on the person's wishes and needs.

The team had been accredited the Home Treatment Accreditation Scheme (HTAS) of the Royal College of Psychiatrists (RCP). The award is given to services which have been assessed as meeting set standards which cover area's such as; staffing, service provision, care plans, transfer between services and interventions people receive.

The manager told us the team referred to the, 'Mental Health Crisis Care Concordat' (February 2014) publication by HM Government to ensure they were following best practice guidance. They were able to explain to us how they had used the guidance to improve the service provided.

This demonstrated that the service was committed to providing positive outcomes for people based upon evidence based practices.

The results from the exit questionnaire survey which the team sent to people who had used the service were overall very positive with people reporting high levels of satisfaction with the service received.

Are services effective?

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, equipment and facilities

Staff we spoke with told us there were sufficient numbers of staff to deliver the care and support which people needed overall. They said the 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 range of training relevant to their role. The staff we spoke with told us that they felt well supported by their manager.

On the day of our visit, one of the rooms within the team building was not in use due to an infestation of bees. We were told by staff that this had been reported and pest control had undertaken a site visit and were dealing with the problem.

Multi-disciplinary working

There was evidence of effective multi-disciplinary team working within the service. The team included; nurses, health care assistants, a social worker, consultant psychiatrist and a staff grade doctor.

The team had daily contact with the acute wards to identify people who may be suitable for early discharge from hospital with support from the team. The team had established MDT meetings to review people who used the service. Staff told us that they usually had contact with the persons' care co-ordinator on a weekly basis to promote joint working and continuity of care.

Staff told us they had weekly input from a psychologist who they could discuss complex cases with and who also provided staff with monthly peer group supervision.

Medical staff were supportive and responsive to the crisis staff, going out at their request to do joint assessments when concerns had been raised.

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Mental Health Act

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

Are services caring?

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

Summary of findings

We found that people were fully involved in planning their care, and could discuss their health, beliefs, concerns and preferences with staff.

Staff supported people to participate in social and community activities to maintain and develop their networks and to help them recover.

Staff supported people's carers and family members. This included offering carer assessments to identify their specific needs. People's family members, friends and advocates were involved in the person's care as appropriate and according to the person's wishes.

Our findings

Hull Crisis Home Treatment Team

Kindness, dignity and respect

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

People using services involvement

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

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

Emotional support for care and treatment

The service provided support to people who were experiencing an acute crisis and deterioration in their mental health to prevent the need for the person to be admitted into hospital. Staff also provided support to people who were in the process of being discharged from hospital to ease the transition into the community and prevent relapse. Staff provided a range of flexible support to people dependent upon their needs. This included telephone contact and face to face visits with people in their own homes for up to four times a day.

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

Staff also provided support to people's carers and family members which included offering carer assessments to identify their specific needs.

Staff supported people to participate in social and community activities and to maintain and develop their networks to support their recovery. People were supported to stay connected to their family, friends and community, (including education) so that they did not become isolated and disconnected.

East Riding Crisis Home Treatment Team

Kindness, dignity and respect

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Staff also provided support to people's carers and family members.

Staff supported people to participate in social and community activities and to maintain and develop their networks to support their recovery. People were supported to stay connected to their family, friends and community, (including education) so that they did not become isolated and disconnected.

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 teams had a clear 'care pathway' to help people access the service. They also linked well with the acute wards to identify people they could support to be discharged early from hospital.

There were differences in the level of service which was provided to people by the two teams, due to one serving a urban community and the other a rural one. This was also related to the differences in commissioning arrangements for the two services. This meant that people receiving support from the Hull team could be visited at home up to four times a day whereas some people receiving support from the East Riding team were only visited once a day even if they preferred more frequent visits.

Staff were working to develop their skills to respond to people's changing needs and provide them with the most appropriate care.

Our findings

Hull Crisis Home Treatment Team

Planning and delivering services

The service had a system in place which ensured that all new referrals were made through the 'Single Point of Access' (SPA) Team. The SPA team reviewed each new referral based upon the information they received and assessed whether the person required support from the CRHHT team. The SPA team used a Red (emergency), Amber (urgent) and Green (routine) RAG matrix rating system to triage each referral made to the CRHHT team. All referrals where people were triaged as Red were seen within four to 24 hours. People triaged as Amber were contacted by telephone on the day of referral and an appointment was offered for them to be seen by the team within five days of referral. People triaged as Green were contacted by letter or phone and offered an appointment within 30 days of referral by the CRHHT.

The service advertised the telephone number for the Single Point of Access (SPA) service in various community based settings such as local General Practitioners surgeries and libraries to enable people to contact the service directly. The service had built up good links with specialist services such as perinatal and eating disorder teams. These teams accepted referrals directly from the Crisis Home Treatment Team which meant that people were able to access these services in a timely manner.

We were told that the nature of people's crisis was changing and the staff group were working to develop their skills to respond to people's needs and provide them with the appropriate care. For example; one nurse had recently completed training in trauma care and had begun undertaking joint assessments with the trauma team who provided care and support to armed forces veterans.

The service had also established links with two voluntary organisations that supported people who were seeking asylum and refugees to improve engagement and access to the service for these groups of people. People had access to interpreting and advocacy services if necessary.

Right care at the right time

The service operated 24 hours a day, seven days a week. From 6.00pm to 8.00am when the SPA was not available, telephone calls were re-directed to the Crisis Home Treatment Team.

The team visited people in their own home up to four times a day dependent upon their needs and level of risk. People were also supported by regular telephone calls or an agreed level of contact. The team provided telephone support to people between 8.00pm and 8.00am however; they did not provide home visits to people during these hours. This was due to the commissioning arrangements for the service which did not include providing visits to people out of hours. If people required a face to face assessment during these hours, the team re directed the person to the local Accident and Emergency (A & E) Department to be assessed by the A & E based psychiatric liaison service.

Staff told us they had no problems accessing an acute bed when needed.

Care Pathway

The team accepted referrals from a range of sources including self-referrals from people or their carers, General Practitioners, National Health Service 'Choose and Book' system, the acute wards, and Community Mental Health Teams.

Each person had a comprehensive assessment completed as part of the assessment process which included people's

Are services responsive to people's needs?

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

social, cultural, physical and psychological needs and preferences. This also included a risk assessment. A care plan was then developed with the person to meet their identified needs under the framework of the Care Programme Approach (CPA).

Staff told us that the average length of stay was three months. They told us that they had not had any problems accessing an acute bed for someone who needed one due to deterioration in their mental health.

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

Staff did say that sometimes they were unable to discharge a person who was ready to be discharged from the team if there was a delay in them being allocated a care co-ordinator within a CMHT. They told us that they did not discharge a person unless they had a care co-ordinator allocated in line with the CPA requirements.

Learning from concerns and complaints

People were provided with an information booklet about the service which included details about how they could raise complaints or concerns about the team. The team was proactive in its approach to gaining feedback from people who used the service through the use of an exit questionnaire. We saw evidence of positive changes that had been made in response to feedback from people. This included the introduction of a 'carer liaison officer' position within the team following concerns raised by some carers that they felt isolated. The carer liaison officer provided support to carers which included completing carer needs assessment forms and developing individual carer support plans with carers if required.

Complaints and concerns which people had raised were discussed in the team meetings and the service's clinical governance meetings which took place monthly. This meant that the team ensured that learning from complaints, comments and compliments were embedded in their governance processes.

We found evidence to show that the manager had taken timely action in response to complaints which they had received from some GPs about difficulties they had accessing the service by telephone. The manager had sent a letter to all GPs requesting that they also use other avenues available to contact the service if they were unable to do so by telephone. These included using the teams own e-mail account or fax facility both of which were checked regularly by the shift co-ordinator.

This demonstrated that the service was responsive and acted on feedback received to improve the service provided.

East Riding Crisis Home Treatment Team

Planning and delivering services

The service advertised the telephone number for the Single Point of Access service in various community based settings such as local GP surgeries and libraries to enable people to contact the service directly. The service had built up good links with specialist services such as perinatal and eating disorder teams. These teams accepted referrals directly from the Crisis Home Treatment Team which meant that people were able to access these services in a timely manner.

We were told that the nature of people's crisis was changing and the staff group were working to develop their skills to respond to people's needs and provide them with the appropriate care. For example; one nurse had recently completed training in trauma care and had begun undertaking joint assessments with the trauma team who provided care and support to armed forces veterans.

The service had also established links with two voluntary organisations that supported people who were seeking asylum and refugees to improve engagement and access to the service for these groups of people. People had access to interpreting and advocacy services if necessary.

Right care at the right time

The service operated from 8.00am to 8.00pm seven days a week. Between 8.00am and 6.00pm, all referrals to the team were managed through the Single Point of Access Team (SPA). Outside of these hours, telephone calls were re-directed to the Hull Crisis Home Treatment Team. The team provided telephone support to people between 8.00pm and 8.00am however; outside of these hours, people who required a face to face assessment were re directed to the local Accident and Emergency (A & E) Department to be assessed by the A & E based psychiatric liaison service. This was due to the commissioning arrangements for the service which did not include providing visits to people out of hours.

Are services responsive to people's needs?

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

People were supported by regular telephone calls or an agreed level of contact including home visits. Staff we spoke with told us that due to the rural geographical location the team covered however, it was not always possible to provide more than one visit a day to some people. This was because it could take staff a full day to travel and see a person for a visit if they lived in a remote part of the location covered. This meant that some people, who may have required more than one daily visit by the team, were only being visited once a day. Staff told us they felt if they had been able to visit some people more than once a day, that it may have prevented them from being admitted into hospital.

Staff told us they had no problems accessing an acute bed when needed. Overall, people we spoke with told us they had no problems accessing help when they needed it and they were happy with the support provided by the service. However, one person who had used the service did contact us to report that they were unhappy with the service they had received. They told us that staff had not visited them at home when they felt they had required a home visit.

Care Pathway

The team accepted referrals from a range of sources, including self-referrals from people or their carers, GP, National Health Service 'Choose and Book' system, the acute wards, and Community Mental Health Teams.

Each person had a comprehensive assessment completed as part of the assessment process which included people's social, cultural, physical and psychological needs and preferences. This also included a risk assessment. A care plan was then developed with the person to meet their identified needs under the framework of the Care Programme Approach (CPA).

Staff told us that the average length of stay was three months. They told us that they had not had any problems accessing an acute bed for someone who needed one due to deterioration in their mental health.

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

Staff did say that sometimes they were unable to discharge a person who was ready to be discharged from the team if there was a delay in them being allocated a care co-ordinator within a CMHT. They told us that they did not discharge a person unless they had a care co-ordinator allocated in line with the CPA requirements.

Learning from concerns and complaints

People were provided with an information booklet about the service which included details about how they could raise complaints or concerns about the team. The team was proactive in its approach to gaining feedback from people who used the service through the use of an exit questionnaire. We saw evidence of positive changes that had been made in response to feedback from people. This included the introduction of a 'carer liaison officer' position within the team following concerns raised by some carers that they felt isolated. The carer liaison officer provided support to carers which included completing carer needs assessment forms and developing individual carer support plans with carers if required.

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We found evidence to show that the manager had action in response to concerns received from people regarding accessing prescriptions in a timely manner by developing a nurse prescriber led clinic which was being piloted for six months.

This demonstrated that the service was responsive and acted on feedback received to improve the service provided.

Are services well-led?

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

Staff told us that they felt well supported by their manager and were proud to work for the service. Although both teams shared the same manager, staff said that the manager was a visible presence in the teams. Staff told us the doctors within the teams were accessible if they required specialist medical advice, support or supervision. They told us the doctors were responsive to the crisis staff and went out with them to do joint assessments if they were requested to do so.

All staff we spoke with told us the teams had a positive learning, transparent culture and they were committed and motivated to continually improve and develop the services.

Our findings

Hull Crisis Home Treatment Team

Vision and strategy

All of the staff we spoke with told us that they felt proud working for the team. Some staff said they had felt detached from the trust at times, but that this had improved since the new manager had been in post. All the staff we spoke with told us that they felt supported by their manager and felt they could approach them if needed. Some staff were aware of the chief executive and board level leadership through the trust and were able to identify the trust values.

Responsible governance

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

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

The service had an audit programme in place to monitor and review the quality of the service provided. This included care records, medication, infection control and staff training.

Leadership and culture

The crisis team was well-led at local level. Staff told us that their manager was very accessible and contactable. They told us they worked closely with the doctors within the team who provided them with specialist medical advice, support or supervision as needed. Staff told us they felt the team had a healthy culture where they felt comfortable discussing any issues they may have with colleagues within the team. One member of staff told us they felt the team worked very well with the resources they had available.

One member of staff we spoke with told us that there used to be a senior Band 7 member of staff who worked out of hours within the team; however, this had now ceased. They told us that they now had to contact the on-call senior manager if they required advice, but that the manager was not always knowledgeable about mental health issues. They said this could sometimes lead to delays in decision making.

Engagement

Staff were proactive in their approach to engaging with people who used the service and their carers. This included in-reach work on the acute wards to identify people who may be suitable for early discharge with support from the team. This gave people the opportunity to engage with staff from the team before they commenced periods of leave or were discharged from the ward. This enabled people and staff members to meet each other before staff began visiting people in their own homes.

Staff also proactively contacted people's carers to offer support and a carer's assessment if required.

People were asked to complete an exit questionnaire when they were being discharged from the team. The manager told us that any feedback people provided was considered and changes implemented where needed to improve the service.

Are services well-led?

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.

An advocacy service was in place within the trust and its service appeared to be well embedded particularly with people who used the service at team level.

Staff we spoke with told us they felt engaged with the trust and the team they worked in. Staff said they felt supported within their roles and were able to discuss any issues they needed to with their manager.

Performance Improvement

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

All staff we spoke with were committed and positive about changes they had made to improve the service provided. They were motivated to continually improve and develop the service.

East Riding Crisis Home Treatment Team

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