Good

Cheshire and Wirral Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXAX2	Trust Headquarters, Redesmere	Liaison psychiatry, The Countess of Chester Hospital	CH2 1UL
RXAX2	Trust Headquarters, Redesmere	Crisis Resolution Home Treatment Team, Cheshire West	CH2 1BQ
RXAX2	Trust Headquarters, Redesmere	Crisis Resolution Home Treatment Team, Cheshire East	CW12 1BU

Summary of findings

RXAX2	Trust Headquarters, Redesmere	Health based place of safety, the Countess of Chester Hospital	CH2 1UL

This report describes our judgement of the quality of care provided within this core service by Cheshire and Wirral Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Cheshire and Wirral Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cheshire and Wirral Partnership NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- Teams were fully staffed and carried a caseload which was monitored and assessed daily with input from the consultant psychiatrist or junior doctor. Risks were considered from the point of referral to discharge and clearly documented within service users records. Workflow was discussed in handover. Work was prioritised by the teams and co-ordinated through a dedicated member of the team responsible for triage and shift co-ordination. This helped to ensure the teams worked efficiently to meet the daily demands of the service each day.
- We saw good working relationships between teams: crisis care, street triage, liaison psychiatry, community teams, accident and emergency staff. The hospital inpatient wards and a dedicated member of the crisis team communicated on a daily basis to offer a structured approach to support people who use services. Care plans and crisis intervention plans were present and up to date. Staff understood the guiding principles of the Mental Health Act. We saw evidence of this in practice where staff always looked to provide the least restrictive care options, in collaboration with the person and their family/carer.
- Teams received mostly positive feedback from people who use the service with regard to their care and treatment. The Care Quality Commission carry out an annual survey of community mental health service users, sending a questionnaire to service users who are in receipt of care from community teams. The survey carried out in 2014 showed the trust scored better than average overall in comparison with other trusts.
- We observed a collaborative approach between teams to support people being referred to crisis services. This helped to prevent inappropriate admissions to inpatient services and supported timely discharge from hospital with home treatment packages. Staff had a good awareness of the timeframes for urgent admissions and recorded times from referral throughout the process in individual service user records. Trust data showed a low number of complaints received into the service. Staff made us aware that any issues were often dealt with at a local level and did not get escalated through the complaints process. In support of the crisis care concordat, street triage teams were introduced to East and West Cheshire in November 2014 on a one year pilot scheme. This had resulted in a 92% reduction in the number of people detained under the Mental Health Act under section 136 and a subsequent reduction in the use of the health base place of safety.
- Staff we spoke with were aware of the organisations vision and values. The trust was working to embed aspects of the Crisis Care Concordat through improvements in service design and delivery. All staff reported enjoying their work but in teams where there had been lots of change, morale varied. Staff training was mostly up to date.

However:

- The Crisis Care Concordat and Royal College of Psychiatrists recommend that teams are multi-disciplinary in composition but the teams at Cheshire and Wirral Partnership NHS Foundation Trust were mainly composed of registered nursing staff.
- The health based place of safety at the Countess of Chester Hospital was basic. The toilet facility was not easily accessible or assessed as safe for people in an acute phase of a mental health crisis.
- Staff did not always understand their role with regard to assessing mental
- capacity and consent to treatment. This was not always clearly documented within patient records.
- Service users did not always feel involved in their care planning. We observed that some plans lacked detail and evidence of patient involvement. Staff did not routinely offer copies to service users.
- Management information was not available to support the monitoring, analysis and evaluation of referral, or triage and treatment times. This meant teams could not effectively review their performance levels or ensure adherence to trust policy and recommendations included within the Crisis Care Concordat.

Summary of findings

- Staff supervision and appraisal was low in some areas where there had been changes within the teams. This was also highlighted as an issue at trust level. Enhancing the skills of appraisers, supervisors and line manager's formed part of the overall trust strategy.
- Team managers acknowledged that teams had different strengths and different ways of working. Previously team managers held meetings on a quarterly basis but there was no current link to unite the teams and share best practice.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Staff saw service users at locations that were clean, safe and provided confidentiality.
- All teams were fully staffed and carried a caseload which was monitored daily. Risk issues were assessed, discussed by the Teams and managed throughout the process from referral to discharge.
- Individual risks were assessed at the point of referral and updated at regular intervals throughout the assessment and treatment process.
- Effective safeguarding arrangements were in place with consideration for all ages and family members.
- Team meetings and regular trust bulletins were used to share learning from incidents. Staff could describe changes to practice following incidents.

However:

- Crisis plans were not always comprehensive and people who use the service did not routinely receive a copy.
- There were no toilet facilities located near the room used for people detained under section 136 of the Mental Health Act at The Countess of Chester Hospital. The public toilets situated within the A&E department, which people detained in the 136 suite had to use had not been risk assessed.

Are services effective?

Good

We rated effective as good because:

- All service users had care plans which were updated on a regular basis
- Physical health care was considered and service users were supported to attend their GP. A registered mental health nurse worked within one of the primary care teams in West Cheshire to support a joined up approach between physical and mental health care needs.
- We saw evidence of effective communication across teams. Crisis teams attended hospital wards and community mental health teams daily to ensure there were good lines of communication and support. This enabled wards to provide packages of care to patients during the discharge process and crisis teams had a good understanding of bed availability for urgent admissions.

Summary of findings

- Staff had an understanding of the guiding principles of the Mental Health Act and how it affected their role.

However

- Team composition was predominantly nursing staff and not multi- disciplinary in nature as recommended by The Royal College of Psychiatrists and the Mental Health Crisis Care Concordat.
- The quality of interventions contained within care plans varied between services.
- Staff did not always understand their role with regard to assessing mental capacity and consent to treatment. This was not always recorded within patient records.

Are services caring?

Good

We rated caring as good because:

- There were positive comments from people who used the services about their experience of receiving care from all teams.
- At the start of treatment, service users and carers were offered a pack containing information to support their treatment. This included telephone numbers of who to contact in a crisis and details of other supportive agencies both within the trust and externally.

However:

- Some care plans were very directive and did not show patient involvement. Service users were not routinely offered copies of their care plans.

Are services responsive to people's needs?

Good

We rated responsive as good because

- We observed a joined up approach between teams to prevent inappropriate admissions to inpatient services and support timely discharge from hospital with home treatment packages.
- All teams were aware of objectives within trust policy of timely assessment of service users in crisis. We observed teams arranging for people to be seen for urgent assessment by restructuring workloads and being flexible to the needs of individuals.
- People who use the service could access information on a wide range of support organisations through discussions with staff and information available on wards or within information packs.

Summary of findings

- The introduction of the street triage teams had recorded up to 92% reduction in the number of people detained under the Mental Health Act under section 136 and a subsequent reduction in the use of the health based place of safety.
- Trust data showed a low number of complaints received into the service, staff made us aware that any issues are often dealt with at a local level and do not get escalated through the complaints process.

However:

- There was a lack of management information available to support the monitoring, analysis and evaluation of referral, triage and treatment times. This meant team's were not able to review their performance levels to ensure adherence to trust policy and recommendation's within the Crisis Care Concordat effectively.

Are services well-led?

Good 

We rated well led as good because

- Staff we spoke with had an awareness of the organisations vision and values. We saw posters displaying the six C's; Courage, Care, Compassion, Commitment, Competence and Communication. Staff made reference to these when asked.
- We saw evidence that the trust was working to embed aspects of the Crisis Care Concordat through improvements in service design and delivery. There was a regular meeting to discuss implementation and work to an action plan.
- Staff training was above the trust target in most areas.
- Staff morale varied within teams. Where services had been impacted with large amounts of change, there was some anxiety expressed by staff members with regard to staff consultation and involvement in the changes to service delivery. Most staff told us teams are supportive of each other and they enjoyed their work.

However:

- Staff supervision and appraisal figures in some localities were low. We were advised by one of the team managers this had been impacted by staff sickness, the rotation of more staff onto night duty and new staff coming into the teams.
- There was a lack of structure around monitoring of detailed performance of teams as recommended within the Crisis Care Concordat at local or board level.

Summary of findings

- Crisis care team managers acknowledged that teams had different ways of working. There had previously been meetings of team managers on a quarterly basis but there were no current links to unite the teams to share best practice.

Summary of findings

Information about the service

The Cheshire and Wirral Partnership NHS Foundation Trust provided a range of crisis services to adults within Cheshire and Wirral. The service included crisis resolution and home treatment teams, psychiatric liaison teams and a street triage team.

The crisis resolution home treatment teams were located at Upton Lea, Chester (West), Congleton Library (East) and Clatterbridge Health Park (Wirral). The teams provided a 24 hour, 7 day a week service to adults in an acute phase of mental illness who, without intervention might require an admission to a psychiatric hospital. The teams were also actively involved in discharge planning with the provision of intensive home treatment to help minimise length of hospital admissions. We visited teams at Upton Lea (West Cheshire) and Congleton (East Cheshire) for the purpose of this inspection.

The psychiatric liaison teams were located at Macclesfield District General Hospital, Leighton Hospital, Crewe, Countess of Chester Hospital, Arrowe Park Hospital (Wirral University Teaching Hospitals) and Clatterbridge Cancer Centre. The teams aimed to provide a multi-disciplinary, specialist mental health service to assess, support and treat patients in hospital settings. We visited the team at the Countess of Chester Hospital for the purpose of this inspection.

The policing and criminal justice bill (2015) and the Mental Health Crisis Care Concordat (2014) indicated the need to review the efficacy and efficiency of health-based places of safety. The Care Quality Commission report Right Here, Right Now (2015) identified innovative approaches towards crisis care. Most of these are effective where partnership working is evident and services are integrated around the needs of the person in crisis.

The Cheshire and Wirral Partnership NHS FoundationTrust operated a street triage service as a joint approach with Cheshire Police in East and West Cheshire. This was a one year pilot scheme started in November 2014. Street triage workers accompanied police officers to incidents where police believe people need immediate mental health support. The teams ensured people get the medical attention or professional input quickly, which avoided the need to place people in police custody inappropriately or section 136 assessments under the Mental Health Act. The triage team covered East and West Cheshire and consisted of four registered mental health nurses and four police officers. It provided cover on a rotational basis between 8am and 2am each day.

There were three health based places of safety across Cheshire and Wirral. They are operated by the appropriate acute trust. Staff employed by Cheshire and Wirral Partnership NHS Foundation Trust work out of the premises. They are located within the accident and emergency departments of Arrowe Park Hospital, the Countess of Chester Hospital and Macclesfield District Hospital. We visited the place of safety at the Countess of Chester Hospital.

The health-based place of safety (HBPoS) is where people arrested by the police under section 136 of the Mental Health Act are taken, for an assessment of their mental health for their safety or the protection of others. Police would always attempt to make use of a health based place of safety unless there are clear risks, for example, risks of violence which would require the person being taken to a police cell instead. The HBPoS at The Cheshire and Wirral Partnership NHS offered a 24 hour, 7 day a week service, open 365 days per year.

Cheshire and Wirral Partnership NHS Foundation Trust had been inspected previously. However, the Care Quality Commission had not previously inspected mental health crisis service or health based places of safety for this trust.

Our inspection team

Our inspection team was led by:

Chair: Bruce Calderwood, Director Mental Health, Department of Health (retired)

Summary of findings

Head of Inspection: Nick Smith, Care Quality Commission

Team Leaders: Sharon Marston, Inspection Manager (mental health), Care Quality Commission,

Simon Regan, Inspection Manager (community health services), Care Quality Commission.

The team was comprised of: a CQC inspector, a consultant psychiatrist, a social worker specialising in crisis resolution home treatment teams, a mental health act reviewer and an expert by experience with lived mental health experience.

Why we carried out this inspection

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

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?

Prior to the inspection we reviewed a range of information we held about mental health crisis services and health based places of safety and asked other organisations to share what they knew.

We carried out an announced visit on 23 and 25 June 2015 and visited:

- Crisis resolution home treatment team (Cheshire West) based at Upton Lea, psychiatric liaison team based at the Countess of Chester Hospital and the health based place of safety at the Countess of Chester Hospital.

We also carried out an announced visit on 7 July 2015 and visited:

- Crisis resolution home treatment team (Cheshire East) based at Congleton Library.

The inspection team:

- Spoke with a service manager and deputy service manager.
- Spoke with three managers or acting managers that manage the service locations
- Spoke with 18 other staff members including: clinical lead, doctors, nurses, a pharmacist and support workers.
- Spoke with the team leader for the street triage service and a mental health nurse by telephone.
- Spoke with a nurse working in the accident an emergency department at The Countess of Chester Hospital by phone.
- Accompanied a member of the team on one home visit.
- Spoke with one patient in hospital and nine people who have used the service and one carer by telephone.
- Attended one handover meeting.
- Looked at 17 treatment records of patients.
- Carried out a specific check of the medication management.
- Viewed minutes of team meetings.

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 looked at 16 feedback questionnaires collected by the Cheshire East team from service users. This

Summary of findings

feedback provided positive comments about the service, stating: staff are professional, caring and approachable. One service user described how staff arranged a hospital admission quickly, another commented on staff always being available when you need someone.

Carer feedback collected by the Cheshire East team was a small sample of five comment cards and one carer we spoke with by phone;Three out of five carers had been updated on changes to care plans, felt they had been involved in the assessment process and had treatment explained to them. Only one carer reported being informed of carer services and being offered a carers' assessment. Additional comments included; 'overall satisfied with help and consideration', 'support has been excellent'. There was no carers group, carers were seen on an individual basis as required. some carers did not feel their views had been sought and had not been informed about carer's services.

Good practice

In November 2014 Cheshire and Wirral NHS Foundation Trust teamed up with Cheshire Police to participate in a new approach to policing incidents involving people with mental ill-health. The service has demonstrated up to 92% reduction in the number of people detained under section 136 of the mental health act.

Areas for improvement

Action the provider SHOULD take to improve

The trust should take steps to ensure that crisis resolution home treatment teams and liaison psychiatry teams are multi-disciplinary in composition in accordance with their own policy, the Crisis Care Concordat and Royal College of Psychiatrists' recommendations.

The trust should ensure that the health-based place of safety at the Countess of Cheshire Hospital has toilet facilities that are easily accessible and safe to comply with the requirements of the Crisis Care Concordat.

The trust should ensure that medicine management is audited in accordance with trust policy and national guidance to ensure practice is reviewed.

The trust should ensure that staff understand their responsibilities with regard to assessing mental capacity for consent to treatment and ensuring this is clearly documented in patient records.

The trust should ensure that patients are involved in their care planning and are routinely offered a copy of their care plan.

The trust should ensure that there is a system to capture all the data requirements of the Crisis Care Concordat to asses, monitor and improve the quality and safety of the service

The trust should ensure staff receive regular supervision and appraisal and they keep records to evidence compliance.

Cheshire and Wirral Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Liaison psychiatry, The Countess of Chester Hospital	Redesmere, Liverpool Road,Countess of Chester Health Park, Chester. CH2 1BQ
Crisis Resolution Home Treatment Team, Cheshire West	Redesmere, Liverpool Road, Countess of Chester Health Park, Chester. CH2 1BQ
Crisis Resolution Home Treatment Team, Cheshire East	Redesmere, Liverpool Road, Countess of Chester Health Park, Chester. CH2 1BQ
Health based place of safety, the Countess of Chester Hospital	Redesmere, Liverpool Road, Countess of Chester Health Park, Chester. CH2 1BQ

Mental Health Act responsibilities

Mental Health Act training formed part of the mandatory training for staff, 78% of staff working in crisis home treatment teams had undertaken this training.

Staff we spoke with were able to describe how they aimed to deliver care at home thus supporting the principle of least restrictive option for care. There was no Approved Mental Health Professional within the teams, however one staff member at Upton Lea had just completed the necessary training and was awaiting confirmation of their status. The team described how people using services on a community treatment order would remain in regular contact with their care coordinator within the CMHT who would retain responsibility for advising service users of their rights at regular intervals. A member of the crisis team

would always attempt to attend a Mental Health Act assessment. This would support the option of intensive home treatment as an alternative to detention wherever appropriate in consultation with the assessment team and the service user.

All teams knew how to access the trust policy. However, staff we spoke with were not aware of the recent changes to the Mental Health Act code of practice. Staff informed us that if they had any concerns they would refer to the Emergency Duty Team.

The street triage workers support colleagues in the field to assess people in crisis situations where mental health issues are impacting the situation. Police officers attending the scene are responsible for any detention under 136 of the Mental Health Act

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training formed part of the mandatory training for staff. Eighty five percent of staff working in crisis home treatment teams had undertaken this training.

Service users being treated by the crisis team were living in the community and had a high degree of autonomy and independence to make informed decisions about their care.

- At Upton Lea staff were able to describe how they always discussed options with service users and sought clarification and agreement but this was not well documented.
- At Congleton we found evidence that capacity and consent was discussed and clearly documented within care records.
- Street triage teams worked closely with police at the scene to assess capacity and consider a range of supportive options to minimise hospital admission.
- In liaison psychiatry, staff described how capacity and consent was dealt with by the medical staff on the wards. However there was no evidence in the patient records that we viewed in liaison psychiatry to demonstrate that issues around mental capacity or consent had been discussed with patients.

All teams knew how to access the trust policy and who to contact for further advice and support.

Good

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Our findings

Crisis Resolution and Home Treatment Teams at Upton Lea, Chester (Cheshire West) Crisis resolution home treatment Team at Congleton Library (Cheshire East)Street Triage for Cheshire East biased at Upton Lea

Safe and clean environment

Most service users were seen by the crisis home treatment team in their own homes to support on going care and treatment during a crisis period. The teams worked flexibly to support the needs of the person using services and agreed to meet in other places by prior arrangement.

The crisis and home treatment team at Upton Lea rarely saw patients at the team premises but there was an interview room available. The room was well furnished, clean, safe and appeared sound proof. There was an alarm system fitted to allow staff to call for assistance if required. Staff told us they never had to wait for a room to become available. People did not visit the team at Congleton library.

The designated place of safety at The Countess of Chester Hospital was a room located within the accident and emergency (A&E) department and reserved for the use of patients with mental health issues. The room was ligature free and furnished with two chairs and one sofa made of durable material which was anti-ligature and heavy to prevent it being thrown. The room had two exits and an alarm fitted to the wall to call for assistance if needed. Staff would make drinks and snacks available as required outside of the facility. The nearest toilet was located on the corridor of the A&E department. This was a toilet used for all visitors to the A&E department. It had no risk assessment for use by people using the health base place of safety. The A&E department provided emergency resuscitation equipment.

Safe staffing

The staffing establishment at Upton Lea was:

- Team manager - 1
- Qualified nurses - 16
- Clinical lead - 1
- Occupational therapist - 1
- Nursing assistants - 3

A deputy service manager had been appointed by the trust on a one year secondment to help shape the service in accordance with the mental health crisis care concordat.

There had been a number of staffing changes over the past 12 month this was due to retirements and changes in ways of working to improve efficiency. New staff had been recruited into vacancies and the team was fully staffed. Sickness levels had risen to 9% at April 2015. All of these shifts had been covered by senior members of the team working in the shift, staff working additional hours and regular bank staff. There had been difficulty covering some night shifts to facilitate two staff on each shift. On three occasions a contingency plan had been implemented where there had only been one staff member on duty, this resulted in a limited service through the night. Members of staff advised us this had caused some confusion and anxiety amongst the team. We were able to feed this back during our inspection and the team leader was going to circulate the night cover protocol once again to all staff members and discuss in the team meeting.

The staffing establishment at Congleton was:

- Team leader - 1
- Qualified nurses - 16
- Nursing assistants - 3.5
- At the time of the inspection two staff were away on maternity leave

The team was fully staffed, sickness at April 2015 was 6% and there were two staff members currently on maternity leave. An additional member of staff had been recruited to help cover maternity leave but had since been successful in acquiring a permanent post in the team. Further advertising to fill the maternity post had not been successful. In the three months prior to the inspection 25 shifts had been covered by regular bank staff and 12 shifts had not been covered. This had resulted in staff

rescheduling work, ensuring all risks were considered. The service operated from 8.30am to 9pm and handed over to Limewalk Rehabilitation Assessment Unit for night cover by telephone.

The Royal College of Psychiatrists' and the mental health crisis care concordat recommend that crisis teams are multi- disciplinary in composition to also include: registered mental health nurses, social workers, occupational therapist, psychologists, support workers, pharmacists, consultant psychiatrist and nurse prescribers, to simplify and improve access. We asked team leaders why teams were mainly staffed with mental health nurses. We were advised that this had been requested by the trust until recently when recruitment had been opened to other disciplines. However the only suitable applications had been received from nursing staff. The trust policy clearly stated that teams should be multi-disciplinary in composition.

Crisis teams described a shared caseload model of working utilising a team approach to care delivery. This helped provide a consistent way of working across a 7 day a week service. At Upton Lea we saw caseloads varying from usually around 25 but up to 40 in any given day. At Congleton the caseload varied from 8 to 20 in any given day. They described how work was prioritised by risk rating each service user and prioritising visits and phone contact each day. Both teams covered a large geographical area and this was taken into account when planning visits to make better use of staff time and reduce travelling. Service users and carers were also involved in decisions about visit times, location and duration. Visits might be re-arranged during any staffing difficulties and on occasion where appropriate, people who use services were provided with telephone support as an alternative. Risk would always be considered and face to face visits undertaken whenever risk necessitated.

Both teams had access to psychiatrists. The crisis team at Upton Lea had a psychiatrist attached to the crisis team who also had responsibility for 12 patients on an acute inpatient ward. There was also access to another consultant psychiatrist who had responsibility for a 24 bedded ward. Both psychiatrists worked in the same building as the crisis team and the team reported having immediate access to psychiatry support. The crisis team at Congleton had access to a psychiatrist and a senior house officer based at Millbrook Unit at Macclesfield. Due to the remoteness of the Congleton base, most communication with the doctors was by phone and video link, the team reported that this worked well. Outside of normal working hours, teams could access a psychiatrist on call.

Mandatory training for the mental health crisis teams across the trust was 89% which was higher than the trust objective of 85%. There were two areas below 75%,basic life support 72% and venous thromboembolism 53%.

Staff shortages had not previously been recorded. However during the last month all staff teams had started using the datix system to report any shifts not filled.

The street triage team consisted of four mental health nurses and four police officers that worked across East and West Cheshire on a rota basis covering the hours from 8am to 2am the following day. Outside of these hours, police get advice and support through the crisis teams by phone. During periods of absence, shifts were not covered and the crisis teams offered support by telephone.

Assessing and managing risk to patients and staff

A member of staff was allocated the role of co-ordinator for each shift. This included taking referral calls and making an initial assessment which included a basic risk assessment to support categorising the clinical response according to priority and clinical need. Trust policy states that urgent referrals should be seen within one hour. The teams advised that urgent referrals were seen as priority and their aim was to attend within one hour wherever possible, there was no central point data available to monitor and evaluate this requirement. Assessments undertaken post end of working shift (9pm) were carried out in a place of safety, such as accident and emergency departments. Any assessments for new referrals were seen by two staff members, one of whom will be a qualified member of staff. If staff consider the service user to be a risk to themselves or others, they may call the emergency services. The crisis teams had access to beds on the acute and psychiatric intensive care wards within the trust. Should the service user require a hospital admission, this would be sourced by the team co-ordinator. We saw evidence that risk assessments were completed at point of referral and at regular intervals throughout the treatment cycle.

Crisis plans were in place for service users but some were quite basic with the only detail being the telephone number of the crisis team. The crisis teams did not routinely leave copies of crisis plans with patients, we were

Good

Are services safe?

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

informed that any crisis plans left with patients are usually hand written and contain basic information. The service users we spoke with confirmed this; they did however feel that crisis plans contained sufficient detail for them to access additional support as required. Service users' were always provided with details of who to contact in an emergency.

There was little evidence that teams make referrals to the advocacy service and service users confirmed this. Staff members also confirmed there was little use of advocacy services. Packs given to service users at the start of treatment did contain details of the advocacy service.

We saw evidence of some use of advance decision making within service user records but this was not offered as routine by the team.

All teams had a good working knowledge of the trust lone working policy and were able to demonstrate how this worked in practice.

In the crisis teams medicines were safely stored and appropriate records were made of medicines receipt and handling.

Staff were trained in safeguarding, Upton Lea 74% and Congleton 92%. Staff had a good understanding of safeguarding issues which were flagged and shared during handovers. Staff knew how to report safeguarding concerns and who to refer to within the trust for support and guidance.

The street triage team offered advice to officers working in the field and followed a street triage pathway to make a decision with the officers and the person concerned about support with mental health issues. The team offered support at the scene and endeavoured to find the least restrictive option to support the person. If this resulted in detention under 136 of the Mental Health Act, this would be done by the attending police officers and the person would be accompanied to the nearest health based place of safety. Where possible, those attending would seek appropriate transport to hospital and ideally this would be by ambulance. Where this was not possible, and there were no physical health issues, a police vehicle may be used. The street triage team would register the person to accident and emergency department which enabled any physical health issues to be treated. They then make contact with the Emergency Duty Team who would attend the health based place of safety to complete an assessment under the Mental Health Act. It was common practice for the police to remain with the person until the person was assessed. This assessment was supported by a member of the crisis team, who worked with the police, approved mental health practitioner and the person involved to see if there could be a solution to offer home treatment rather than a hospital admission.

Track record on safety

Upton Lea reported 27 incidents in the last 12 months and Congleton reported 54 incidents. Managers were able to share examples of how learning from incidents had been shared and how changes to practice had been made.

Reporting incidents and learning from when things go wrong

Staff had an understanding of how and when to use the incident reporting system DATIX. Staff had only just started to report any staff shortages where shifts were not covered through the DATIX system to monitor trends.

Staff members described how details of learning and changes in practice from incidents were circulated to teams by the trust through email in a regular bulletin. This was also a regular agenda item at team meetings.

Staff had access to additional support and supervision following serious incidents if required.

Psychiatric Liaison at The Countess of Chester Hospital, Chester

Safe and clean environment

The psychiatric liaison team saw patients in A&E where there were a number of rooms available or on the hospital wards. Patients were offered a confidential place for discussion and this was afforded to them as required.

Safe staffing

The psychiatric liaison team consisted of: a team leader and four mental health nurses. Trust policy stated that the service aimed to offer a multi-disciplinary approach, however we noted only nursing staff working within the team. There was recently a social worker attached to the team for a fixed term but there were no plans to replace this provision. The service operated with two staff on duty from 9am to 5pm and one staff member on duty between 1pm and 9pm each weekday and one staff member each shift during the weekend. After 9pm the service handed over to the crisis night team at Upton Lea.

Good

Are services safe?

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

Sickness levels at April 2015 were high at 13%. Staff were working additional shifts and regular bank staff were covering shifts. There were nine shifts not covered during April and May 2015. At times the team had needed to hand over to the crisis team at 5pm. This meant that staff would only respond to urgent requests to see patients from A&E and did not respond to routine referrals, this had limited impact on service provision.

The psychiatric liaison team at The Countess of Chester Hospital had access to a psychiatrist who also worked on the acute wards and in primary care, the team advised that the arrangement worked well. They did not have access to an old age psychiatrist and this had been raised as a concern.

Assessing and managing risk to patients and staff

Risk assessment within psychiatric liaison:

- The team see patients on the wards and work closely with ward based staff to assess risk and plan support as required.
- Where service users are known to the service, the risk assessment would be updated, where people are new to mental health services, a full risk assessment is completed.
- Referrals into the service were categorised as emergency, urgent or routine based on certain criteria. Trust policy stated that emergency referrals were seen within one hour. The information we viewed showed this was achieved.
- The risk assessments we viewed were completed and updated at regular intervals.

Staff had a good understanding of safeguarding issues, training showed 83% of staff were up to date with training. Any issues identified would be noted and shared during handovers. Staff described how to report safeguarding concerns and who to refer to within the trust for support and guidance.

Liaison psychiatry did not store or handle medication; this was done by medical staff on the wards.

Are services effective?

Good

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

Summary of findings

Our findings

Crisis Resolution and Home Treatment Teams at Upton Lea, Chester (Cheshire West), Crisis resolution home treatment Team at Congleton Library (Cheshire East), Street Triage for Cheshire East and West based at Upton Lea.

Assessment of needs and planning of care

We examined 10 care records in the crisis team. There was a current care plan present for each service user. In eight care plans, we found evidence of service user's views and involvement, nine were holistic taking into account a full range of problems and needs and all were recovery focused and orientated around strengths and goals. In eight cases we found evidence that the service users had not received a copy of their care plan. We asked the teams why this was the case and were informed that staff needed to return to base to write care plans therefore copies were not routinely given to people who use services.

Paper files were used to support the handover process and were updated each time a new care plan or risk assessment was completed on the electronic records system. Records were stored securely.

Best practice in treatment and care

Although the crisis teams had a named pharmacist contact there was no regular or frequent input from the trusts clinical pharmacy service.

At Upton Lea, medicines reconciliation was not routinely completed and there was no nominated individual overseeing the process. One record showed a delay of a month in recording and taking action on a test result showing a sub therapeutic medicines level. The named pharmacist advised that medicines reconciliation had been discussed with local leads and training would be provided in this area. Medicines management activities were not audited on a regular basis in order that practice could be reviewed in accordance with trust policy and national guidance.

At Congleton, following risk assessment medicines were removed from patients' homes for safe administration, supported by trust staff. This level of support was not provided at Upton Lea although staff explained that they would prompt and observe medicines administration in patients' homes. Support with medicines administration was provided by qualified nurses or suitably trained support workers. Entries were made in patients' electronic care notes recording for example, 'took medicines in my presence' but medicines administration charts were not used. This meant it was not possible to easily audit the prescribing and administration of patients' medicines. Nurses described a step-wise risk based approach to returning medicines responsibility to the patient but trust policy did not provide guidance, or assess best practice in this.

There was no input into any of the teams from psychology unless specific referrals were made. Teams did work closely with the **Improving Access to Psychological Therapies (IAPT) and the Community Mental Health Teams (CMHT) to support future therapy post discharge from the crisis team.**

At Upton Lea, there was a monthly training session held after the team meeting where guest speakers were invited to deliver short training, advisory sessions to the staff team. Staff described how they received emails from the trust highlighting best practice and updates to NICE guidance. There was a plan to support staff in development options when the new team was embedded.

There had been a number of new initiatives introduced into the team;

- an interactive white board to co-ordinate shifts, improve co-ordination and maintain a permanent record of the day's activity for future reference,
- a change in shift patterns to support continuity of service delivery and improve efficiency,
- expanding night provision to two staff members on each shift,
- clustering of activities throughout the shift into geographical areas to reduce travel time
- the introduction of the street triage team.

At Congleton, there were three community specialist practitioners in the team and there was evidence of updates on national guidance on staff notice boards. Video conferencing was utilised each day for handovers with the

Are services effective?

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doctor at Macclesfield, saving valuable time travelling. This team also worked with the street triage scheme. The team was considering options to extend the night time provision with a crisis team member on duty.

Staff we interviewed were able to describe interventions to assist service users for example with anxiety, medication compliance and relapse prevention work, use of standard assessment tools for depression and we saw evidence of this in care plans.

Service user's physical health needs were discussed and supported through referral to GP services in the community. We were able to track some referrals through to longer term care packages to support physical health issues.

The street triage team were able to supply us with details to support their effectiveness since the start of the project in November 2014 to February 2015.

East Cheshire

- Number of incidents dealt with - 220
- Potential section 136 incidents intervened at - 52
- Number of section 136 detentions undertaken by the team - four

West Cheshire

- Number of incidents dealt with - 209
- Potential section 136 incidents intervened at - 43
- Number of section 136 detentions undertaken by the team - seven

The figures help to demonstrate the effectiveness of the street triage team in reducing the number of section 136 detentions by the police.

Skilled staff to deliver care

The crisis teams consisted of mental health nurses, support workers, one occupational therapist, consultant psychiatrists and a junior doctor. The teams had a comprehensive team handover at the start of each shift and in the middle of each day. They could make referrals to other allied professionals. Because interventions are short term, usually up to six week duration, service users were often receiving support from their nominated care co-ordinator or members of the community mental health team on an on-going basis. Crisis teams tried to maintain relationships by attending community mental health team multi-disciplinary meetings and ward rounds on a daily basis.

Staff we spoke with described receiving supervision which they found beneficial to support their development and improve clinical practice.

At Upton Lea trust data reported supervision rates at 11% and appraisal rate of 7%, the team manager had found difficulty meeting with staff due to staff sickness and an increase in staff working night duty. There had been a 50% turnover of staff number to the team some of whom were recently appointed. Mandatory training overall was 75% which was below the trust target of 85%. New staff into the team had been allocated training but this was awaiting completion.

At Congleton trust data reported 69% of staff were receiving supervision and 90% for appraisal, the team manager thought these figures might be impacted by staff on maternity leave and long term sick. Mandatory training overall was 96%.

Both crisis teams had a mixture of staff with different skills. There were three community specialist practitioners, two staff members at Congleton were enrolling on the nurse prescriber training, and the team at Upton Lea were hoping to develop staff skills through on going training when the new team had become embedded. New staff to the teams receive an induction, a buddy to work alongside and two weeks to shadow experienced team members.

Multi-disciplinary and inter-agency team work

Handovers take place at the start of every shift and at 1.30pm each day. Each service user was discussed in detail with regard to the level of risk, interventions and visits were prioritised and co-ordinated by the shift co-ordinator for the shift. Doctors participated in the meetings routinely during the week.

Both crisis teams demonstrated good working relationships with other parts of the trust and external providers:

- Staff from the teams attended the hospital wards and CMHT meetings each day to support the discharge of patients with integrated care packages for intensive home treatment as required.

Are services effective?

Good

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

- The teams worked closely with the bed manager to make available suitable places for urgent admissions.
- Staff attended all Mental Health Act assessments to try and offer alternative packages of care to people helping reduce the need for them to be detained in hospital where appropriate.
- There were good links with primary care through a mental health nurse specifically placed within primary care to support people who use services.

The street triage team worked closely with the crisis teams and one team were located within the same building at Upton Lea. They met every 4-6 weeks with members of the wider team including: police officers, local safeguarding team, crisis team, emergency duty team.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Mental Health Act training formed part of the mandatory training for staff, 78% of staff working in crisis home treatment teams had undertaken this training.

Staff we spoke with were able to describe how they aimed to deliver care at home thus supporting the principle of least restrictive option for care. There was no Approved Mental Health Professional within the teams, however one staff member at Upton Lea had just completed the necessary training and was awaiting confirmation of their status. The team described how people using services on a community treatment order would remain in regular contact with their care coordinator within the CMHT who would retain responsibility for advising service users of their rights at regular intervals. A member of the crisis team would always attempt to attend a Mental Health Act assessment. This would support the option of intensive home treatment as an alternative to detention wherever appropriate in consultation with the assessment team and the service user.

All teams knew how to access the trust policy. However, staff we spoke with were not aware of the recent changes to the Mental Health Act code of practice. Staff informed us that if they had any concerns they would refer to the Emergency Duty Team.

The street triage workers support colleagues in the field to assess people in crisis situations where mental health issues are impacting the situation. Police officers attending the scene are responsible for any detention under 136 of the Mental Health Act.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training formed part of the mandatory training for staff. Eighty five percent of staff working in crisis home treatment teams had undertaken this training.

Service users being treated by the crisis team and liaison psychiatry were mainly living in the community and had a high degree of autonomy and independence to make informed decisions about their care.

- At Upton Lea staff were able to describe how they always discussed options with service users and sought clarification and agreement but this was not well documented.
- At Congleton we found evidence that capacity and consent was discussed and clearly documented within care records.
- Street triage teams worked closely with police at the scene to assess capacity and consider a range of supportive options to minimise hospital admission.
- In liaison psychiatry, staff described how capacity and consent was dealt with by the medical staff on the wards. However there was no evidence in the patient records that we viewed in liaison psychiatry to demonstrate that issues around mental capacity or consent had been discussed with patients.

All teams knew how to access the trust policy and who to contact for further advice and support.

Street triage teams worked closely with police at the scene to assess capacity and consider a range of supportive options to minimise hospital admission.

Psychiatric Liaison at The Countess of Chester Hospital, Chester

Assessment of needs and planning of care

We examined four care records in liaison psychiatry. There was a current care plan for each patient. We found these to be more specific to a particular issue rather than covering a range of problems and needs. There was no evidence of the assessment of mental capacity or consent. We asked the nurses about this and we were informed that capacity issues are the responsibility of the medical team on the wards. Trust policy does state that the psychiatric liaison team has responsibility for issues of capacity and consent. Patients had not been given copies of their care plans.

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.

Best practice in treatment and care

The team took referrals from within the hospital wards and they also visited oncology and cardiology one day weekly and the older persons ward at Ellesmere Port Hospital. they also attended a clinic for a local employer one day a week to offer support on mental health related issues.

Physical health care needs were dealt with by medical staff.

Interventions for support with mental health issues were limited due to the time spent on the ward. However staff were able to make referrals to other services and these were followed up post discharge.

Staff did not describe using any routine clinical outcome measures and we did not find any evidence of this in patient care records.

Skilled staff to deliver care

The team was made up of nursing staff only. The staff team was experienced and there had been no new starters into the team for some time. Staff described how the team had been reduced in size recently when a staff member who left had not been replaced. They had the benefit of a social worker for a fixed term over the winter months but this had not been replaced at the end of the term. The team felt this had impacted on service provision together with high sickness. this had meant some shifts had not been covered.

Staff described how they received supervision from the deputy service manager and found this beneficial. Trust data reported supervision at 22% and appraisal at 56%..

Mandatory training overall for the team was 97%.

Multi-disciplinary and inter-agency team work

Handover took place at the start of every shift and the team also had handovers with the crisis team at Upton Lea. There was a pager to summon staff to A&E and this was held by the shift co-ordinator and handed to the crisis team each night. One staff member was allocated to walk around the wards each day to speak with ward staff and monitor the mental health needs of patients.

Staff described how they made referrals depending on their assessment to a range of acute health, mental health, voluntary and social services. We spoke with a patient on one of the medical wards who was awaiting discharge. The patient described how staff had discussed options for further support and provided information for him to use post discharge. Staff often direct patients to external agencies and we saw a range of literature available to support this, for example, Cruise, Samaritans, MIND, and Rethink.

Adherence to the MHA and MHA code of practice

All staff had received training in the Mental Health Act, they had limited knowledge about the guiding principles of the Act. Staff were not aware of the recent changes to the code of practice. Staff informed us that if they had any concerns they would refer to the Emergency Duty Team.

Staff described how they do not get involved in Mental Health Act assessments. Support to the health based place of safety was completed by the crisis team at Upton Lea.

Good practice in applying the MCA

All staff had received training in the MCA.

Staff described how capacity and consent was dealt with by the medical staff on the wards and this was not seen as part of their role. There was no evidence in patient records that issues around capacity or consent were discussed with patients. One staff member advised us they would ring a colleague if they needed support and they had no awareness of any support mechanism provided by the trust with regard to MCA issues. Another staff member advised us they would contact the Emergency Duty Team. Trust policy does list consent, capacity and mental health act assessment as part of the role.

Good

Are services caring?

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

Summary of findings

Our findings

Crisis Resolution and Home Treatment Teams at Upton Lea, Chester (Cheshire West), Crisis resolution home treatment Team at Congleton Library (Cheshire East), Street Triage for Cheshire East biased at Upton Lea

Kindness, dignity, respect and support

Due to the nature of the service, we had limited access to people that use services service users during our visit. We accompanied one staff member on a patient visit and spoke with nine service users and one carer by telephone. We also looked at feedback that had been collected from the leaflets given to people who use services service users and carers in packs at the start of their treatment.

People had an opportunity to make comment on the service they receive on CQC comment cards prior to the inspection. We received 197 returned comment cards but there were no comments that specifically related to the crisis resolution home treatment team.

We observed staff speaking with service users by telephone, interactions were positive and friendly, staff allowed plenty of time for service users to respond to questions asked of them. . Service users reported that staff were quick to respond and were easy to contact. One service user described how a hospital admission had been arranged quickly, another commented on staff always being available when you needed someone. Some service users had regular daily visits and this could result in different staff members going out to see them. Most service users understood the reason for this and found all staff to be professional, supportive, respectful and caring. Only one service user made comment that seeing different staff had been difficult as they had needed to keep going over things with different staff members.

The involvement of people in the care that they receive

The service provided support to people who were experiencing an acute crisis or deterioration in their mental health. Staff provided a range of interventions to support the individual from needing an admission to hospital. This included regular face to face meetings at home or any other agreed venue or telephone contact.

At the start of treatment, service users and carers were offered a pack containing information to support their treatment care. This included telephone numbers of who to contact in a crisis and details of other supportive agencies both within the trust and externally.

Care plans were written in collaboration with people who use services, their family or carer as appropriate and with the consent of the person. The people we spoke with told us they felt involved in choices regarding their treatment and care. Crisis plans and care plans were contained within the daily notes of each service user. The level of detail contained within crisis plans varied: at Upton Lea the crisis plans we examined contained a telephone number to contact in a crisis, at Congleton we saw more detailed interventions on how people that use services could develop strategies to manage their levels of distress more independently. Only two people across both services told us they had been offered a copy of their care plan/crisis plan. We did not find anything in the records we examined to indicate that staff offered a copies to people who use services.

People who use services were offered family / carer support and acknowledged that details were contained in the pack they were given at the start of treatment. Carer feedback from the five questionnaires was mixed: Three out of five carers had been updated on changes to care plans, felt they had been involved in the assessment process and had treatment explained to them. Only one carer reported being informed of carer services and being offered a carers assessment. Additional comments included; ‘overall satisfied with help and consideration’, ‘support has been excellent’. There was no carers group, carers were seen on an individual basis as required.

Details of how to contact advocacy were contained in the pack given at the start of treatment. Of the people we spoke with; one advised they were not aware of advocacy services. Two were actively using advocacy services.

People who use services were not involved in staff recruitment.

Good

Are services caring?

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

The crisis home treatment team did not carry out a survey of service user or carer feedback. Feedback forms were contained within the pack given at the start of treatment.

Psychiatric Liaison at The Countess of Chester Hospital, Chester

Kindness, dignity, respect and support

Staff we spoke to had a good working knowledge of the service. Due to the nature of the service, we were not able to accompany a nurse during our visit .We did manage to speak with a patient awaiting discharge. He described how he had been admitted in the early hours of the morning. A member of the liaison team had visited him the next morning to assess his mental health and offer support.. The patient was known to mental health services and had a community psychiatric nurse within the CMHT. The nurse from the liaison team had advised on medication, provided some information for use post discharge and had advised they would update his GP and CPN regarding his admission. The patient described the liaison nurse as easy to talk to and very knowledgeable about medication. He was offered a private area to meet with the nurse.

The involvement of people in the care they receive

We viewed care records of four patients.

Patient involvement with liaison psychiatry was time limited due to the nature of the stay on a medical ward. We found care plans to be nurse led and directive in the interventions that would be delivered. We found little evidence of patient involvement within the records. Risk assessments were comprehensive and this allowed for signposting on to appropriate services post discharge with the potential for more long term treatment as required.

There was no formal method to capture patient feedback on the service they received.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Crisis Resolution and Home Treatment Teams at Upton Lea, Chester (Cheshire West), Crisis resolution home treatment Team at Congleton Library (Cheshire East), Street Triage for Cheshire East and West based at Upton Lea

Access and discharge

The crisis home treatment team philosophy was based on a belief that rapidly responding to service users and their support network at crisis point can facilitate improved outcomes. Risk of deterioration and harm to self and others can be reduced and this period is an ideal time to develop positive resolutions to distress.

Referrals to the service came from; community mental health teams, early intervention service, inpatient wards in order to facilitate timely discharge, emergency duty team, liaison psychiatry, accident an emergency, GP out of hour's service. Referrals were received by telephone directly to the shift co-ordinator on duty and were considered strictly against service criteria. The teams offered advice and information to any referrals that did not meet the criteria. The service operated 24 hours a day, seven days a week.

Trust policy stated that crisis teams aim to respond to urgent assessments within one hour. Both teams were aware of this and shift co-ordinators triaged all calls and completed a standard telephone assessment to categorise clinical response according to priority and need. Teams reported their response times in different ways; at Upton Lea, a record book was used to record a number of statistics around referral and treatment times and options. At Congleton, times were recorded on individual patient referral and assessment records but there was no central point to collate the information. The records we viewed showed response times were within the target times. Both teams were able to demonstrate the referral process and show us individual records with regard to referral to triage and further assessment. There was no standard format for collating, analysing or evaluating any information with regard to the efficiency of the referral or treatment process.

We spoke with staff at The Countess of Chester Hospital who told us that people who presented at A&E under 136 detentions by the police were registered as a patient of The Countess of Chester Hospital. The hospital records time of arrival, time the Emergency Duty team were called, the time of attendance of the approved mental health practitioner and doctors involved in the assessment process. This information was detailed within the patients' notes with any supplementary information regarding delays or other issues. The A&E department also completed aspects of paperwork regarding detention for the attending police officers.

The Crisis Care Concordat lists a range of information that should be collated and monitored for each place of safety used: sociodemographic characteristics, mode of transport, transfers between places of safety, time taken for MHA assessment, time the police remained at the place of safety, time taken to complete assessment, outcome of assessment, total time spent in place of safety and any serious untoward incidents. The information should be collated and used by the multi-agency group to review service provision and should be available to the Care Quality Commission during the inspection process. We were not able to locate any central point for the collation of this information to support monitoring and evaluation. We asked for this centrally collated information from several sources including crisis teams, A&E, street triage and liaison psychiatry. Each service was only able to provide information specific to individual service users within their care.

The crisis teams act as gatekeepers to the acute services provided within the trust. We saw evidence of daily links with the wards. Bed numbers were monitored throughout the day by daily attendance on the wards by a member of the crisis team nominated by the shift co-ordinator and regular email updates by the bed managers. It was rare that an inpatient bed could not be made available but on occasion service users might be admitted by wards in other areas of the trust. There was no information available to support this.

The wards started to plan discharge arrangements for patients from admission. This process helped to ensure patients were only in hospital for the shortest possible duration. The crisis team had daily contact with the wards and offered input into treatment options that might be

Are services responsive to people's needs?

Good

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

available by the crisis resolution home treatment teams to facilitate timely discharge from hospital. This also included support during periods of agreed leave from the wards prior to discharge.

Staff described how they took additional steps to engage with people who use services. When people do not answer to a staff member at the door, the team will make phone calls to try and get a response. Staff might also contact other significant people involved in their care or visit places they tend to go if safe to do so. If they had concerns for an individual they would consider contacting the police.

Appointments were arranged or confirmed at the start of each shift by the team and collated by the shift co-ordinator. The requests of service users were taken into account when planning visits. Care and treatment was reviewed each day by the team and visits were prioritised based on clinical need. During periods of sudden staff shortages due to sickness, visits were always arranged to ensure those service users rated as high priority were seen face to face. Staff explained how they phone people if appointment times might need to be changed at short notice. The service users we spoke with told us staff were mostly available, easy to contact and advised them if their appointment time was changed or if they were running late.

The facilities promote recovery, comfort, dignity and confidentiality

Most service users were seen by the crisis home treatment in team in their own homes to support on going care and treatment during a crisis period. The teams worked flexibly to support the needs of the patient and agreed to meet in other places by prior arrangement.

The crisis and home treatment team at Upton Lea rarely saw patients at the team premises however, there was an interview room available for staff to use. The room was well furnished, clean, and safe and appeared sound proof. There was an alarm system fitted to allow staff to summon assistance if required. Staff told us they never have to wait for a room to become available. The rooms were suitable to be used by people with physical disabilities.

The crisis team at Upton Lea do not see service users on the premises.

At the start of treatment, people who use services and carers are offered a pack containing information to support their treatment care. This included telephone numbers of who to contact in a crisis, how to make a complaint, contact advocacy and details of other supportive agencies both within the trust and external to the trust.

Meeting the needs of all people who use the service

Staff had access to interpreting services and services for people with visual impairment or hearing difficulties. We saw information displayed detailing how staff could access support as required. None of the people we spoke with were in need of these services. Individual, cultural and religious beliefs were taken into account and demonstrated by the content of care plans and observation within handover. People told us how information they received was easy to read and understand.

Listening to and learning from concerns and complaints

Information we received from the trust listed five complaints from mental health crisis services and health based places of safety received in the last 12 months. One of the complaints was upheld and none were referred to the ombudsman. The teams we visited did not have a record of complaints received to share with us. Details of how to complain were contained within the information pack given to service users and carers at the start of treatment. Four of the service users we spoke with did not know how to complain, one told us they did not feel confident to make a complaint.

Staff understood the complaints process and where to access further information.

Staff members described how details of learning and changes in practice from incidents was circulated to teams by the trust through email in a regular bulletin. This was also a regular agenda item on team meetings. An example of a change in practice occurred following a complaint from a carer who had changed the visiting address for her family member whilst she visited her parents over the weekend. Despite being informed of the changes, staff had attempted to visit the service user at their home address. This had prompted an apology from the acting team leader and discussion with the team on how changes were updated on the system and handed over each shift.

Are services responsive to people's needs?

Good

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

Psychiatric Liaison at The Countess of Chester Hospital, Chester

Access and discharge

Trust policy described liaison psychiatry as the sub-speciality that focused on the interface between psychological and physical health. The service provided specialist assessment and interventions for patients undergoing assessment and treatment in hospital settings, both inpatient and outpatient.

Referrals were made by telephone, letter or electronic referral according to locally agreed procedures. They were recorded in a referral book and submitted monthly for analysis and evaluation. Categories were: emergency- respond within 1 hour, urgent- same working day if received prior to 11.30am or next working day if after 11.30am, routine- not usually exceeding 7 days, outpatient- less than 13 weeks. Information was collated using a record book and this was used by the Countess of Chester Hospital to monitor assessment outcomes.

The team accepted referrals for patients over 65 who have a functional mental health problem. There was a dementia service operated by The Countess of Cheshire Hospital to support patients over 65 with organic mental health problems, however this did not include patients who do not live in the catchment area. This caused confusion to ward based staff and had generated inappropriate referrals to the team. The team also supported referrals from the Ellesmere Port hospital..

Following initial assessment, the team made a decision with regard to treatment options.

The facilities promote recovery, comfort, dignity and confidentiality

Patients were mainly seen on the wards or in accident an emergency departments. The room designated for 136 detained patients may be utilised if not in use or there were other rooms in A&E departments that could be made available. Staff told us that patients were always offered a private place to meet with staff where physical health conditions allow. The one patient we spoke with confirmed that he had been offered a private meeting place.

Meeting the needs of all people who use the service

We saw a wide range of leaflets available to patients to support their on going care and treatment. Examples of this were details on: Cruise, Samaritans, advocacy, how to complain, medication leaflets, who to contact in a crisis and accessing support with communication with language or disability.

Listening to and learning from concerns and complaints

The service had not received any complaints in the last 12 months. Staff had an understanding of the complaints process and how to advise patients to make a complaint. Staff members did not recall any patients wanting to make a complaint.

Feedback on any complaints or investigations was communicated through the trust bulletin and shared in weekly team meetings as part of the agenda.

Are services well-led?

Good

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

Summary of findings

Our findings

Crisis Resolution and Home Treatment Teams at Upton Lea, Chester (Cheshire West), Crisis resolution home treatment Team at Congleton Library (Cheshire East), Street Triage for Cheshire East biased at Upton Lea

Vision and values

Staff we spoke with had an awareness of the organisations vision and values. We saw posters displaying the six C's; Courage, Care, Compassion, Commitment, Competence and Communication and staff made reference to these when asked.

Staff we spoke with were aware of some of the more senior managers in the organisation but they did not see them very often and were not able to recall the last time they had visited.

Good governance

The trust had identified improvements to data quality on the trust risk register. Part of the action to support this was the production of a locality data pack to all teams and these packs had recently been supplied to team leaders. The quality of the information used to produce the data was questioned by the team managers; however they did not have evidence available to support their views. The data used to produce the information below was taken from the locality data packs.

Mandatory training at Upton Lea was at 75% overall but the element of training requiring renewal at 1 year was 48% (infection control 44% and Information governance 53%)and 3 year renewals at 69% (breakaway training 52%). At Congleton mandatory training was 96% overall.

Supervision and appraisal at Upton Lea 11% of staff were reported to be having supervision and 7% had been appraised in the last 12 months. At Congleton 59% of staff were reported to be undertaking supervision and 90% of staff had been appraised in the last 12 months.

There was a lack of reporting, analysis and evaluation around the numbers of referrals taken and the efficiency of how this was translated or referred on to more appropriate services. This did not support systems to ensure workloads and efficiency were maximised to support the needs of people who use services.

We viewed minutes from the Pan Cheshire Strategic Mental Health Board and the action plan detailed progress in implementing the Crisis Care Concordat. The meeting was attended by a number of agencies.

Staff knew how to report incidents and learning was shared by the trust through the regular bulletin and a regular agenda item at team meetings.

Staff were not always able to describe the guiding principles of the Mental Health Act or the Mental Capacity Act but we did see evidence of both Acts in action within handovers, assessments and care plans. Staff had an understanding of safeguarding procedures and recognised that they had access to the full family situation when visiting service users in their homes. They knew how to raise an alert and who to contact within the trust or local authority.

Leadership, morale and staff engagement

Staff reported that local managers were approachable and supportive.

The team at Upton Lea had been through a period of change and some staff reported that recent changes had seen staff with lots of experience leave the team. There had been a 50% turnover of staff which included a new deputy service manager and acting team leader. All vacancies had been filled and the new team was embedding the new shift patterns, additional night cover, work with street triage and use of the interactive white board to manage workflow. Some staff members we spoke with reported not being involved in some of the decisions to make changes to the service and did not feel their views were listened to. All staff acknowledged there had been big changes in the team and there had been a period of alignment to take the new ways of working on board.

At Congleton, the team was more established and located separately from any of the hospital buildings. The team had developed a separate pool of bank workers who often stepped in at short notice to help out during staff shortages. The team described good morale within the team with regular meetings which kept them up to date with current issues. The staff told us they felt well managed and supported.

Are services well-led?

Good

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

The street triage team were a small team mainly working opposing shifts. There was a team manager who also acts as forensic lead for the trust. The team were working as part of a one year pilot and were six months into the scheme.

Commitment to quality improvement and innovation

The CRHT across the Cheshire and Wirral Trust did not appear to have regular contact with the other team. We observed teams having strengths in different areas:

At Upton Lea the Crisis Care Concordat was being implemented and the team had experienced changes to practice to support this process. Supervision and appraisal was not embedded into the team and some team members were still unsure about the changes in practice and did not always feel they had a voice in the decision making process.

At Congleton, the team were challenged due to the remote nature of their location. The team were in receipt of regular supervision and appraisal and felt well informed and involved in the decision making process. They had established ways of working and an experienced team but no aspiration to participate in national accreditation schemes.

The street triage team were working within a one year pilot scheme undergoing regular evaluation.

We did not inspect the the Crisis Resolution Home Treatment Team based at Springview Hospital, Clatterbridge (Wirral). This team had received accreditation through the Home Treatment Accreditation Scheme by the Royal College of Psychiatrists..

The trust acknowledged that there was work underway to enhance the skills of appraisers, supervisors and line managers. This would ensure responsibilities were clear and that quality, performance and risks were understood and managed to assure delivery of high quality person centred care.

Crisis care team managers acknowledged that teams had different ways of working. There had previously been meetings of team managers on a quarterly basis but there was no current link to unite the teams and share best practice and learning from incidents.

Psychiatric Liaison at The Countess of Chester Hospital, Chester

Vision and values

Staff we spoke with had an awareness of the organisations vision and values. We saw posters displaying the six C's Courage, Care, Compassion, Commitment and Communication and staff made reference to these when asked.

Staff we spoke with were aware of some of the more senior managers in the organisation but they did not see them very often and were not able to recall the last time they had visited.

Good governance

This was a small team consisting of five staff members which included the acting team leader. The team leader spents two days per week undertaking work elsewhere within the hospital and community. The deputy service manager supported the team with supervision which staff felt was beneficial. The locality data pack reported supervision rates at 22% and appraisal rates at 56%. Mandatory training levels were high at 97%.

There was a monthly reporting process to monitor referrals and response times by the Countess of Chester Hospital however staff advised they were not aware of this and information was not shared with them. The team did not feel involved in decisions about the service and told us they have recently been made to move into a small office next to the accident and emergency department. Whilst they did not support the move, they could see the benefits of being located close to the accident and emergency department.

Leadership, morale and staff engagement

The team were located in an office close to accident and emergency at The Countess of Chester Hospital. They worked with staff on the wards to deliver support with mental health problems identified by medical staff. The team had recently reduced in size and staff felt this had impacted on the delivery of care. The acting team manager worked in other areas of the hospital for two days a week and the team was supervised and appraised by the deputy service manager.

Staff reported low morale within the team at present but described enjoying their role and they are normally a happy team.

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.

Commitment to quality improvement and innovation

The liaison psychiatry team at the Countess of Chester Hospital do not participate in any national accreditation schemes.

The liaison psychiatry team at Arrowe Park Hospital had received accreditation through the Royal College of psychiatrists as excellent with renewal due August 2015.

There was no forum for the sharing of best practice between liaison psychiatry teams.